SAADAT ANSARI, M.D.

INTERNAL MEDICINE

PATIENT INFORMATION

PLEASE PRINT

DATE _____

Patient's Name _____ Referred By _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

SS# _____-_____-_____ Sex M F D.O.B _____/_____/_____

❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single

Patient's Occupation _____ Employer _____

Employer's Address _____ Employer's Phone ( ) _____

Spouse's Name _____ Spouse's D.O.B. _____/_____/_____ Spouse's SS#_____-_____-_____

Spouse's Occupation _____ Spouse's Employer _____

Employer's Address _____ Employer's Phone ( ) _____

Notify in case of emergency _____ Relationship _____

City _____ State _____ Phone ( ) _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	
Insurance Company Name	

SECONDARY INSURANCE TO FILE

2nd Policy #	2nd Group #
2nd Insured's Name	2nd Relationship to Patient
2nd Insured's Social Security # or I.D. #	
2nd Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE ( ) _____

Payment is required for all services at the time they are rendered. In the event of financial hardship, our office will attempt to negotiate a payment plan or file the appropriate insurance when hospitalization or major procedures are required. However, before such claims are filed, coverage will be pre-certified, and you will be asked to pay any unmet deductible, non-covered services and copayments. Your signature below signifies your understanding and willingness to comply with this policy.

I authorize all physicians, medical professionals, hospitals and other medical care institutions, insurers, prepaid health plans, employers, group policy holders, contract holders, and benefit plan administrators to provide insurer with information concerning medical care, advice, treatment or supplies provided to the patient.

Signature _____ Date _____

SAADAT ANSARI, M.D., LLC
201 Longwood Dr. S.E., Suite B
Huntsville, AL 35801

DATE: _____

NAME: _____

DATE OF BIRTH: _____

AGE: _____

APPT. TODAY WITH:

WHAT OTHER DOCTORS/SPECIALIST DO YOU SEE:

NAME/SPECIALTY _____

_____

REASON FOR VISIT: _____

ANY NEW OR WORSENING PROBLEMS? IF YES, PLEASE DESCRIBE: _____

_____

PLEASE CHECK IF YOU HAVE ANY OF THE BELOW:

PAST MEDICAL HISTORY:

- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ ANEMIA
- ☐ ANXIETY
- ☐ AUTOIMMUNE DISEASE (LUPUS)
- ☐ BILIARY CIRRHOSIS
- ☐ BLOOD TRANSFUSION
- ☐ BRAIN TUMOR
- ☐ CEREBROVASCULAR
- ☐ DISEASE (STROKE)
- ☐ CIRRHOSIS
- ☐ CVA/STROKE
- ☐ COPD (LUNG DISEASE)
- ☐ COLON CANCER
- ☐ CORONARY HEART DISEASE
- ☐ CROHN'S DISEASE
- ☐ CHRONIC RENAL FAILURE
- ☐ DEPRESSION
- ☐ DIABETES - JUVENILE ONSET
- ☐ DIABETES - ADULT ONSET
- ☐ DIVERTICULITIS
- ☐ DVT (BLOOD CLOT IN LEGS)
- ☐ GI BLEED
- ☐ GERD (ACID REFLUX)
- ☐ HEMOCHROMATOSIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HYPOTHYROIDISM
- ☐ HYPERTHYROIDISM
- ☐ GOITER
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HEPATITIS C
- ☐ INFERTILITY
- ☐ KIDNEY DISEASE
- ☐ KIDNEY STONES
- ☐ LIVER DISEASE
- ☐ MI (HEART ATTACK)
- ☐ NEUROLOGIC DISORDER
- ☐ OSTEOARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ PVD
- ☐ PUD (STOMACH ULCERS)
- ☐ RHEUMATOID ARTHRITIS
- ☐ SEIZURE DISORDER
- ☐ THYROID DISORDER
- ☐ TUBERCULOSIS
- ☐ VALVULAR HEART DISEASE
- ☐ UTI - RECURRENT
- ☐ VARICOSE VEINS/PHLEBITIS
- ☐ ABNORMAL PAP SMEAR
- ☐ BREAST DISEASE
- ☐ BREAST CANCER
- ☐ CERVICAL CANCER
- ☐ DES EXPOSURE
- ☐ GESTATIONAL DIABETES
- ☐ RH SENSITIZED
- ☐ SLEEP APNEA
  ***USING CPAP YES/NO

OTHER _____

PAST SURGICAL HISTORY:

- ☐ AMPUTATION
- ☐ AV FISTULA CREATION
- ☐ AV GRAFT
- ☐ AORTIC VALVE REPLACEMENT
- ☐ AORTIC VALVE REPLACED
- ☐ APPENDECTOMY
- ☐ BOTH LEGS BYPASSED
- ☐ BACK SURGERY
- ☐ BRONCHOSCOPY (LUNG SCOPE)
- ☐ CABG (HEART BYPASS)
- ☐ CAROTID ENDARTERECTOMY
- ☐ CARPAL TUNNEL
- ☐ CATARACT EXTRACTION
- ☐ GALLBLADDER REMOVED
- ☐ COLON RESECTION
- ☐ CRANIOTOMY
- ☐ GASTRIC BYPASS
- ☐ HEMORRHOIDECTOMY
- ☐ HIP REPLACEMENT
- ☐ INVASIVE PAIN PROCEDURE
- ☐ KIDNEY TRANSPLANT
- ☐ KNEE ARTHROSCOPY
- ☐ KNEE REPLACEMENT
- ☐ KYPHOPLASTY
- ☐ LUMPECTOMY
- ☐ MASTECTOMY
- ☐ MITRAL VALVE REPLACED
- ☐ NEPHRECTOMY
- ☐ PACEMAKER IMPLANTED
- ☐ PARATHYROIDECTOMY
- ☐ PNEUMONECTOMY
- ☐ PTCA (ANGIOPLASTY)
- ☐ ROTATOR CUFF REPAIR
- ☐ ABD. HYSTERECTOMY
- ☐ HYSTERECTOMY/OVARIES
- ☐ **OVARIES REMOVED YES/NO
- ☐ PROSTATE SURGERY
- ☐ SHOULDER SURGERY
- ☐ SLEEP APNEA SURGERY
- ☐ THYROID SURGERY
- ☐ TONSIL'S REMOVED
- ☐ VASCULAR SURGERY
- ☐ BREAST AUGMENTATION RIGHT/LEFT
- ☐ MASTECTOMY RIGHT/LEFT
- ☐ LUMPECTOMY RIGHT/LEFT

OTHER _____

FAMILY HISTORY: Patient name: _____ DOB: _____

	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
HEART ARTERY DISEASE/HEART ATTACK	☐	☐	☐	☐	☐
KIDNEY DISEASE (CHRONIC)	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐
THYROID DISORDER	☐	☐	☐	☐	☐
CANCER (TYPE)	☐	☐	☐	☐	☐

OTHER: _____

SOCIAL HISTORY: (CHECK OR CIRCLE APPROPRIATE)

MARRIED/SINGLE/DIVORCED/WIDOWED

WORKS PART-TIME/ FULL-TIME

OCCUPATION: _____

☐ RETIRED

☐ DISABLED

☐ CHILDREN - YES OR NO

☐ RELIGIOUS AFFILIATION

_____

ALLERGIES OR MEDICATION REACTIONS: ☐ NO KNOWN DRUG ALLERGIES

ALLERGIC TO: REACTION:

_____ _____

_____ _____

_____ _____

RISK FACTORS: (CHECK OR CIRCLE APPROPRIATE)

☐ CURRENT TOBACCO USE YEAR STARTED: _____

☐ TYPE OF TOBACCO: (CIRCLE APPROPRIATE)
CIGARETTES, CIGARS, SNUFF, VAPOR

☐ FORMER TOBACCO USE YEAR QUIT: _____

☐ NEVER SMOKED

SECOND HAND SMOKE YES NO

DO YOU WEAR YOUR SEAT BELT? YES NO

CAFFEINE USE YES NO

HOW MANY DRINKS PER DAY _____

ALCOHOL USE YES NO

HOW MANY PER DAY _____

TYPE: _____

HOW MANY DRINKS PER DAY _____

EXERCISE YES NO

TIMES PER WEEK: _____

TYPE: _____

CURRENT MEDICATIONS: ☐ REFER TO LIST ☐ REFER TO BOTTLES

PLEASE INCLUDE THE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION (NO NEED TO LIST BELOW IF YOU BROUGHT A LIST OR BOTTLES)

NAME	DOSAGE	HOW MANY TIMES PER DAY	AS NEEDED (PRN)

Patient name: _____ DOB: _____

MEDICAL PROBLEMS: *HAVE YOU HAD ANY RECENT OR PERSISTENT PROBLEMS WITH THE FOLLOWING?*

General:
- o WEIGHT GAIN / LOSS
- o DIABETES
- o BACK PAIN

Skin:
- o RASHES
- o NAIL / HAIR PROBLEMS
- o ABDOMINAL MOLES

Extremities:
- o JOINT PAIN
- o GOUT
- o VARICOSE VEINS
- o LEG SWELLING

Neck:
- o GOITER
- o SWOLLEN GLANDS
- o THYROID

Mouth:
- o DENTURES
- o HOARSENESS
- o GUMS

LAST DENTAL EXAM: _____

DENTIST: _____

Heart:
- o CHEST PAIN
- o HYPERTENSION
- o HIGH CHOLESTEROL
- o CONGESTIVE HEART FAILURE
- o HEART MURMUR
- o PALPITATIONS

LAST EKG: _____

Gastrointestinal:
- o TROUBLE SWALLOWING
- o REFLUX / GERD
- o VOMITING
- o DIARRHEA
- o CONSTIPATION
- o BLOODY / BLACK STOOL
- o HEMORRHOIDS
- o HEPATITIS

LAST COLONOSCOPY: _____

Urinary:
- o FREQUENCY
- o TROUBLE STARTING OR STOPPING
- o URINARY PAIN
- o URINATE AT NIGHT
- o LEAKAGE
- o BLOOD IN URINE
- o KIDNEY STONES
- o INFECTIONS
- o PROSTATE TROUBLE

Neuro:
- o HEADACHE
- o HEAD INJURY
- o BLACKOUTS / DIZZY
- o SEIZURES / TREMORS
- o MEMORY LOSS
- o DEPRESSION / ANXIETY

Lungs:
- o PERSISTANT COUGH
- o COUGH UP BLOOD
- o EMPHYSEMA / BRONCHITIS
- o SHORTNESS OF BREATH
- o PNEUMONIA

Lifestyle:
- o REGULAR EXERCISE _____ TIMES A WEEK
- o LOW SALT DIET
- o LOW FAT DIET

Sexual:
- o PROBLEMS WITH SEX
- o MULTIPLE PARTNERS
- o HISTORY OF STD
- o HIV

ENT:
- o ALLERGIES
- o SINUS TROUBLE
- o HEARING LOSS
- o GLASSES / CONTACTS
- o BLURRED VISION
- o RINGING

LAST EYE EXAM: _____

EYE DOCTOR: _____

Women:
- o IRREGULAR PERIODS
- o PELVIC PAIN
- o BIRTH CONTROL PILLS
- o NIPPLE DISCHARGE
- o LUMPS IN BREASTS
- o SELF BREAST EXAM

PLEASE ENTER THE MOST RECENT DATE AND RESULTS OF THE FOLLOWING:

	DATE	RESULTS	PERFORMED BY WHO/WHERE
COLONOSCOPY	_____	_____	_____
PAP SMEAR	_____	_____	_____
MAMMOGRAM	_____	_____	_____
BONE DENSITY SCAN	_____	_____	_____
MENSTURAL PERIOD	_____	_____	_____
PSA (PROSTATE SCEEN)	_____	_____	_____

WHEN WAS YOUR LAST VACCINE ON THE FOLLOWING:

	DATE	Would you like one?
FLU VACCINE	_____	Yes / No
TETANUS VACCINE	_____	Yes / No
PNEUMONIA VACCINE	_____	Yes / No
ZOSTAVAX	_____	Yes / No

SAADAT ANSARI, M.D.
INTERNAL MEDICINE
BOARD CERTIFIED
201 LONGWOOD DRIVE, SUITE B • HUNTSVILLE, AL 35801
PHONE (256) 536-9604 • FAX (256) 536-9606

APPOINTMENTS: Unless cancelled at least 24 hours in advance our policy for missed appointments at the rate of 1/2 normal office visit charge. Please help us serve you better by keeping scheduled appointments.

INSURANCE: We will file your insurance as a courtesy. Health care insurance is intended to cover some but not all of the cost of your treatment. Regarding insurance plans where we are a participating provider . . . all co-pays and deductibles are due prior to treatment.

PRESCRIPTION REFILL POLICY: Allow 48 hours for all refills. No controlled substances will be called in after normal hours or on weekends. Because we specialize in the care of adults, it is the patient's responsibility to notify this office within the specified time.

Saadat Ansari, M.D.

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICIES.

NAME: _____

DATE: _____

INDIVIDUAL PATIENT'S AUTHORIZATION

SAADAT ANSARI, M.D.
201 Longwood Drive S.E., Suite B
Huntsville, AL 35801
Telephone: (256) 536-9604

❑ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information.

Name _____ DOB _____ Social Security # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

Specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information,etc.)

_____

The information will be used or disclosed for the following purpose ("at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):

_____

I request the following restrictions to the use or disclosure of my health information:

_____

Name/Identification of person(s) to whom the covered entity may make the requested use or disclosure:

_____

Expiration date or event that relates to the individual or the purpose of the use or disclosure:

_____

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Individual Patient's Signature

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

X _____ _____ _____
Signature of Patient or Legal Representative | Date | Witness Signature

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

X _____ _____ _____
Signature of Patient or Legal Representative | Date | Witness Signature