ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

GENERAL

Name (Last, First, Middle) : _____

Date of Birth (M/D/Y): _____ Social Security#: _____

Gender:_____ Driver's Licence Number: _____ State: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partner ☐ Other

CONTACT INFORMATION

Home Address: Street _____ City _____ State _____ Zip _____

Home Phone #: _____ Fax # : _____ Cell Phone # : _____

Employer Name: _____ Occupation :_____

Work Address: Street _____ City _____ State _____ Zip _____

Work Phone #: _____ Email # : _____

Emer. Contact: _____ Relationship: _____ Phone # : _____

Different from yours

PRIMARY INSURANCE

Name of Primary Insurance Co: _____ Phone # : _____

ID / Policy # : _____ Group # : _____

Subscriber/Insured : _____ Relationship : _____ Gender: _____

Date of Birth(M/D/Y): _____ Social Security # : _____

Employer Name: _____ Emp. Phone # : _____

SECONDARY INSURANCE

Name of Primary Insurance Co: _____ Phone # : _____

ID / Policy # : _____ Group # : _____

Subscriber/Insured : _____ Relationship : _____ Gender: _____

Date of Birth(M/D/Y): _____ Social Security # : _____

Employer Name: _____ Emp. Phone # : _____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, the undersigned, assign directly to Acharya & Sharma Medical Corp., all surgical and / or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not. I hereby authorize the Doctor to release all information necessary to secure payment of benefits.

Signature : _____ Date: _____

(If patient is a minor, Signature of parent or Guardian authorizing treatment)

ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

INTERNAL MEDICINE, HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____

Address _____ Occupation _____

Phone (Home) _____ (Work) _____ Date of Birth _____

Chief complaint _____

DRUG ALLERGIES

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason _____

_____ Date _____

Reason _____

_____ Date _____

WOMEN ONLY

Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ Headaches	☐ Claudication	☐ Liver disease	☐ Incontinence	☐ Chest pain/Angina
☐ Hypertension	☐ MI	☐ Ulcer	☐ Venereal disease	☐ Dizziness/Fainting
☐ Stroke/TIA's	☐ Congenital heart disease	☐ GI disorder	☐ Anemia	☐ Asthma
☐ Epilepsy	☐ Orthopnoea	☐ Lactose Intolerance	☐ Gout	☐ COPD
☐ Fatigue	☐ Hyperlipidaemia	☐ Renal disease	☐ Scarlet fever	☐ Bowel irregularity
☐ Shortness of breath	☐ Congestive heart failure	☐ GU disorder	☐ Rheumatic fever	☐ Prostate Disease
☐ Heart palpitations	☐ Arrhythmia	☐ Sexual dysfunction	☐ Diabetes	☐ Arthritis
☐ Heart murmur	☐ Allergies/Hay fever	☐ Menstrual dysfunction	☐ Endocrine disease	☐ Osteoporosis
			☐ Anxiety	☐ Osteoporosis

PAST MEDICAL HISTORY

☐ Smoke: Pack daily _____ How long _____ When stopped _____

☐ Exercise routine: _____ ☐ Coffee: Cups daily _____ Other caffeines _____

☐ Alcohol: type/Amount _____ Diet: Salt intake _____ Fat intake _____

☐ Sleep: Difficulty falling asleep _____ Continuity disturbances _____ Early morning awakening _____

Snoring _____ Daytime drowsiness _____

☐ Contact with blood or body fluid at work: _____

1240 E. Chapman Ave, Orange, CA 92866 (714) 771-2800 (714) 771-3200

ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information.

We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfil your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or charge to your health information. Give us a your request to make changes in writing, If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file, If we agree to an amendment or changes, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

ACKNOWLEDGEMENT

I have received a copy of Acharya & Sharma Medical Corporation Notice of Practices. Date _____

Signed _____ Print Name _____

If Signing as parent or guardian, please note the name of the patient

ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "Partner in health", we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for me age, gender, and personal and family history. I understand I may need to complete these recommended health screenings or any other testing. These health screening are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screening, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-Up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover an treat a serious health condition. If I miss an appointment and do not reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make ever effort to reschedule missed appointments as soon as possible.

Call the Office When I do not Hear the Results of Labs and other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform my Doctor if I Decide to **Not** Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that **not** following my treat plan can have serious negative affects on my health. I will let my doctor know whenever I decide to **not** follow his or her recommendation so that he or she may fully inform me of any risk associated with my decision to delay or refuse treatment.

Thanks you for you partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health conditions please ask.

Patient Signature _____ Date _____

Print Name: _____

1240 E. Chapman Ave, Orange, CA 92866 (714) 771-2800 (714) 771-3200

ACHARYA & SHARMA
MEDICAL CORPORATION

SHASHI B. ACHARYA, M.D., F.A.C.P.
Diplomate, American Board of Internal Medicine & Geriatrics
PRAVIN V. SHARMA, M.D.
Diplomate, American Board of Internal Medicine

A SPECIAL WORD TO OUR PATIENTS ABOUT YOUR RESERVATION TIME WITH US

The unique quality of our practice is shown by the high level of professional care provided to each of our patients. Health care is expensive and quality care should not be compromised. We believe on faith, that if a patient says they are going to arrive for an appointment that they will be here at out office on time. This means that we will hold your appointment especially for you and not give it to any other patient. If you miss your appointment we still have to pay our professional staff who was available for you.

Please understand our policy related to your appointment:

1. There will be no penalty for patients who cancel their appointment twenty-four (24) hours in advance. Thank you for your courtesy. We will reschedule you for another date.

2. If you cancel your appointment with less than twenty-four (24) hours notice to us, or do not show up for your appointment you will be charged as follows,
   a) Office Visits - $ 90
   b) Physical exams - minimum $ 150
   c) Procedure Appointment - minimum $ 150

Remember, our costs continue, whether or not you are treated. If we do not have the opportunity to treat you, then we cannot bill your insurance. Understand, please, that any type of insurance coverage never covers charges for missed appointment, and these expenses will be directly out of your pocket.

We really do not want to apply any of the regulations found in this letter. Our goal is to achieve for you the highest quality of care in an efficient and timely manner. We hope you understand our position in these sensitive matters and we look forward to working with you.

Date _____ Signature _____

Print Name: _____

Please Note: This does NOT pertain to any delay either being seen by the physician or a delay to your appointment for unforeseen reasons. Every attempt will be made to accommodate you in case you are late for your appointment.

1240 E. Chapman Ave, Orange, CA 92866 (714) 771-2800 (714) 771-3200