Labs: Yes/No

Cleveland Clinic
Elyria
Quest
Premier
Other:

Ultrasound: Yes/No

Cleveland Clinic
Elyria
Other:

REVIEW OF SYSTEMS

PATIENT NAME: ______________________________

Date: ____________ Your Phone ____________

ANY CHANGE IN MEDICATIONS or HAS ANYTHING CHAGNED SINCE YOUR LAST VISIT?

____

Last flu shot ____________

Only for DIABETICS- Last eye exam ____________ Last foot exam ____________

GENERAL	*EYES*	*EARS*	*NOSE*
Weight change Night sweats Loss of Appetite Fatigue	Glaucoma Cataracts	Ear Discharge	Sinus Problem
THROAT	***RESPIRATORY***	***CARDIOVASCULAR***	***NEUROLOGY***
Difficulty Swallowing	Cough Wheezing Shortness of Breath	Chest Pain Swelling in Legs Irregular Heart Beat	Numbness Tingling Tremors Weakness
GASTROINTESTINAL	***GENITOURINARY***	*** PSYCHIATRIC***	***MUSCULOSKELETAL***
Diarrhea Abdominal Pain Constipation Vomiting	Kidney Stones Dysuria-pain urinating Urinate at night	Depression Anxiety/Panic Attacks Sleep problem/ Insomnia	Joint Pain Muscle Aches H/O falls Broken Bone
SKIN	***ENDOCRIN***	***REPRODUCTIVE***	
Rash Dryness Sweating	Hot Flashes Heat Intolerance Cold Intolerance Hair Loss	Post Menopausal Irregular Periods Erectile Dysfunction Sexual Problems	Smoker: Y/N Glucose Log: Y/N

PATIENT'S SIGNATURE: ______________________________ Date ____________

Diabetes Thyroid and Endocrinology of Northern Ohio
Vikram Kumar M.D INC

1. Consent form

I consent to treatment by Dr. Vikram Kumar and /or such physicians and assistance and we will select by him to diagnose and treat the condition or conditions for which I am suffering, by such means including diagnostic exam/testing and in-office procedures, as he believes indicated by my studies on my case.

I authorize the above to submit all healthcare information to a health insurance program for both review and payment. I also understand some services, tests and consultations may not be covered by my insurance plan and that I am financially responsible or any services that are not covered by my benefit plan, including but not limited to coverage of visits or failure to obtain prior authorization for referral.

I understand copayments and deductibles are due at the time of service, which I will pay directed by my health insurance plan. By signing below, I also verified that I have legal authority to authorize medical treatment, as well as authorize payment to be made to Vikram Kumar M.D. INC by my insurance carrier.

2. Notice of Privacy

I understand that my healthcare information will be kept confidential except for reasons including treatment referrals, billing and insurance entities.

3. Office policy and Patient Responsibility

It is required that all patients show a valid proof of photo identification. Examples include but are not limited to driver's license, state ID, or passport. It is the responsibility of the patient to keep all scheduled appointments. If the patient is unable to keep their appointment, they must contact the office 48 hours in advance with intention to either cancel or reschedule the appointment. Penalty for not contacting the office is a no-show fee of up to $40.
All copayments, deductibles, no-shows and other pending bills are required to be paid before the patient will be seen. The office has the right to discharge you from the practice for unpaid bills.

4. Telehealth Visits

I understand that telemedicine is the use of electronic information and two way communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. Verbal consent will be taken over the phone and visits will follow national and state guidelines.

____________________ ____________________

Signature of Patient — Relationship
(Office staff in case of verbal consent) — (If signing for patient)

____________________ ____________________

Printed Name DOB — Date

Vikram Kumar M.D. INC

Please present insurance card, medications list, photo-identification and co-payment at the front desk.

First name:____________________ MI_____ Last name:________________________

Address:______________________________ City______________ State_______ ZIP_______

Home phone:________________________ Cell phone_________________________

Social Security #__________________ Birthday:______________ Gender M F Other

Emergency contact name ________________________________Relationship:________________

Phone number__________________ May we leave medical information with this person Yes / No

Pharmacy: Name___________________ Phone_________________

Responsible person or party for insurance same/if other

First name ______________________ MI:__________ Last name:________________________

Social Security# _______________ Birthdate: _____-_____-_____ Phone number:________________

Address if different from above: ____

Primary insurance name ______________________Policy number_________________________

Secondary insurance name _____________________Policy number_________________________

I understand that I am responsible for the full payment of my bill in a timely fashion whether the insurance pays or not. I authorize the release of followed medical information necessary to process this claim and I authorize a payment of medical benefits to the provider.

Patient signature:______________________ Printed name:_______________________ Date:________

NAME: ______________________________ D.O.B.________

REASON FOR VISIT: ______________________________

REFERRING PHYSICIAN: ______________________________

CURRENT MEDICATIONS: ______________________________

____

ALLERGIES NO YES TO: ______________________________

CIRCLE ALL THAT APPLY

PAST MEDICAL: DIABETES, HIGH BLOOD PRESSURE, HEART DISEASE, HIGH CHOLESTEROL, THYROID (SLOW,OVERACTIVE,NODULE), OSTEOPOROSIS, FRACTURE, CANCER

PAST SURGERIES: GALL BLADDER, APPENDIX, TONSILS, OPEN HEART (CABG), STENTS, PACEMAKER, THYROID, HYSTERECTOMY, HIP, KNEE

FAMILY HISTORY: DIABETES, HEART DISEASE, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, OSTEOPOROSIS, KIDNEY STONES, CANCER OF____________

PERSONAL HISTORY: ALCOHOL- NEVER RARE REGULAR

DRUGS- YES NO

SMOKING- YES NO HOW MANY PACKS PER DAY________