Prime MD Plus

Divya Javvaji, M.D.

Name: _____Date of Birth: _____

Social Security: _____

Full Address: _____

E-Mail:_____Phone #: _____

Primary Care Provider: _____

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Relationship to Patient: _____

Pharmacy information:

Pharmacy name: _____ City _____

Street_____ Phone:_____

Insurance information

Name of Primary Insurance _____

Policy Holder name _____

Policy number _____

Group number _____

Relationship to policyholder (select one) _____ Self _____Spouse ____Child _____Other

Name of Secondary Insurance (if applicable) _____

Policy Holder name _____

Policy number _____

Group number _____

Relationship to policyholder (select one) _____ Self _____Spouse ____Child _____Other

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Chief Complaint: What is the main reason for your visit today?

_____

Medical History (Select all that apply)

- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Amblyopia
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Aneurysm
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Biliary Tract Disease
- ☐ Bipolar Disorder
- ☐ Blindness
- ☐ Cancer
- ☐ Cataplexy
- ☐ Cataracts
- ☐ Chronic Pain
- ☐ Cirrhosis
- ☐ Collapsed Lung
- ☐ Color Blindness
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Cryptococcus
- ☐ Cystic Fibrosis
- ☐ Cytomegalovirus
- ☐ Degenerative Arthritis
- ☐ Depression
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Ectopic Pregnancy
- ☐ Endometriosis
- ☐ Epilepsy
- ☐ Erectile Dysfunction
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Glomerulonephritis
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Immune Deficiency
- ☐ Infections (chronic)
- ☐ Infertility
- ☐ Insomnia
- ☐ Ischemic Bowel Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Macular Degeneration
- ☐ Menopause
- ☐ Multiple Sclerosis
- ☐ Narcolepsy
- ☐ Nephrotic Syndrome
- ☐ Ocular Misalignment
- ☐ Osteoporosis
- ☐ Ovarian Cysts
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Pleural Effusion
- ☐ Prostate Enlarged
- ☐ Prostatitis (chronic)
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Pulmonary Fibrosis
- ☐ Reflux Esophagitis
- ☐ Renal Failure
- ☐ Retinal Detachment
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell Anemia
- ☐ Sinusitis (chronic)
- ☐ Sleep Apnea
- ☐ Sleepwalking
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thalassemia
- ☐ Tinnitus
- ☐ Toxoplasmosis
- ☐ Tuberculosis
- ☐ Ulcers

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Previous hospitalizations/Surgeries/Serious Illness and when?

_____
_____
_____
_____
_____

Are you on medications? Yes ___ No ___ If yes, please list below.

Medication Name	Dose	Frequency	Capsule or tablet

Are you allergic to any medications? Yes ___ No ___ If yes, which ones?

_____ _____
_____ _____
_____ _____

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Social History

Marital status	Single ___ Married ___ Separated ___ Divorced ___ Widowed ___
Use of alcohol	Yes ___ No ___ If yes, how much and how often?
Smoking	Yes ___ No ___ If yes, how much per day?
Illicit drug use (past and present)	Yes ___ No ___ If yes, what type, how often, and last time of use?
What is your current work status?	Working ___ Retired ___ Unemployed ___ Disabled ___
Who lives with you at home?	_____
Have you had the flu vaccine?	If yes, when? _____

Family History	**YES**		**YES**
Diabetes	___	Lung Cancer	___
Heart Disease	___	Heart Attack	___
Liver Disease	___	Colon Cancer	___
Prostate Cancer	___	Stroke	___
Kidney Cancer	___	High Blood Pressure	___
Breast Cancer	___	High Cholesterol	___

Patient signature: _____ **Date:** _____

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Financial Policies

- The patient is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service and for your convenience, we accept Visa, MasterCard, American Express, Discover, and checks at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Prime MD Plus. These charges may include (but are not limited to)
    - the charge for missed appointments without 24-hour advance notice
    - the charge for the copying and distribution of patient medical records
    - the charge for extensive forms completion
    - Any costs associated with the collection of patient balances.
- FMLA/Handicap placard/other paperwork policy
    - Any FMLA, disability, or other paperwork requiring physician review and completion is subject to a minimum of $75 fee per form. Please allow up to 2 weeks for this paperwork to be completed.
- Canceled Appointments
    - We require 24-hour notice for the cancellation of all doctor visits. It is the policy of Prime MD Plus to bill a cancellation fee to a patient that does not show or cancel at least 24 hours in advance of a procedure, test, or appointment. This is to ensure that our treatment team is using their time to diagnose and treat patients that are in need of our services. A patient that arrives 20 minutes past the time of the appointment will be considered a "no show" for the purposes of this policy. Fees for no-show appointments will be $75.00

I _____ (patient's name) have read, understand, and agree to the above policy by Prime MD Plus. I will be responsible for any non-covered services not covered by my health insurance plan(s).

_____ _____

Patient's Name (PRINT) **Patient Signature & Date**

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Patient Authorization for Disclosure of Protected Health Information

Patient Name: _____

SSN (last four digits-optional): _____ **Date of Birth:** _____

Entity Requested to Release Information: **Prime MD Plus**

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI. This could be a family member or a friend):

Individual/Entity Name: _____Relationship: _____
Phone: _____

Individual/Entity Name: _____Relationship: _____
Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

□ Complete Records **OR** select the following that apply:

□ History & Physical	□ Progress Notes	□ Radiology Reports (U/S, CT scans, X-rays, MRI's)
□ Care Plan	□ Lab Reports	□ Operative Reports
□ Pathology Reports	□ Treatment Record	□ Other (please specify) _____
□ Hospital Records	□ Medication Record	

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

□ Patient Request □ Other (please specify): _____

The released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.
This authorization will expire on the 365th day after it is signed, unless as provided otherwise upon the expiration date or event given here: _____

I understand that I may revoke this authorization at any time in writing, but if I do so, it will not have any effect on any actions taken prior to the clinic receiving the revocation.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

I understand that treatment and payments are not a condition of signing this authorization. You have the right to receive a copy of the signed authorization upon request.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient or representative signature _____ **Date** _____

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Divya Javvaji, MD
Primary care, Geriatric Care, and Aesthetic services: 972-393-1699
452 TX 121, Suite 130, Coppell, TX 75019

MEDICAL RECORDS REQUEST

PLEASE FAX BACK PATIENT RECORDS WITH A COPY OF THIS PAGE AS COVER

FAX TO: 972-393-1702

Records Requested:

Patient: _____ DOB: _____

From: _____ Fax: _____

Address: _____Phone: _____

Date: _____Time: _____

Description of information being requested – I authorize the practice to request the following protected health information about me.

□ Complete Records **OR** select the following that apply:

□ History & Physical	□ Progress Notes	□ Radiology Reports (U/S, CT scans, X-rays, MRI's)
□ Care Plan	□ Lab Reports	□ Operative Reports
□ Pathology Reports	□ Treatment Record	□ Other (please specify) _____
□ Hospital Records	□ Medication Record	

The released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. This authorization will expire on the 365th day after it is signed, unless as provided otherwise upon the expiration date or event given here: _____

Patient Signature: _____Date: _____