New Patient Paperwork

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security Number: _____ Sex: ☐ Male or ☐ Female

Employer: _____ Work Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
If married, Spouse's Name: _____

Do you have a Power of Attorney? ☐Yes or ☐No Do you have a Living Will? ☐ Yes or ☐No
If yes, who: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Copays and Deductible Payments are due at the time of service – please refer to the Financial Agreement. In the event of an outstanding balance, please feel free to ask our office staff about setting up a payment plan. If you are unable to make these payments your appointment will be rescheduled unless otherwise determined by Dr. George Koppuzha MD.

	Primary Insurance		Secondary Insurance
Subscriber	_____	Subscriber	_____
Policy Number	_____	Policy Number	_____
Group Number	_____	Group Number	_____
Insured's DOB	_____	Insured's DOB	_____

Patient: _____ Date of Birth: _____

Medical History

☐	Asthma	☐	Gallstones	☐	Stroke
☐	Angina/Chest Pain	☐	Heart Attack	☐	Thrombophlebitis
☐	Anemia	☐	Heart Murmur	☐	Thyroid Disease
☐	Arthritis	☐	Headaches	☐	Tuberculosis
☐	Glaucoma	☐	Hepatitis	☐	Ulcers
☐	Cancer	☐	High Blood Pressure		
☐	Chronic Bronchitis	☐	High Cholesterol		Other – Please List Below
☐	Cirrhosis	☐	HIV + / Aids		_____
☐	Clotting Disorder	☐	Kidney Disease		_____
☐	Diabetes	☐	Kidney Stones		_____
☐	Emphysema	☐	Migraines		_____
☐	Epilepsy	☐	+ TB Test		_____
☐	Fractures	☐	Rheumatic Fever		_____
					_____

Family History

If any blood relative has ever had any of the following, please check box and indicate relationship		Relationship	Please indicate the age and either L or D for each of the following	L = Living D = Deceased Age
☐	Blood Tendency	_____	Father	_____
☐	Cancer	_____	Mother	_____
☐	Diabetes	_____	Siblings	_____
☐	Heart Attack	_____		_____
☐	Heart Disease	_____		_____
☐	High Blood Pressure	_____		_____
☐	Kidney Disease	_____		_____
☐	Liver Disease	_____		_____
☐	Migraine/Headaches	_____		_____
☐	Stroke	_____		_____
☐	Tuberculosis	_____		_____

Operations and/or Hospitalizations

Reason	Date	Reason	Date

Medications

List all prescriptions and over-the-counter medications, supplements and vitamins you take including the dose/strength.

Medication	Dose	Frequency

Generic Allergies: _____

Medication Allergies: _____

Preferred Pharmacy: _____

The easiest, most efficient and most accurate way to refill prescriptions is by contacting your local pharmacy directly. The pharmacy will then send us an electronic prescription request that we will review. There is a 48-hour turnover rate for prescription renewals so please monitor your medications and call in **before** you run out.

Habits

☐ Smoking Packs Daily? _____
How Long? _____
Interested in stopping? ☐ Y ☐ N
If you quit, when did you quit?
_____
How long did you smoke?
_____

☐ Coffee Cups Daily? _____
Other Caffeine: _____
☐ Alcohol Type: _____
Frequency: _____
Amount: _____
Diet: Salt Intake:_____
Fat Intake: _____

Sleep: Snoring ☐ Y ☐ N
Daytime Drowsiness ☐ Y ☐ N
Difficulty Falling Asleep ☐ Y ☐ N
Continuity Disturbances ☐ Y ☐ N
Early Morning Wakening ☐ Y ☐ N
Other: _____

Do you exercise routinely? ☐ Y ☐ N What do you do for exercise? _____

Have you ever used illegal drugs? ☐ Y ☐ N If so, what drugs? _____

Review of Symptoms

Check box if you have any of the following symptoms

Respiratory
- ☐ Shortness of Breath
- ☐ Congestion
- ☐ Cough
- ☐ Short of Breath on Exertion

Cardiology
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Sweating
- ☐ Swelling
- ☐ Fluttering Sensation

General
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Fevers
- ☐ Weakness
- ☐ Fatigue

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Increased Thirst

Female Reproductive
- ☐ Pregnant
- ☐ Menopause

Male Reproductive
- ☐ Difficulty with Erection

Ophthalmology
- ☐ Diminished Vision
- ☐ Blurring of Vision
- ☐ Loss of Vision
- ☐ Vision Floaters

Neurology
- ☐ Headaches
- ☐ Tingling
- ☐ Fainting
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Memory Loss

Gastroenterology
- ☐ Nausea
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Indigestion
- ☐ Abdominal Pain

Hematology
- ☐ Easy Bruising
- ☐ Bleeding

Dermatology
- ☐ Rash
- ☐ Flushing
- ☐ Wound
- ☐ Dry Skin

Musculoskeletal
- ☐ Joint Pain
- ☐ Leg Cramps
- ☐ Back Pain
- ☐ Arm Pain
- ☐ Neck Pain
- ☐ Leg Pain
- ☐ Muscle Pain

Urology
- ☐ Frequent Urination
- ☐ Difficult/Painful Urination
- ☐ Blood in Urine

Psychology
- ☐ Depression
- ☐ Anxiety
- ☐ High Stress

Financial Policy

Thank you for choosing Charlotte Internal Medicine Associates for your primary care. We are committed to providing you with the highest quality care possible. We are contracted with most insurance companies but please contact your insurance to verify that we are in network. If your plan is an HMO you must list **Dr. George Koppuzha MD** as your primary care provider before coming into care.

In order to provide the best care in the most cost effective way we have devised the following financial policies to keep you current on your medical fees. You must inform us on any and all changes in insurance while in care as this will facilitate the claims process and will reduce the amount of claims being denied. In the event that a claim is denied by your insurance, you – the patient – are responsible for all fees accrued for services rendered.

☐ **INSURED – Commercial Insurances, Medicare Replacements, Self-Insured Plans**

I understand and agree that health insurance coverage is an agreement between my insurance carrier and me. I agree that all services are charged directly to my insurance and that I am personally responsible for any balance that comes back. All copays are due at the time of my appointment. I understand that if I have a deductible and I have not met that amount, I must make a payment towards this at the time of service. New patients will be responsible for a deductible payment of $100 and established patients will be responsible for a deductible payment of $60 at every appointment until the deductible is met. I acknowledge that if my deductible amount is more than my payment per my insurance, I am also responsible for the remaining balance. If I cannot pay my copay or deductible payment my appointment will be rescheduled unless otherwise determined by Dr. George Koppuzha MD.

☐ **MEDICARE**

I understand that Medicare is a federal insurance program. I acknowledge that Medicare has an annual deductible and if my appointment fee is applied to this deductible then I, the patient, am responsible for the balance. I understand that if I have a secondary insurance or supplemental policy to my Medicare plan and fail to provide the plan information then my secondary or supplement will not be billed. I understand that I am responsible for any balances that come back as coinsurances.

☐ **SELF PAY – New Patient Appointment $120 – Established Patient Appointment $60**

I acknowledge the self-pay rates set down by Charlotte Internal Medicine Associates. I understand that the cost of my appointment is due at the time of service unless otherwise determined by Dr. George Koppuzha MD. I agree that any other services beyond routine appointments (vaccines, injections etc.) will accrue additional fees. It is my responsibility to inquire about the cost of said services before they are performed as I will be responsible for any and all balances accrued.

Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Standard Privacy Statement

Patient: _____ Date of Birth: _____

With this consent, Dr. George Koppuzha MD or staff may call (Check all that apply):

☐ Call my home or alternative location to speak with me directly in reference to any items that assist the practice in carrying out treatment, payment, health care operation, appointment reminders, insurance items, and calls pertaining to my clinical care including lab/other results.

☐ May leave a message at my home or alternate location or with person(s) below.

Name	Relationship	Phone Number

The above may be revised by forwarding in writing the changed to our office except to the extent that the office may already have made disclosures to the above prior to the revision.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Notice of Privacy Practice for Charlotte Internal Medicine Associates.

Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____