Allen Family First Clinic
Chanda Reddy, D.O., F.A.A.F.P

(Personal Information)

Name:____
Last First MI

Address:____
Street City State ZipCode

Home Phone:____________________ Cell Phone:____________________

SocialSecurity#____________________ Drivers License#:____________________

Date of Birth:____________________ Age:________Gender: ( ) Male ( ) Female

Marital Status: ( )Single ( )Married ( ) Divorced ( )Seperated ( )Widowed

Employer:________________________ Work #:____________________

Wk.Address:________________________ E-Mail:____________________

In Case Of Emergency Notify:____

Relationship:________________________ Telephone #____________________

(Insurance Information)

Primary Insurance Company:____

Name of Insured:________________________ Relationship to Patient:______________

Identification #:________________________Group #:____________________

Insured's Date of Birth:____________________ Insured's Employer:________________

Insurance Telephone Number:____

Who referred you to our office?____

Financial Agreement And Authorization of Treatment

I understand that I am required to give my current Insurance card, driver's license, and billing information for insurance to be filed on my behalf. I also understand that I will notify Allen Family First Clinic of any changes in my insurance or billing information. If accurate billing and insurance information is not given then I will be responsible for all charges incurred due to timely filing requirements by my insurance company. I am also responsible for services denied by my insurance company as "non-covered" or "not medically necessary." I authorize the treatment of the person named above and agree to pay for all fees for such treatment. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pending of such claims and that all proceeds of insurance will be assigned to this office. I authorize the release of any medical information necessary to process insurance claims and also request payment of Government benefits either to me or the party that accepts assignment below.

Signature on File:________________________ **Date:**____________________
Relationship to Patient:____

Allen Family First Clinic
Chanda Reddy, D.O.

Patient Health History Form

Name: ______________________ Date: ______________________
Gender: __ Male __ Female Age: _______ Birth Date: ______________________
Marital Status: __Single __ Married __Separated __Divorced __Widowed
Currently Living: __Alone __With Family __With Friends __With Significant Other
Profession(Job): ______________________ __Currently Working __Retired

Health History (please check all items)

	No	Yes		No	Yes
Abnormal EKG			Headache (frequent)		
Alcoholism			Heart Attack/Heart Disease		
Anemia			Heart Murmur		
Anxiety			Hemorrhoids/Rectal Problems		
Arthritis/Sore Joints			Hepatitis A.B. or C		
Asthma/HayFever			Hernia		
Bleeding/Bruising			High Blood Pressure		
Broken Bones			High Cholesterol		
Bronchitis/Emphysema			HIV/AIDS		
Cancer			Jaundice		
Cataracts			Kidney/Bladder problems		
Chemical Dependency			Leg or Foot Pain		
Chest Pain			Liver Disease		
Circulation Problems			Night Sweats		
Deafness/Dizziness			Phlebitis/Blood Clots		
Depression/Sadness			Psychiatric Care		
Diabetes			Sexually Transmitted Disease		
Difficulty Sleeping			Shortness of Breath		
Ear Infections			Sinus Trouble		
Epilepsy/Seizures			Skin Disease/Psoriasis/Eczema		
Fatigue/Tiredness			Stomach problems/Ulcers		
Forgetful			Stool/Bowel Problems		
Gall Stones			Stroke		
Glaucoma			Thyroid Problems		
Gout			Tuberculosis/Positive TB test		
Head Injury			Weight Loss or Gain		

Habits

Do you: If Yes, how much?

Smoke Tobacco _Y _N ________Packs/Day
Chew Tobacco _Y _N ________ Tins/Day
Drink Caffeine _Y _N ________ Cups/Day
Drink Alcohol/Wine _Y _N ______Drinks/Day
Drink Beer _Y _N ______ Cans/Day
Gamble _Y _N
Use Street Drugs _Y _N
Exercise _Y _N

Medications

Please list all medications you are now taking including over the counter meds.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________

Immunizations			
Flu Shot	__No	__Yes	Date: ________
Hepatitis B	__No	__Yes	Date: ________
MMR	__No	__Yes	Date: ________
Pneumonia	__No	__Yes	Date: ________
Tetanus	__No	__Yes	Date: ________

Allergies	
1.____________	Reaction____________________
2.____________	Reaction____________________
3.____________	Reaction____________________
4.____________	Reaction____________________
5.____________	Reaction____________________

Hospitalizations (including Surgeries)	
1.____________________	Year________
2.____________________	Year________
3.____________________	Year________
4.____________________	Year________

Serious Illness(not requiring hospitalization)	
1.____________________	Year________
2.____________________	Year________
3.____________________	Year________
4.____________________	Year________

Family History

Circle No or Yes and the family member associated

Condition			
Alcoholism	No	Yes	Family Member__________
Allergies	No	Yes	Family Member__________
Anemia	No	Yes	Family Member__________
Arthritis	No	Yes	Family Member__________
Asthma	No	Yes	Family Member__________
Birth Defect	No	Yes	Family Member__________
Cancer	No	Yes	Family Member__________
Colon/Bowel Issues	No	Yes	Member__________
Congenital Heart Defect	No	Yes	Member________
Diabetes	No	Yes	Family Member__________
Emphysema	No	Yes	Family Member__________
Epilepsy	No	Yes	Family Member__________

Circle No or Yes and the family member associated

Condition			
High Blood Pressure	No	Yes	Family Member__________
Kidney Disease	No	Yes	Family Member__________
Leukemia	No	Yes	Family Member__________
Liver Disease	No	Yes	Family Member__________
Mental Illness	No	Yes	Family Member__________
Migraines	No	Yes	Family Member__________
Nervous Breakdown	No	Yes	Family Member__________
Obesity	No	Yes	Family Member__________
Rheumatic Fever	No	Yes	Family Member__________
Sickle Cell Anemia	No	Yes	Family Member__________
Stomach Ulcers	No	Yes	Family Member__________
Stroke	No	Yes	Family Member__________

Men Only

Pain/Lumps in Testicles? __N __Y
Penile (penis) itching/burning/discharge? __N __Y
Prostate disease or problems? ___N ___Y
Problems with urine stream? ___N ___Y
Wake in night to use bathroom ? __N ___Y
Sexual problems/concerns? ___N ___Y
Do you feel safe in your home? ___N ___Y
Do you have a living Will? ___N ___Y

Women Only

Last Pap Smear ____________Abnormal? ___Y ___N
Last mammogram__________Abnormal? ___Y ___N
Age Period Started _________Problems? ___Y ___N
Ovarian Cysts? ___Y ___N
Sexual problems/concerns? ___Y ___N
Vaginal itching/burning/discharge? ___Y___N
Wake in night to use bathroom? ___Y___N
Number of Pregnancies_________ # of Births______
Number of Miscarriages_______ # of abortions _____
Birth Control Method:___________________________
Do you feel safe at home? ___Y__N
Do you have a Living Will? ___Y__N

Allen Family First Clinic
Request for Confidential Communications

Patient's name_____________________________

Date of Birth______________________________

I have been presented with a copy of the Notice Of Privacy Practices, detailing how my Health information may be used and disclosed as permitted under federal law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, or otherwise) by Dr. Chanda Reddy DO and staff are handled as follows:

1.) For **WRITTEN** communication, address as follows:

Mailing Address:____
FAX:____
Email:____

2.) For **ORAL** communication call the following number:

____
May we leave a detailed message (example: billing, labs, etc.)____**YES**____**NO**

3.) I give permission for Allen Family First Clinic to provide my personal healthcare Information to:

___________________________(relationship to patient)___________________
___________________________(relationship to patient)___________________

I understand that in the event I wish this document be changed, I will inform the office staff personally and sign a new document.

Patient signature:

____

Responsible Party Signature (if pt underage)

____

Relationship to Patient:

____

Date:

____

Allen Family First clinic
Chandana Reddy, D.O.,F.A.A.F.P.

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in this notice
I have reviewedthis office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

____
Name of patient (please print)

____
Signature of patient

____
Date

____
Signature of patient representative
(Requires is a minor or an adult that is unable to sign this form)

____
Relationship to patient

Allen Family First Clinic
ChandaReddy, D.O., F.A.A.F.P. (972)678-4600
977 Raintree Circle #110 (972)678-4602Fax
Allen,TX 75013

Financial Office Policy

Thank you for choosing our practice for your healthcare services. Your clear understanding of our Financial Policy is important to our professional relationship. Please speak with the office manager if you have any questions regarding this policy.

Payment is expected at the time of service

Payment is expected at the time services are rendered unless other arrangements have been made in advance. Such payments include co-payments, coinsurance, deductibles and non-covered services for participating services. We accept cash, credit and personal check. There is a $25.00 service charge on all returned checks. If the patient is a minor, the parent or guardian who brings the child in for the visit is the responsible party.

Insurance

If we are contracted with your insurance company we will file your claims for you. However, your insurance policy is contracted between you and your insurance company. It is important you understand your policies previsions. We cannot guarantee payment of your claims as the insurance company only "quote" benefits, they never guarantee benefits. It is your responsibility to make sure we have your most up to date insurance information so that we may correctly file your claims in a timely manner as all insurance companies have timely filing limits. You will be asked to show your insurance card at every visit for identification and to prevent insurance fraud. If we are not contracted with your insurance you will be expected to pay for the visit in full before seeing the doctor.

Referrals

If you are on an insurance plan that requires referrals, it is your responsibility to obtain a referral for your visits. The referral must be requested from your primary care physician prior to the appointment.

Forms and Prescriptions

School, camp and physical forms may be mailed, faxed or dropped off to our office. We require 24-48hours notice for completion. For written prescriptions, please call 24hours in advance of pick up to notify our office.

Medical Records

We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Medical records will be completed within 15 business days as mandated by the Texas Board of Medical Examiners and may be subject to a processing fee as determined by the board.

I have read and understand Allen Family First Clinic's Financial Policy. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for cost of collection.

Signature of Responsible Party: Date:

________________________ ________________________