GILLETTE INTERNAL MEDICINE ASSOCIATES, P.C.

KIRTIKUMAR L. PATEL, M.D.
407 SOUTH MEDICAL ARTS COURT
SUITE D
GILLETTE, WYOMING 82716
(307) 682-0400

CHECKLIST FOR COMING TO OUR OFFICE

- ☐ Please arrive 15 minutes early
- ☐ Insurance Cards
- ☐ Prescription Card
- ☐ Photo ID (driver's license)
- ☐ Bring all medications in original package (including any over the counter meds or vitamins/supplements)
- ☐ Any refills you may need
- ☐ Co-pay and/or your payment for your bill
- ☐ List of Problems you may be having

PLEASE BE PATIENT

Please remember, it is important for us to keep on time, however many times there are unexpected medical problems that are found that have to be attended to by our providers.

Thank you.

GILLETTE INTERNAL MEDICINE ASSOCIATES, P.C.

KIRTIKUMAR L. PATEL, M.D.

Patient Name_____
(Print Full Name)

Date of Birth_____

Financial Agreement

I hereby authorize treatment of the person named above and agree to pay all fees for such treatment. I agree to pay all charges presented unless credit arrangements are agreed upon in writing. Charges shown by statement are agreed to be correct unless protested in writing within 30 days of the billing date. In the event legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and any other costs associated with the collection of this account. I also agree that payments will not be delayed or withheld because of any pending insurance coverage and that all proceeds of insurance are assigned to this office where applicable. It is also agreed that the clinic holds no responsibility for the collection of insurance payments. _____ (Initial)

Authorization for Treatment

I hereby apply for and consent to such medical/surgical treatment for the above named patient as may be prescribed by the physicians of this clinic for proper health care. I also authorize this clinic to release appropriate information to the patient's referring doctor, health agency, government agency, insurance company or third party payee, and/or professional consultant for the payment of this account, continuing medical care, or as required by law. _____ (Initial)

Privacy Notice Receipt

I acknowledge receipt of the Privacy Practices Notice from this clinic. _____ (Initial)

This is a yearly authorization unless specifically revoked in writing by the undersigned.

Signature of Responsible Party_____

Relationship to Patient _____Date_____

Witness_____

407 S. Medical Arts Court, Suite D • Gillette, Wyoming 82716 • (307) 682-0400 • Fax (307) 686-7420

RELEASE OF INFORMATION AUTHORIZATION

Patient Name (please print)

I, _____ _____ _____
Name Birthdate SS#
hereby authorize and request the use and disclosure of all health information that pertains to me. I authorize **Gillette Internal Medicine Associates, PC** to make these disclosures of my health information to the following persons and elect not to provide a statement of purpose for the use of the disclosure to the following persons (please print):

_____ Do not release information to anyone other than myself

_____ Release my protected health information to the following people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that any information disclosed pursuant to this authorization may be re-disclosed to additional parties and may no longer be protected.

I understand that this authorization will automatically expire one year from the date signed, but that I may revoke this authorization at any time by signing the revocation section of this form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

_____ _____
Signature Date

AUTHORIZATION FOR APPOINTMENT REMINDERS AND MESSAGES

I hereby authorize **Gillette Internal Medicine Associates, PC** to call my residence for the purpose of reminding me of my appointments AND to leave messages regarding my health care. In case I am not available to receive the reminder call, I also authorize **Gillette Internal Medicine Associates, PC** to communicate the reminder by:

- leaving a message with the person who answers the telephone call; or by
- leaving a message on my answering machine/voice mail.

I understand that the message will identify the call as coming from **Gillette Internal Medicine Associates, PC** and will include the date and time of my appointment. If necessary, the message will also include special instructions regarding the appointment.

_____ _____
Signature Date

********ONLY COMPLETE THIS SECTION IF YOU WISH TO REVOKE AUTHORIZATION********

I revoke this authorization effective (date)_____.

_____ _____
Signature Date

REGISTRATION FORM

PATIENT INFORMATION *(Please Print Clearly)*

Name:_____ Birthdate:___/___/___
(Last) (First) (Middle) (Maiden)

Mailing Address:_____
(Street) (City) (State) (Zip)

Primary Telephone:_____ Home:_____ Work:_____ Cell:_____

Marital Status: __Child __Single __Married Sex: __Male __Female SSN: _____

Race:_____ Ethnicity:_____ Preferred Pharmacy:_____

Employer:_____ Employer's Telephone:_____

RESPONSIBILITY PARTY INFORMATION: *(Please do not list insurance carrier)*

Name:_____ Birthdate:___/___/___
(Name of both parents or name of spouse)

Mailing Address: _____

Relationship to Patient: _____Primary Telephone:_____

Employer:_____ Employers Telephone:_____

Employers Address: _____

EMERGENCY INFORMATION: (Whom we may notify in case of emergency)

(1)_____
(Name of spouse or close relative & relation to patient)

Address: _____ Telephone: _____

(2)_____
(Name & relationship of friend or relative not residing at your present address)

Address: _____ Telephone: _____

INSURANCE INFORMATION

Primary Insurance Name:_____

Address: _____ Telephone: _____

Policy Holders Name:_____ Policy Holders DOB:_____

ID #:_____ Group #: _____ Effective Date: _____

Secondary Insurance Name:_____

Address: _____ Telephone: _____

Policy Holders Name:_____ Policy Holders DOB:_____

ID #:_____ Group #: _____ Effective Date: _____

All information provided above is true & correct.

X_____
Signature of Responsible Party Date

MEDICAL HISTORY

Name_____SS#_____Date_____
Mailing Address_____ Occupation _____
Phone (home)_____(work)_____(cell)_____Date of Birth_____Age_____
Chief Complaint_____

CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER AND VITAMINS/SUPPLEMENTS)

DRUG ALLERGIES

OTHER ALLERGIES (FOOD, ANIMALS, ETC.)

FAMILY HISTORY

	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
Heart Disease	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒
Epilepsy/Convulsions	❒	❒	❒	❒	❒	❒
Bleeding Disorders	❒	❒	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒	❒	❒
Thyroid Disease	❒	❒	❒	❒	❒	❒
Mental Illness	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

❒ Hypertension_____ ❒ Pneumonia_____ ❒ Prostate Disease_____ ❒ Venereal Disease_____
❒ Hyperlipidemia_____ ❒ Liver Disease_____ ❒ Bowel Irregularity_____ ❒ Frequent Infections_____
❒ Arrhythmia_____ ❒ Sexual Dysfunction_____ ❒ Incontinence_____ ❒ Hepatitis_____
❒ Myocardial Infraction_____ ❒ Menstrual Dysfunction_____ ❒ Dizziness/Fainting_____ ❒ Scarlet Fever_____
❒ Stroke/TIAs_____ ❒ Endocrine Disease_____ ❒ Anxiety_____ ❒ Rheumatic Fever_____
❒ Claudication_____ ❒ Headache_____ ❒ Fatigue_____ ❒ Mumps_____
❒ Congestive Heart Failure_____ ❒ Heart Palpitations_____ ❒ Shortness of Breath_____ ❒ Measles_____
❒ Congenital Heart Disease_____ ❒ Heart Murmur_____ ❒ Orthopnea_____ ❒ Rubella_____
❒ Epilepsy_____ ❒ Nervousness_____ ❒ COPD_____ ❒ Polio_____
❒ Chest Pain/Angina_____ ❒ Depression_____ ❒ Gout_____ ❒ Chronic Rashes_____
❒ Peripheral Vascular Disease____ ❒ Ulcer_____ ❒ Osteoporosis_____ ❒ Diphtheria_____
❒ Allergies/Hay Fever_____ ❒ Lactose Intolerance_____ ❒ Arthritis_____ ❒ Other_____
❒ Asthma_____ ❒ GI Disorder_____ ❒ Diabetes_____ ❒ Other_____
❒ Bronchitis_____ ❒ Gallbladder Disease_____ ❒ Anemia_____ ❒ Other_____

Women Only: Are you pregnant? ❒ Yes ❒ No Are you planning pregnancy? ❒ Yes ❒ No

Men Only: *It's common for men to occasionally experience erection difficulties.* Is this something that happens to you? ❒ Yes ❒ No

HABITS

❒ Tobacco: Type_____ How often?_____ How long?_____ Interested in stopping?_____
❒ Exercise Routine:_____
_____
❒ Coffee: Cups Daily_____ Other Caffeine_____
❒ Alcohol: Type_____ Amount_____
❒ Diet: Salt Intake_____ Fat Intake_____
❒ Sleep: Difficulty Falling Asleep_____ Continuity Disturbances_____ Snoring_____ Early morning awakening_____ Daytime Drowsiness_____ Other_____