PATIENT INFORMATION SANJAY AGGARWAL, MD PA

Name: _____ Previous Last Name: _____
LAST FIRST INITIAL

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ DOB: _____ Sex: Male Female

Marital Status: Single Married Widowed Divorced SS#: _____

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian/other Pacific Islander

☐African American ☐White ☐Hispanic ☐Other Race

Language: ☐English ☐Spanish ☐Indian ☐Russian ☐Other

Emergency Contact Name: _____ Relation: _____ Phone: _____

Referring Physician: _____ Primary Physician: _____

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize the medical offices of Sanjay Aggarwal, MD including but not limited to Dr. Sanjay Aggarwal, his staff and his agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to process any claims for insurance or reimbursement. I hereby also authorize and assign payment of any and all medical benefits to Dr. Aggarwal for services rendered. I hereby authorize and permit Dr. Sanjay Aggarwal, MD or his associates to examine me and permit him/them to perform any necessary physical or lab tests are deemed necessary to treat my illness. Failure to do so will make you responsible for full payment of services rendered from our office.

_____ _____
Signature Date

Pharmacy Name: _____

Location: _____

If you also use a mail in pharmacy, please list name, address, and fax. _____

_____

HIPAA Notification: Permit Title: Acknowledgement of Receipt of Privacy Notice Permit Text: We are required by law to maintain the privacy of, and provider individuals with the notice of our legal duties and privacy respect to protected health information. If, after having read the HPIAA Notice of Privacy Practices, you have any objections to that form, please as to speak with our HIPAA Compliance Officer in person or by phone at the main office number. Your signature below is only an acknowledgement that you have received the Notice of our Privacy Practices. This authorization shall remain in effect until you specifically notify Dr. Aggarwal in writing that you are revoking this authorization. Edited 01/17/2005 by Sanjay Aggarwal, MD. MDR 11/29/2005

_____ _____
Signature Date

Reason for Visit: _____

Have you had a recent Chest X-Ray or CAT Scan of the chest? ☐ **NO** ☐ **YES**
If so, please indicate when and where the test was performed: _____

_____

Have you ever had a Sleep Study? ☐ **NO** ☐ **YES**
If so, please indicate when and where the sleep study was performed: _____

_____

Medication Allergies: ☐ **NONE** ☐ **YES**

If so, please list allergies: _____

_____

List names of all physicians you have seen in the past year: _____

_____

_____

Do you currently take any medications: ☐ **NO** ☐ **YES**
If so, please list medications (including over-the-counter) below or if you have a list please attach a copy.

Medication Name	**Strength**	**Directions**

PATIENT NAME: _____

SANJAY AGGARWAL, MD, PA

Please assist us in completing this questionnaire. Please ask the staff if you need assistance. Your cooperation is appreciated.

Do you have any of the following-

Cough	Yes	No	Snoring	Yes	No
Shortness of breath	Yes	No	Excessive sleepiness	Yes	No
Coughing blood	Yes	No	Sinus drainage	Yes	No
Coughing sputum	Yes	No	Heart Burn	Yes	No
Swelling of legs	Yes	No	Problems with bowels	Yes	No
Weight loss	Yes	No	Problems with urination	Yes	No
Weight gain	Yes	No	Rash	Yes	No
Fever	Yes	No	Arthritis	Yes	No
Lumps	Yes	No	Stomach pain	Yes	No
Sore throat	Yes	No	Runny Nose	Yes	No
Dizziness	Yes	No	Abnormal Heart Beat	Yes	No
Hoarseness	Yes	No	Trouble sleeping	Yes	No

Do you have or been treated for the following -

Lupus	Yes	No	Diabetes	Yes	No
Osteoporosis	Yes	No	COPD	Yes	No
Esophageal Reflux	Yes	No	High Blood pressure	Yes	No
Angina (chest pain)	Yes	No	Chronic Bronchitis	Yes	No
Heart Attack	Yes	No	Emphysema	Yes	No
Pacemaker	Yes	No	Asthma	Yes	No
Heart Failure	Yes	No	Tuberculosis	Yes	No
Depression	Yes	No	Lung cancer	Yes	No
Any cancer	Yes	No	Nerves	Yes	No
Sinuses	Yes	No	Sleep Apnea	Yes	No
Kidney Problems	Yes	No	Stomach ulcers	Yes	No
Liver problems	Yes	No	Prostate problems	Yes	No
Allergies	Yes	No	Seizures	Yes	No
Eye problems	Yes	No			

Please list any operations/procedures you have had or any other medical problems (including dates) –

_____

_____

_____

IMPORTANT: Must be completed – Please list any family medical problems (if known) –

- FATHER: _____
- MOTHER: _____
- SIBLINGS: _____

Do you currently smoke tobacco? Yes No If so, how many _____ per day
Have you done so in the past? Yes No If so, how long since you quit? _____