ARVIND K. WADHWA, M.D
INTERNAL MEDICINE

Name:______________________________ Date:____________

DOB:__________ Age:_____ Gender:__________ SSN#:__________

Address:__________________________ Apt #__________

City:______________ Zip code:______________

Home Phone:________________ Cell Phone:______________

E-Mail:______________________________

Who referred you to our practice?______________________

Emergency Contact:

Name:____________________ Relationship:______________

Home/Cell Phone:________________

May we disclose necessary medical information to this person? Yes or No

INSURANCE INFORMATION:

Primary Insurance

Name:______________ ID #:______________ Group #:__________

Insured Person's Name:______________ DOB:____________

Relationship of patient to insured:______________

Past Medical History

Have you ever had or been diagnosed to have (please check all that apply)

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Artrial Fibrillation
- ☐ Cancer: What Kind:__________
- ☐ Cataracts
- ☐ Chickenpox
- ☐ Colon Polyps
- ☐ COPD/ Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Migraines/ Headaches
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizure/ Epilepsy
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Urinary Incontinence
- ☐ Other:

Medication List:

Please list all prescriptions and non-prescription medications or attach a list.
Please include Vitamins, birth control, pain medications, etc...

Medication	Dose	How many times per day?

☐ **TAKE NO MEDICATIONS**

Allergies or intolerance to medication (include type of reaction):____
____
____

I hereby acknowledge and understand that as a new patient of Dr. Wadhwa, I will be referred out for pain management/ narcotic prescriptions, and psychiatric care and medication.

____
Patient Signature/ Date

Pharmacy OR Mail Order:

Pharmacy Name:______________________________

Address:______________________________

Phone Number:______________________________

HOSPITALIZATION AND SURGERIES

List any hospitalization and surgeries, or procedures you have had performed

WHAT	DATE	WHAT	DATE

OTHER HEALTH ISSUES:

TOBACCO USE

Smoke Cigarettes: ☐ Never ☐ No ☐ Yes
(If you never smoked please go to alcohol use question)

Quit Date: ________ How many years did you smoke? ________

Approximately how many packs a day did you smoke: ________

Current Smoker: Pack(s)/day: _____ # of years: _______

Other tobacco: ☐Pipe ☐Cigar ☐ Snuff ☐ Chew

ALCHOL USE

Do you drink alcohol? ☐ No ☐ Yes
# of drinks/week: _____ ☐Beer ☐Wine ☐ Liquor

DRUG USE

Do you use marijuana or recreational drugs? ☐ No ☐ Yes
Have you ever used needles to inject drugs? ☐ No ☐ Yes

SEXUAL ACTIVITY

Sexually involved currently ☐ No ☐ Yes
Sexual partner(s) is/are/have been ☐ Male ☐ Female
Birth control method (circle below all that apply) None ☐
Condom, pill, diaphragm, vasectomy, other______

EXCERISE

Do you exercise regulary? ☐ No ☐Yes
What kind of exercise? ____
How long (minutes)? _________ How Often? ____________

DIET

How would you rate your diet? ☐ Good ☐ Fair ☐ Poor
Would you like advice on your diet? ☐ No ☐ Yes

SAFETY

Do you use a bike helmet? ▭ No bike ▭ No ▭ Yes
Do you use seatbelts consistently? ▭ No ▭ Yes
Does your home have a working smoke detector? ▭ No ▭ Yes
If you have guns in your home, are they locked up? ▭ No ▭ Yes ▭ Not Applicable
Is violence at home a concern at you? ▭ No ▭ Yes

Have you ever been convicted of felony? ▭ No ▭ Yes

Have you completed an Advanced Directive for Health Card, Health care proxy, Living Will or MOLST (circle above all that apply) ▭ No ▭ Yes

If yes, please attach

SOCIAL HISTORY

Occupation (or prior occupation): ________________ Retired/Unemployed/Leave of absence/ Disabled(Circle one)
Employer:________________________Years of education or highest degree:______________
Marital status (circle one): Single, Partner, Married, Divorced, Widowed
Spouse/partner's name: _____________ Number of children: ______________
Who lives at home with you? ________________________________
Leisure activities, group involvement, volunteer work, recent travel:____
____
____

WOMEN'S HEALTH HISTORY

Total number of pregnancies: ______________ Number of births: ___________
Date (month/day if known) of last menstrual period: _______________
Age at beginning of periods(menstruation): _______
Age at end of periods(menopause): _________

SPECIALISTS

List any other doctors involved in your care.

Name	Specialty

HEALTH MAINTENANCE:

If you've had a test or vaccine done, list when last performed:

- ☐ Bone density:__________
- ☐ Cholesterol screen:_______
- ☐ Colonoscopy:________
- ☐ Dental Exam:________
- ☐ Eye Exam:________
- ☐ Flu Vaccine:____________
- ☐ Pneumonia Vaccine:_______
- ☐ Tetanus Vaccine:________
- ☐ Hep B Vaccine:_________
- ☐ HIV Testing:________
- ☐ HPV Vaccine:_________
- ☐ Mammogram:_________
- ☐ Meningococcal Vaccine:_______
- ☐ Pap Smear:_______
- ☐ Shingles Vaccine:_______

FAMILY HISTORY

Please indicate if your blood relative(s) have had or currently have the following by placing who has it

	FAMILY MEMBER
ALCOHLISM OR DRUG PROBLEMS	
MENTAL HEALTH ISSUES	
HEART ATTACK/DISEASE	
HIGH CHOLESTEROL	
HIGH BLOOD PRESSURE	
DIABETES	
CANCER	
OTHER	

PATIENT TREATMENT WAIVER

DATE_______________________________________

I ____ am fully aware that I am responsible for any payment due to Dr. Arvind Wadhwa that my insurance company may not cover for any reason.

I ____ understand that all copayments are due at the time of service. If I am unable to make my copayment at the time of service and a bill needs to be sent out.

I ____ There is also a fee of $50.00 for **NO SHOWING** for any scheduled appointment. Please be courteous and call the office if you cannot make one of your appointments. Most days there are patients that are on a waiting list for a cancellation. This would give us the opportunity to offer the appointment to one of those patients in need. Thank you for your consideration.

*****Some insurance plans require you to assign a primary care physician, please call your insurance company. The phone number for customer service is located on the back side of your insurance card. Please have Dr. Wadhwa listed as PCP prior to your scheduled appointment.*****

Signing below states you understand the policies in place for the office. It also indicates that you agree with the terms and conditions of policies.

____
PRINT NAME

____
PATIENT SIGNATURE

____
PRINT WITNESS NAME

____
WITNESS SIGNATURE

273 Division Street, North Tonawanda, NY 14120
Phone: (716) 693-3344 Fax: (716) 693-2448

Arvind K. Wadhwa, M.D.
Internal Medicine

CANCELLATION / NO SHOW POLICY

Welcome to the practice of Dr. Arvind K. Wadhwa, MD. As you will find here at the practice, we pride ourselves on working closely with patients. Most of you will find that coming here for a visit is a not like other doctor visits. With my practice and my office staff, you will feel the reassurance of being in good hands.

As many of my patients know, I am usually able to accommodate a patient when needed due to the urgent need of my patient and or family availabilities. Because of this, I am asking for the courtesy of at least a **24 hour notice** for any cancellation of appointments to avoid a $50.00 **late cancellation fee (LCF)**. This fee is not covered by insurance

I am also enforcing a **missed appointment fee (MAF)**, our office provides you with a courtesy call prior to your appointment (2 days' notice), and in the event of a "no show" there will be a charge of $50.00 applied to your account that is **NOT** covered by insurance. I am simply asking for the courtesy of a call if you cannot make your appointment that has been scheduled. This fee will stand for any new patient scheduled that does not show. In the case of a new patient, you will not be able to schedule with me again.

Although there are circumstances beyond our control, this decision for these fees will be a standard procedure that will be followed. If you are assessed one of these fees, please know that it is based on MY discretion as to the standing or reduction of the fee. Feel free to address this with me at the time of your next visit.

The assessment of these fees are not meant as a punishment, but rather a way for patient's to understand the importance of my office hours. As I am looking for a way to fulfill all the needs of by patients in the hours that I have available in the office.

Thank you for your understanding with this policy, my only goal is to provide the best quality of care to all of my patients in a manner that is acceptable for all parties involved.

SIGNATURE OF PATIENT ______________________ DATE ____________

273 Division Street, North Tonawanda, NY 14120
Phone: (716) 693-3344 Fax: (716) 693-2448

HEALTHeLINK Authorization for Access to Patient Information Through HEALTHeLINK

Patient First Name

Patient Last Name

Date of Birth ___/___/_____ (M M / D D / Y Y Y Y)

Patient Address

Street ______ Apartment ______

City ______, State ______ Postal Code ______

Gender
- ☐ Male
- ☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

	Choice	Description
☐	1. YES	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.
☐	2. YES, EXCEPT SPECIFIC PARTICIPANT(S)	**I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below. Participant's Name (Provider Office): ______ Participant's address or phone number: ______
☐	3. YES, ONLY SPECIFIC PARTICIPANT(S)	**I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK. Participant's Name (Provider Office): ______ Participant's address or phone number: ______
☐	4. NO, EXCEPT IN AN EMERGENCY	**I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.
☐	5. NO, EVEN IN AN EMERGENCY	**I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, *even* in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Print Name of Patient's Legal Representative (if applicable)

Signature of Patient or Patient's Legal Representative

X______

Date of Signature ___/___/_____ (M M / D D / Y Y Y Y)

Relationship of Legal Representative to Patient (if applicable)
- ☐ Parent
- ☐ Healthcare agent/proxy
- ☐ Guardian
- ☐ Other______

This Box To Be Filled Out Only By The Provider

Arvind K Wadhwa MD

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

Print Name of Witness ______ Signature of Witness ______

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.) ______

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
DR. ARVIND WADHWA 273 DIVISION ST N. TON NY 14120 FAX # 716-693-2448

9(a). Specific information to be released:
- ☐ Medical Record from (insert date) ________ to (insert date) ________
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: ________

Include: (*Indicate by Initialing*)
- ________ **Alcohol/Drug Treatment**
- ________ **Mental Health Information**
- ________ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ________ (Initials) I authorize ________ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

________ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

____
Signature of patient or representative authorized by law.

Date: ________

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**