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PATIENT INFORMATION- ***PLEASE PRINT***

First Name	Middle Name	Last Name
Social Security	Date of Birth	Age
Gender	Marital Status	Race
Address		
City	State	Zip
Student Status:	Work Status:	Email Address:
Home Phone #:	Work Phone #:	
Cell Phone #:		
Emergency Contact Name:	Emergency Contact Relation:	Emergency Contact Phone #:
Referred By:		
Pharmacy Name and Phone #:		

RESPONISBLE PARTY

(Who is responsible for paying your medical bills?)

Self? Yes or No (If no, please provide details below)		
Relationship to patient:		
First Name	Middle Name	Last Name
Address		
City:	State:	Zip:
Phone #:	Cell Phone #:	Email Address:

Do you have Power of Attorney? Yes or No	If yes, Name:	Phone #:
Do you have DNR (Do not Resuscitate)? Yes or No	Do you have a Living Will? Yes or No	
Do you have any special requests from the physician regarding care at the end of life?		

Baba Health Care, Inc
Dr. Geetha Priyanka, M.D.
948 S. Wickham Rd. Ste 101
West Melbourne, FL. 32904
P. 321-956-7370 F. 321-956-7873

Policies of the Office

1. Our office hours are: 8:00AM - 6:00PM | Monday – Friday
2. All payments and/or copays are due at the time of service. We accept all credit and debit cards, along with cash and check. There will be a return check charge of $40.00.
3. We ask the patient or family to contact our office 24 hours prior to canceling an appointment. If three (3) missed appointments occur, it will result in being discharged from the practice. If you miss an appointment and do not contact our office to cancel it, you will be charged a missed visit fee of $25.00.
4. We advise you to contact our office AT LEAST five (5) days prior to running out of medication. No pain medications will be refilled without seeing the provider. We require you to be seen monthly if we prescribed any controlled medications.
5. If you are more than 15 minutes late to your appointment you might ne asked to reschedule to a different day.
6. NO medications will be called in after hours or on the weekends!!! THERE IS NO EXCEPTION TO THIS POLICY SO PLEASE MAKE SURE YOU HAVE ENOUGH MEDICATION TO LAST THROUGH THE NIGHT/WEEKEND.
7. The PATIENT is responsible for the selection of correct laboratory, radiology, imaging facility and hospital that is acceptable per your insurance company. We can give you recommendations but we will NOT be responsible if your insurance does not cover it. If you are unsure of where to go, please contact your insurance company.
8. Patients need to bring a list of all prescribed and over the counter medications you take routinely so we can update our records.
9. All patient telephone calls will be handled by the office staff so please give them a detailed message. If needed the provider will call you, but majority of the time it will be the staff calling you back.
10. No lab or radiology results will be given over the phone. You will need to come in for a follow up to review your results.
11. If you are referred out to a specialist, please make sure you get the specialist name and phone number prior to leaving the office. If you do not hear back from the specialist within five (5) business days please give them a call to get your appointment scheduled.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

Authorization to Disclose Medical Information

Identifiable Health Information may be disclosed for use of Healthcare Providers involved in the Patient's Care.

Information to be disclosed: All General Medical Records

_____ Yes, I authorize providers involved in patient care to access a health information network portal and review my general medical records. Note: If these records contain any information from previous providers or information about drug/alcohol abuse, genetic test results, HIV/AIDS status, mental health, sexually transmitted disease, or tuberculosis, you are hereby authorizing disclosure of this information.

_____ I understand that my General Medical Records might include sensitive information and specifically authorize disclosure excluding psychotherapy notes. (Please initial to conform authorization).

_____ No, I do not authorize disclosure of my General Medical Records.

Purpose of Disclosure

X Continuity of Care __ Consult Other (specify) _____

Expiration Date: This authorization will expire (insert date of event) _____. I understand that if I fail to specify an expiration date of event, this authorization will be for life.

Patient's Rights and Responsibilities Statement

I acknowledge that I have received the Patient's Right and Responsibilities Statement.

Patient Signature: _____ Date: _____

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Medical Records Release

I hereby authorize: Provider/ Company Name: _____

Address: _____

Phone #: _____ Fax #:_____

Consent for release of Medical Information including HIV, AIDS, Psychiatric, and substance abuse.

I hereby authorize the above name physician/hospital/facility to release information including, if any, psychiatric or psychological information _____, infections or contagious disease information (including HIV/AIDS) confidential information_____, and or information about drugs or alcohol abuse or treatment _____, of same from health record(s): TO RELEASE MY: _____ COMPLETE MEDICAL RECORDS, _____, OTHER (as described):

_____

_____

_____

As soon as possible, to BABA HEALTHCARE, INC to the above address and/or fax.

_____
Patient Signature:

_____ _____
Printed Patient Name: DOB:

_____
Street Address: City, State, Zip Code:

_____ _____
Phone Number: Social Security Number:

_____ _____
Witness Signature: Date:

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Family and Social History

Do you or your family have any problems with:

	Yes/No	Who?		Yes/No	Who?
Heart			Auto Immune Disease		
Blood Pressure			Arthritis		
Diabetes			Osteoporosis		
Bleeding Disorder			High Cholesterol		
Cancer			Other		

Tobacco Use/Alcohol Use/Substance Abuse

Tobacco Use (Circle One) **None** **Chews** **Currently Smoking** **Prev Smoker** _____**packs/day**
Notes:
Alcohol Use (Circle One) **None** Previously Occasional **Moderate to Heavy** _____ **per/day**
Notes:
Substance Abuse History (Circle One) **Yes** **or** **No**
Notes:

Allergies

Medication Allergies	Reaction	Mild	Moderate	Severe
Food and Environmental Allergies				

Prescribed Medications and OTC

Current Medication	Strength	Dose	Frequency

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Patient Name: _____ DOB: _____

PERMISSION FOR TREATMENT

I, undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by BABA HEALTHCARE, INC. deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me because of treatment or examination in the office.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize BABA HEALTHCARE, INC. to furnish information to Medicare/Insurance carriers concerning my condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) Insurance Carrier(s)/Medicare to make payment directly to BABA HEALTHCARE, INC. for medical/diagnostic surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable to me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for any charges incurred if my account is sent to a collection agency or for any returned checks.

DESIGNATED RELATIVE

I have designated Mr./Mrs./Ms. _____

Relationship to Patient: _____

Phone #: _____

For the release of my health information/ medical status if needed in the future.

PATIENT PRIVACY QUESTIONARE

Please list the family members or significant others, if any, whom we may inform about your medical condition and diagnosis (including treatment, payment and healthcare) in case of emergency.

1. Name: _____ Relationship: _____

   Phone #: _____

2. Name: _____ Relationship: _____

   Phone #: _____

Can confidential messages be left on your voicemail? YES or NO

Patient Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

Preventative Screening

Exam Name:	Date:	Results: Normal/Abnormal	Exam Name:	Date:	Results: Normal/Abnormal
Last Physical:			Females Only: Last Mammo		
Last Eye Exam:			Females Only: Last Breast Exam		
Last Rectal Exam:			Females Only: Last Papsmear		
Last Stool Occult:			Last Colonoscopy:		
Last Flu Shot:			Last PPD:		
Last Pneumonia Shot:			Males Only: Last PSA		
Last PT/INR			If abnormal please explain treatment:		
Last Dexa/Bone Scan:					

Past Illness History (IE: Cancer/Shingles, etc.)

Illness Name	**Date**	**Result/Outcome**

Past Surgical History

Surgery	**Date**	**Result/Outcome**

OB/GYN History

Age of Menstruation	Last Menstrual Date	H/O Fibroid/Cyst	H/O Endometriosis
H/O Cancer	Abortions		
Child Births-When	Where	Mode of Birth	Complications
Miscarriages- Why	When	Complications	

Current Medical History (please list any current medical history you would like to discuss with provider)

INSURANCE INFORMATION- ***PLEASE PRINT***

Primary Insurance		
Insurance Company Name:	Insurance ID:	Group #:
Relationship of Insured to Patient?		
Secondary Insurance		
Insurance Company Name:	Insurance ID:	Group #:
Relationship of Insured to Patient?		
Teritary Insurance		
Insurance Company Name:	Insurance ID:	Group #:
Relationship of Insured to Patient?		

NOTICE

Please be advised that all patients with insurance that requires pre-authorization for any specialist visit or procedure, should contact the office at least 4 days prior to your appointment to ensure proper authorization has been received. Your insurance company will not hold this office responsible for non-coverage if you fail to comply with the above listed guidelines.

Patient Name: _____

Signature: _____

Date: _____