Prime Health Medical - Radhika S. Remadevi, MD | **(973) 500-2686** | **Date:_____**

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (FIRST -- MIDDLE INITIAL -- LAST)

ADDRESS	**CITY**	**STATE**	**ZIP**

MOBILE PHONE	**HOME PHONE**

EMAIL	**PREFFERRED METHOD OF COMMUNICATION** ❑ Email ❑ Mobile Phone ❑ Home Phone
HOW DID YOU HEAR ABOUT US? ❑ Internet: _____ ❑ Referral: _____ ❑ Other: _____	**PREFERRED LANGUAGE** ❑ English ❑ Other _____

PATIENT DOB (MM/DD/YYYY)	**PATIENT SSN**	**SEX** ❑ Male ❑ Female	**MARITAL STATUS** ❑ Single ❑ Married ❑ Other_____

ETHNICITY/RACE-choose one or more

❑ **American Indian/Alaska Native** ❑ **Asian** ❑ **African American** ❑ **Hispanic or Latino** ❑ **Native Hawaiian/Pacific Islander** ❑ **White**

❑ **Other**_____ ❑ **Patient Declines to Specify**

PATIENT EMPLOYER NAME	**EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**	**EMPLOYER PHONE**

EMERGENCY CONTACT INFORMATION

NAME	**RELATIONSHIP**	**ADDRESS**	**PHONE**

PHARMACY INFORMATION

PHARMACY NAME	**PHARMACY ADDRESS**	**PHARMACY PHONE**

INSURANCE

ARE YOU THE PRIMARY INSURED?

❑ Yes ❑ No (If **no**, please fill out the box below)

GUARANTOR INFORMATION

RELATION TO PATIENT: ❑ Spouse ❑ Parent/Guardian ❑ Other

NAME (FIRST -- MIDDLE INITIAL -- LAST)	**ADDRESS (If different from patient)**

PRIMARY PHONE	**SECONDARY PHONE**	**SSN**	**DATE OF BIRTH**	**SEX** ❑ Male ❑ Female

EMPLOYER NAME	**EMPLOYER ADDRESS (STREET ADDRESS- CITY- STATE- ZIP)**	**EMPLOYER PHONE**

PRESCRIPTION HISTORY RETRIEVAL & FINANCIAL POLICY

❑ I hereby give consent for the retrieval of my prescription history in its entirety. ❑ I **do not** give consent for the retrieval of my prescription history.

ASSIGNMENT AND RELEASE:

Insured Patients • I hereby authorize that I have given the office accurate and complete insurance information to the best of my knowledge. I agree to pay any and all deductibles, co-payments and/or coinsurance at the time services are rendered. I understand that all benefits are paid directly to Prime Health Medical and that I am financially responsible for any services that may be deemed as not covered or not medically necessary by my insurance company. If payment is not received from my insurance company within thirty (30) days, I understand that I am fully responsible for the balance due. I agree to pay any and all collection and attorney fees in the event that an over-due balance is not paid. **Overdue and Credit Balances • All 90 days over-due patient balances will be charged a late fee of $25 and in the event they are sent to a collection agency, a collections fee of 30% is charged in addition to the account balance as well as any interest accrued.**

Self-Pay Policy • I hereby authorize that I am responsible for any fees associated with medical care given by this facility and Radhika Remadevi, MD. I agree to pay for the office visit before services are rendered. I understand any and all lab work done is also my responsibility and balances are to be paid directly to the lab.

I understand that in order to receive the best medical care, I should not discuss any billing or financial aspects with the physician(s) or medical staff. All questions/concerns should be discussed with my insurance company or Prime Health Medical's billing staff.

SIGNATURE (Patient or, if minor Signature of Parent or Guardian)	**DATE**

Prime Health Medical - Radhika S. Remadevi, MD Date: _____

PATIENT MEDICAL HISTORY

PATIENT NAME (FIRST-- MIDDLE INITIAL -- LAST) **AGE**

Allergies:

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Environmental ❑ Iodine/Shellfish/Contrast Dye ❑ Latex ❑ Morphine
❑ Penicillin ❑ Sulfa Drugs ❑ Seasonal ❑ Wheat
❑ Other: _____

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	**FATHER**	**SIBLING (Brother/Sister)**
High Blood Pressure			
High Cholesterol			
Heart Problems			
Cancer			
Diabetes			
Thyroid Disorder			
Stroke			
OTHER (please specify)			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (Reason: _____)

Do you drink alcohol? -- ☐**Yes** ☐**No** ☐**Former -** If **Yes**, ☐ Daily ☐ Weekly ☐Infrequently **OR** ☐ Recovering Alcoholic

Do you use tobacco? -- ☐**Yes** ☐**No** ☐**Former -** If **Yes**, ☐ Smoke (___ cigarettes per day) ☐ Chew **OR** Number of Years Quit_____

Major Events: Please list any hospitalizations (including child birth), surgeries, fractures or major illnesses you have had.

EVENT	**DATE or YEAR**

Implantable Devices: Do you have or have you ever had an implantable device placed in your body? ☐**Yes** ☐**No**
If **Yes**, please list any/all devices here: _____

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed ❑ Chest Pain ❑ Hypertension ❑ Organ Injury
❑ Allergies ❑ Congestive Heart Failure ❑ Hypothyroidism ❑ Osteoporosis
❑ Anemia ❑ Chronic Fatigue Syndrome ❑ Insomnia/Sleep Problems ❑ Pulmonary Embolism
❑ Arthritis Conditions/Joint Pains ❑ Coronary Artery Disease ❑ Irritable Bowel Syndrome ❑ Shortness of Breath
❑ Asthma ❑ Depression/Feeling Down ❑ Kidney Problems ❑ Sinus Conditions
❑ Atrial Fibrillation ❑ Diabetes ❑ Migraines/Headaches ❑ Seizure Disorders
❑ Bleeding Problems ❑ Fibromyalgia ❑ **OTHER** _____
❑ BPH ❑ Heart Disease _____
❑ Cancer _____ ❑ High Cholesterol / Hyperlipidemia

Prime Health Medical PHQ:

1) During the past month, have you often been bothered by feeling down, depressed or hopeless? ❑ **Yes** ❑ **No**
2) During the past month, have you often been bothered by little interest or pleasure in doing things? ❑ **Yes** ❑ **No**

Medications: List any medications-including OTC medications- you are currently taking. **PLEASE PRINT LEGIBLY – NO CURSIVE**

MEDICATION DOSAGE

_____
_____
_____
_____

NOTES: (For physician use only)