*Please fill out all sections of forms, if not applicable write N/A

Dr. Das will review all new patient paperwork to determine if he can assume your care at this time. If so, we will contact you for scheduling. If he is unable to do so, we will contact you to advise another provider.

Rajive K Das MD Potential New Patient Forms Today's Date: _____

Patient Information:

Patient Name: First_____MI _____Last _____ **Sex: Male / Female**

Date of Birth: _____ **Social Security Number:** _____

Address: Street _____ City _____ State_____Zip_____

Phone: Home_____ Mobile_____

Email _____ **Name of Spouse:** _____

What is preferred method of contact? ☐ Home phone ☐ Mobile phone

Check if you would like to **OPT OUT** of receiving text appointment reminders. ☐

Race: check mark which is appropriate.

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Black or African American ☐ White

☐ Other Pacific Islander ☐ Prefer not to answer.

Ethnicity: Check mark which is appropriate

☐ Hispanic/ Latino ☐ Non-Hispanic/ Latino ☐ Prefer not to answer.

Preferred Pharmacy:

Name: _____

Phone number: _____

Address: _____

Insurance Information:

Primary Insurance Co: _____ Policy #: _____

Policy Holder's Name _____ DOB: _____

Social Security Number of policy holder: _____

Address: _____

Secondary Insurance Co _____ **Policy #:** _____

Complete if not same information as policy holder:

Policy Holder Name: _____ **DOB:** _____

SSN: _____

Address: _____

Complete below if patient is a minor:

Mother's Name (or Guardian) _____ DOB: _____

SSN: _____ Cell Phone: _____

Address: _____

Father's Name (or Guardian)

SSN: _____ Cell Phone: _____

Adress: _____

Medical History: Please fill out all sections to the best of your ability.

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY ARE TAKING

Please list any **allergies** or reactions to medications: _____

Please list any **allergies** or reactions to food: _____

Please check to indicate if you have ever had the following condition in the past;

Underline if this condition is current and/or you would like Dr Das to address it with you:

- Stroke
- Seizures
- Memory loss
- Anxiety
- Depression
- Arrythmia
- Heart Attack
- High Blood Pressure
- Congestive Heart Failure
- Coronary Artery Disease
- Asthma
- COPD
- Thyroid Disease
- Diabetes
- Kidney Disease
- Hepatitis
- Urinary Infections
- Breast Pain/Lump
- Vaginal Infections
- Period Problems
- Acne
- Sexually transmitted disease-type:
- Skin problems-type:
- Other, please explain:

What is your main reason for seeing Dr. Das?

_____

Please list any surgeries or hospitalizations you have had and there approximate date/year:

Type of surgery/reason for hospitalization/location

_____

Are you currently receiving care from any other doctors?

Providers Name condition being treated for

_____

_____

_____

Please note dates of your most recent immunizations:

Tetanus: _____ Pneumonia: _____

Covid-19: _____ Influenza: _____

Hepatitis B: _____ Other: _____

When was your last physical?

_____

If you have had any of the following tests done, please note when the test was done and the result was, if known:

Colonoscopy/ Cologuard: _____ Mammogram: _____

Pap smear/pelvic exam / _____

SWAB FOR Pelvic HPV, Chlamydia: (Recommended for Any Age, if you have been sexually active)

Date (approximate)_____

STI screen by Blood Work: _____

Cholesterol: Sugar, A1C _____

Family History: Circle ones that are applicable.

- Alcoholism/Drug use
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Osteoporosis
- Mental Illness
- Stroke
- Thyroid Disease
- Other:

Health Habits:

Do you smoke or use any tobacco products?

- Yes
- No
- Quit

Do you drink alcohol?

- Yes
- No
- Quit

Have you regularly used other drugs?

- Yes
- No

Sexual History: circle what is applicable.

- Are you sexually active? Prefer Not to answer Yes No
- With: Men Women Both Prefer Not to Answer
- Any history of previous sexual abuse or trauma? Yes No
- Do you feel like you are at risk of HIV/AIDS? Yes No
- Do you have children? Yes No
- How many?_____
- Do you use any form of Birth Control? Yes No

Women only: check what is applicable.

Have you ever been pregnant? ☐ Yes ☐ No

How many times? ☐ Live Births ☐ Miscarriages ☐ Abortions ☐

Do you have menstrual periods? ☐ Yes ☐ No First Period: _____

If not, at what age did they stop? _____

If yes, are your periods regular? _____

Gynecologist: _____ Other Comments: _____

Personal History: check mark what is applicable.

Are you currently married or living with a significant other? ☐ Yes ☐ No

Who lives with you at home? _____

☐ House ☐ Apartment ☐ Condo ☐ Assisted Living ☐ Other

Are you employed? ☐ Yes ☐ No

If yes, what kind of work do you do? _____ Employer _____

If not, is this by choice? _____ Disability? _____ Other reason _____

Birthplace _____ **Education** (Highest level) _____

Do you exercise more than 3 times per week? ☐ Yes ☐ No Type of Exercise: _____

Do you have little interest or pleasure doing things? ☐ Yes ☐ No

Do you often feel down, depressed, or hopeless? ☐ Yes ☐ No

Are you having money problems which limit your access to food, shelter, or medical care? ☐ Yes ☐ No

In the last year, has there been any major changes in your life like marriage, divorce, death of a family member or close friend, illness, injury, or change in job situation? ☐ Yes ☐ No

How did you hear about us? ☐ Online ☐ Insurance company ☐ Referred by:

I certify that the information given by me in applying for payment under my insurance contract [including tax xviii of the social security act] is correct. I authorize release to my insurance carrier, employer, other pertinent **Physicians, Hospitals or Laboratories**, any information needed. This includes copies of records, diagnosis, treatment plans, bills, or any pertinent information. By signing this form, I am consenting to Rajive K Das MD's use and disclosure of my **PHI** to carry out **TPO.** I request that payment of authorized benefits be payable to Rajive K Das MD. I also give permission to Dr. Das's office to submit claims to my insurance carrier, including Medicare.

I understand that I am financially responsible for all charges for services to me including any balance remaining after payment of possible insurance benefits. This authorization and assignment is to be continuing one, **remaining in force until revoked in writing** by the undersigned for services beginning.

Notice of Consent: If patient is a minor and comes in unattended by parent/guardian (example: a minor who can drive to the office or was brought by a friend/relative) and physician deems any medical treatment or procedure the undersigned agrees to it.

Signature: _____ **Date:** _____

Signature of Legal Guardian (if Minor): _____

Updated 02/29/24