Meena Medical Group, Inc.

INTERNAL MEDICINE
NEW PATIENT INFORMATION (16 YEARS +)

Patient Information

Date:_____ My appointment is with: _____

Name:_____ DOB: _____

Address:_____City:_____State:_____Zip: _____

Billing Address: Same as above_____

Home Phone:_____Cell:_____Other:_____

Male Female Single Married Spouse's Name: _____

Race: _____, Prefer not to answer.

Email:_____ SSN: _____

Patient Employer:_____Work Phone: _____

Preferred Pharmacy:_____

Preferred Laboratory:_____

Preferred Imaging Center: _____

Insurance Information:

Primary Insurance Co:_____ Policy#:_____ Group#:_____

Policy Holder:_____DOB:_____ SSN:_____ Relationship to patient:_____ Policy Holder Address:_____

City:_____State:_____Zip:_____ Policy Holder Employer:_____Employer Phone:_____ **Secondary Insurance Co:**_____Policy#_____ Group #:_____ Insurance Co. Phone:_____

Policy Holder:_____DOB:_____SSN:_____ Relationship to Patient:_____

If you have any additional insurance, flex spending plans or health savings plans, please notify the front desk.

Past Medical History:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

Past Surgical/Hospitalization History:

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

9)_____

Patient's Name:_____

Emergency Contact:_____ **Phone:**_____

Authorized Release of Information: (Name) _____

Limit on what information can be shared:_____

Drug Allergies:
_____ No known drug allergies. Drugs_____

Current Medications: *(please include all prescription, birth control pills, over the counter, herbs and vitamins)*

#	Medication	Dose	Reason for taking
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

Immunizations / Injections: (*please put year of last injection)*

_____ Tetanus Booster
_____ Flu Vaccine
_____ Pneumonia Vaccine
_____Hepatitis B
_____Hepatitis A
_____TB Skin Test
_____Other _____

Social History

Tobacco: _____

Alcohol: _____

Drugs: _____

Patient's Name:_____

Family History

- **Father:** _____
- **Mother:** _____
- **Siblings:**_____

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

_____ _____
Signature of Patient or Representative Date

_____ _____
Name of Patient or Representative Description of Representative's Authority

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made by alternative means.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone:
- ☐ Cell Phone: ☐ Call ☐ Text
- ☐ Email
- ☐ Work Telephone

_____ _____
Signature of Patient or Representative Date