Atul Bhasin, MD

Atlas Medical Care, LLC
1001 West Main Street, Ste A • Freehold, NJ 07728 • Ph: 732 637 8444 • Fax 732 637 8440

Patient Information Form

Last Name: ________________________________ First Name: __________________ M.I.__________
Address: ____
City:__________________________________ State: _______________________ Zip:_______________
Birthdate:___________________________________ Sex:_____M_____F Marital Status:____________
Home Phone Number:_____________________________ Cell Number:___________________________
Email:____ SS#:__________________________________

Atlas Medical Care may call my: _____ Home _________ Cell Phone.

Atlas Medical Care may leave a message on _________ Home Phone_________ Cell Phone which may include protected health information.

Race: (please circle one): White Asian Native Hawaiian/Pacific Islander Black/African American American Indian/Alaskan Native Decline to State

Ethinicity (please circle one): Hispanic/Latino Not Hispanic/Latino Decline to Share

Language(s):____

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled. I hereby authorize my insurance plan, including MEDICARE, BLUE CROSS/BLUE SHIELD, ALL PRIVATE AND COMMERCIAL INSURANCES, AND/OR WORKMAN'S COMPENSATION, AND ANY OTHER HEALTH/MEDICAL PLAN, to issue payment/ check directly to Atul Bhasin MD, and/or Atlas Medical Care, LLC for services rendered to me, or my covered dependents regardless of my insurance benefits, if any.

I understand that I am financially responsible for any amount not covered by my designated insurance.

I accept responsibility for accruing interest as well as the fees and/or legal costs associated with the collection of my account, should it become delinquent.

I hereby authorize Atul Bhasin, MD/Atlas Medical Care, LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I hereby authorize said assignee (Atul Bhasin, MD or Atlas Medical Care, LLC) to release any information necessary to secure payment on my behalf.

Patient Name/Responsible Name (if different)/relationship: ____

Responsible Party Signature:________________________ _________________________Date:____________________

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Release of Medical Information

I hereby authorize Atul Bhasin, MD and/or Atlas Medical Care, LLC to release my medical information verbally, in print, and electronically, and via voicemail message to the following individuals:

Emergency Contact: Name:_____________________________________ Relationship:__________________________

Address:____

Contact Number(s):____

Additional Contacts:

Name/Relationship:____Phone:________________

Name/Relationship:____Phone:________________

Name/Relationship:____Phone:________________

Signature of Patient or Representative: ______________________________Date:__________________

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________ Relationship to Patient: __________________________

Signature: ________________________________ Date: _____________________________

Office Use Only : I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: (date, initials, reason)

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Past Medical History Form

Patient's Name:____Age:_______________

Date:____

Allergy Information: Do you have any allergies? Please Circle: None Known YES

If you circled YES – please write what you are allergic to, to and the reaction :_____________________

____

____

Social History: Please Circle:

Do you smoke? Never Yes Previous If yes or previous, how much?___________________

Do you drink? Never Yes Previous If yes or previous how much? __________________

Drugs? Never Yes Previous: Please explain:___________________________________

Occupation:____

Past Medical History:

Please circle if you have or have ever had any of the following:

				Other: Please Indicate:
Coronary Artery Disease	Stroke	Depression/Anxiety	Kidney Disease	
Kidney Stones	Gout	GERD/Reflux	Heart Disease	
High Blood Pressure	COPD	High Cholesterol	Migraines	
Tuberculosis	Diabetes	Pulmonary Embolism	Liver Disease	
Fibromyalgia	Asthma	DVT	Osteoporosis	
Cancer	Diverticulitis	Hyperthyroid (too much)	Hypothyroid (too little)	

If you circled any of the above, please explain:____

____

Family History:

Please explain if Father/Mother or both have/had any of the above conditions, and the age of onset:___

____

____

Females Only: Date of Last Menstrual Period:____

If Post Menopausal, age of onset of menopause:____

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Past Surgical Information – Please state type of surgery and year:________________________________

____

____

Please list any specialists you are seeing, and their contact information:

____ ____________________________

____ ____________________________

Please list all medications you are currently taking, and dosage/frequency: (please include all medications/supplements/vitamins/ birth control pills, etc):

Drug	Dosage	Frequency

Pharmacy Information

Name of Pharmacy: __________________________________ Phone Number:_____________________

Address:____

I hereby give consent for treatment for myself, or the named dependent, by the physicians, physician assistants, nurse practitioners, and/or staff Atlas Medical Care, LLC.

Signature of Patient or Representative:____

Date:___________________________________