East End Primary Care
907 Lyndon Lane
Louisville KY 40222
Phone: 502-412-1904
Fax: 502-412-1905

PATIENT REGISTRATION

Email address:

NAME	Sex M / F	DATE OF BIRTH	
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ( )	WORK # ( )	EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH		PHONE # ( )
IF UNDER 18 **PARENT / GUARDIAN**			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ( )	ADDRESS	RELATION
S.S. # **MUST FILL**		REFERRED BY	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. Ravi Gill MD/ East End Primary Care PLLC for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PAYMENT REQUIRED AT TIME OF SERVICE - If the deductible has not been met, please pay today.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	
		ID#	
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	
		ID#	
OTHER COVERAGE			

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Ravi Gill MD , *to release any medical or incidental information* that may be necessary for either medical care or in processing applications for financial benefit.

*****I shall be charged a fee of 40% of the balance if my account is turned over to collections.*****

No call, No show fee of $10.00 is charged to patients who do not cancel or reschedule @ least 24

Prior authorization for any medication rerquires pre-payment. It is not free. If it is felt to be futile or medically unnecessary, it will be refused.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT NAME *(please print)* .... DATE ....

PARENT / GUARDIAN *(please print)* .... SIGNATURE ....

FOR OFFICIAL USE ONLY (not for patient use)

Cap passport/ Non cap passport/ Medicare 0 - + / Medicaid/ Auto/ Worker Comp

HEALTH QUESTIONNAIRE

Name:

Date: D.O.B.:

FAMILY HISTORY *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) EPILEPSY	6) THYROID	11) OSTEOPOROSIS	16) HIGH CHOLESTEROL
2) MIGRAINE	7) HAYFEVER	12) ARTHRITIS	17) ALCOHOLISM
3) MENTAL ILL.	8) ASTHMA	13) HEART DISEASE	18) HEPATITIS
4) GLAUCOMA	9) ANEMIA	14) STROKE	19) CANCER
5) DIABETES	10) BLEEDS EASILY	15) HYPERTENSION	20)

Past Medical History

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION

ALLERGIES

VACCINE	YEAR OF LAST
Tetanus / Td	
Influenza (FLU)	
Pneumonia	
Hepatitis	

TEST / EXAM	YEAR OF LAST
Rectal/Stool	
Cholesterol	

MEDICAL HISTORY *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet

- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain- *chronic*
- ☐ Gall bladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
- ☐ Weight-loss ☐ Gain-*recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions

- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches - *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping or concentration difficulty
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German Measles
- ☐ Tuberculosis ☐ Herpes
- ☐ Aids / HIV

- ☐ Alcohol ______ oz. per week
- ☐ Coffee ______ cups per day
- ☐ Smoking ___ cig/day ___ #years year quit ___
- ☐ Exercise ______
- ☐ Street Drugs ______
- ☐ Acupuncture / tattoos
- Hair loss: ☐ progressive ☐ recent

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of Flow ___ Length of cycle ___

Date -1st day of last period ______

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ___ Abortions ___

Miscarriages ___ Live births ___

Birth control method ______

B.C. pill (name) ______

☐ Flushing / Menopause

Date of last PAP test ______

☐ Normal ☐ Abnormal

Date of last Mammogram ______

☐ Normal ☐ Abnormal

NOTES

This area for Official use only.

All Blanks Negative. Date______________Signature______________________MD/ARNP

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