MAHENDRA MAHATMA, M.D.
6500 Sierra Dr. Ste. 170
Irving, Texas 75039
Phone: 972-331-1590 Fax: 972-331-1599

PATIENT INFORMATION

******PLEASE PRINT LEGIBLY******

PATIENT NAME:____ SSN#:__________________________
(LAST) (FIRST) (MI)

HOME PHONE:__________________________ CELL PHONE/ALTERNATE:__________________________

E-MAIL:____

HOME ADDRESS:____ APT#______________

CITY, STATE:______________________________________ ZIP____________________

SEX: MALE____ FEMALE____ BIRTHDATE:__________________AGE:_____________

MARTIAL STATUS: MARRIED SINGLE DIVORCED WIDOW

REASON FOR VISIT:____

* *

REFERRING PHYSICIAN: ________________________________ PHONE:______________________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE:______________________

* *

EMPLOYER:____

EMPLOYER'S ADDRESS:__________________________________ CITY:__________STATE:__________

EMPLOYER'S PHONE:_________________________OCCUPATION:______________________________

* *

IN CASE OF AN EMERGENCY NOTIFY:____

RELATION:______________________________________ PHONE:_____________________________

DO YOU HAVE A DRUG CARD?:______

* *

I hereby authorize, Dr. Mahendra Mahatma's office to release written or verbal information to my doctor or insurance carrier, should information be requested. In consideration of services rendered, I hereby assign to Dr. Mahatma, benefit payments due from my insurance company for medical expenses incurred which are payable to me.

Payment is due at time of service! This includes all copays, deductibles, and any other non-covered items.

I have been informed of or received a copy of the "Privacy Notice".

A $25 fee will be charged for all "NO SHOW" appointments not cancelled at least 24 hours in advance.

____ ___________________________

SIGNATURE OF PATIENT **DATE**

PATIENT HISTORY

NAME:_____ **SEX:**_____ **DATE OF BIRTH:**_____
ADDRESS:_____ **HOME PHONE:**_____

NAME OF PHARMACY:_____
PHARMACY ADDRESS:_____ **PHONE NO:**_____

FAMILY PROFILE

SPOUSE:

_____ **LIVING**
_____ **HEALTH STATUS**
_____ **AGE**
_____ **OCCUPATION**

_____ **DECEASED**
_____ **YEAR**
_____ **CAUSE**

CHILDREN:

_____ **NUMBER LIVING**

_____ **DECEASED**
_____ **CAUSE**

OTHERS IN HOUSEHOLD:_____

OCCUPATIONAL PROFILE:

_____ **EMPLOYED**
_____ **TYPE OF WORK**
_____ **LENGTH OF EMPLOYMENT**
_____ **WORKING HOURS**
_____ **SOURCE OF INCOME**

_____ **UNEMPLOYED**
_____ **REASON**
_____ **LENGTH OF TIME**
_____ **PREVIOUS OCCUPATION**

HOUSEHOLD RESPONSIBILITIES:_____
_____

HOBBIES/INTEREST:_____
_____

PERSONAL HISTORY

_____ **ALCOHOL CONSUMPTION**
_____ **SUBSTANCE**
_____ **AMOUNT**
_____ **FREQUENCY**

_____ **CAFFEINE CONSUMPTION**
_____ **AMOUNT**
_____ **FREQUENCY**

_____ **TOBACCO USE**
_____ **NUMBER PER DAY**
_____ **NUMBER OF YEARS**

HEALTH HISTORY

ALLERGIES:_____
FOOD:_____
DRUG:_____
OTHERS:_____

PAST MEDICAL HISTORY

___ High Blood Pressure	___ Diabetes	___ Peptic Ulcer	___ Other:
___ Heart Disease	___ Diverticulosis	___ Pancreatitis	
___ Hepatitis	___ Rheumatic Fever	___ HIV/Autoimmune Disease	

HOSPITALIZATION/SURGERIES:

_____

_____

_____

_____

_____

Please check and give the year of onset of any of the following illnesses you now have or have had in the past.

GENERAL
___ Recent Weight Change
___ General Fatigue
___ Change in Appetite

HEENT
___ Frequent Headache
___ Eye disease or injury
___ Double Vision

___ Worsening Vision
___ Color Blindness
___ Hearing Loss
___ Sinus Trouble
___ Nosebleeds
___ Hoarseness
___ Sore Throat
___ Neck Lumps or swelling
___ Neck Stiffness or pain

CARDIOPULMONARY

___ Shortness of breath
___ Chronic Cough
___ Coughing up Blood
___ Difficulty Breathing
___ Chest pain or Angina
___ Wheezing
___ Sweats or chills

___ Swollen Feet or Ankles
___ Waking at night, smothering
___ Heart Murmur
___ Heart palpations

GASTROINTESTINAL

___ Heartburn/Indigestion
___ Frequent nausea
___ Vomiting Blood
___ Trouble Swallowing
___ Change in Bowel Habits
___ Constipation
___ Frequent Diarrhea
___ Gray/White stool
___ Black bowel movement
___ Blood in the stool
___ Hemorrhoids
___ Cramping or abdominal pain

GENITOURINARY

--- Loss of urine/incontinence
___ Weak urine stream
___ Difficulty starting urine
___ Frequent urination
___ Waking from sleep to Urinate
___ Burning or painful urination
___ Black or bloody urine
___ Kidney stone
___ Urine Infections

FAMILY MEDICAL HISTORY:
Please list any of the above illnesses which have occurred in your family, and who experienced it, i.e., Mother-peptic ulcer, Grandmother-heart disease, etc:

_____

_____

Does anyone in your family have colon cancer?_____ **If so, who**_____

Does anyone in your family have colon polyps?_____ **If so, who**_____

How many brothers and sisters do you have? _____ **Are they alive?**_____

Have you traveled to West African Countries: Guinea, Nigeria, Sierra Leon, Liberia, Sengal, or Dominican Republic of the Cango in the past 21 days? YES___ NO___

Have you been in physical contact or cared for anyone with diagnosed or suspected to have Ebola Virus Disease? YES___ NO___

Have you had a fever (100.4 F) plus any one of the following symptoms: diarrhea, vomiting, headache, weakness, muscle pain, abdominal pain, or hemorrhaging? YES___ NO___

Please list all medications that you are taking on a regular basis.

NAME OF MEDICATION	DOSAGE	HOW OFTEN & WHEN TAKEN

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ATTENTION PATIENTS:

We will attempt to send you to the correct labs (as per current lists). However, you are ultimately responsible to be sure that your insurance is contracted with the lab. Please check with your insurance company or refer to your policy. We will not assume any responsibility for this issue. Please know that a 72-hour notice is required for all procedure cancellations, if not you will be charged a $200.00 cancellation fee. Please sign below to acknowledge that you understand the above statement.

X_____Date_____

NOTICE

Patients who have a HMO or POS Insurance are responsible for obtaining their own referral from their primary care physician.

There must be a valid referral at the time of service or you will be expected to pay for the days charges.