LOS GATOS MEDICAL GROUP
Family Medicine & Urgent Care

SHAMALA MOHANASUNDARAM, MD
FAMILY MEDICINE

555 Knowles Drive, Ste # 109
Los Gatos, CA 95032
Tel: 408 370 0200
Fax: 408 370 0202

NEW PATIENT QUESTIONNAIRE

** Some of this information is required by the CMS (Centers for Medicare and Medicaid Services). Your demographic answers will never affect your care.*

Today's Date:_____ Date of Birth:_____

First Name Middle Initial Last Name

☐ Male ☐ Female

Primary Language: ☐ English ☐ Spanish
☐ Other _____

Race: ☐ White ☐ African-American ☐ Asian
☐ American Indian/Eskimo ☐ Pacific Islander
☐ Other _____

Ethnicity: ☐ non-Hispanic ☐ Hispanic

Social Security Number (if Medicare): ☐☐☐-☐☐-☐☐☐☐

_____
Street Address

_____
City State Zip Code

Cell Phone #:_____ Home Phone #: _____

Email Address:

_____

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Occupation:_____
Employer/School:_____
Work Phone #: _____

Emergency Contact Name: _____
Relation to you: _____
Emergency Contact Phone #: _____

Do you allow the doctor to disclose health information in case of emergency to your Emergency Contact ☐ No ☐ Yes

Pharmacy Name and Address:

_____
_____
_____

SINGLE MAIN REASON FOR DOCTOR'S VISIT TODAY:

_____

PLEASE NOTE: ANY CONCERNS DISCUSSED AND MANAGED AT THE TIME OF WELL VISIT IS CONSIDERED AS AN OFFICE VISIT AND THERE MAY BE ADDITIONAL CHARGE.

Who are your other doctors?

NAME	**SPECIALTY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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PAST MEDICAL HISTORY:

☐ Cancer: (Type and Treatment) _____	MUSCULOSKELETAL ☐ Arthritis ☐ Osteopenia/Osteoporosis
CARDIOVASCULAR ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke/CVA ☐ MI/heart attack ☐ Vascular Disease ☐ Atrial Fibrillation ☐ Check if you have a Pacemaker ☐ Check if you have a Defibrillator? ☐ Heart Problems: What kind?	INFECTION/IMMUNOLOGIC ☐ Hepatitis ☐ Tuberculosis (TB) ☐ Immune Disorder ☐ Lupus ☐ Psoriasis ☐ Rheumatoid Arthritis
ENDOCRINE ☐ High Thyroid Levels (Hyperthyroid) ☐ Low Thyroid Levels (Hypothyroid) ☐ Diabetes ☐ Insulin Dependent	GI/GU ☐ Kidney Disease ☐ Liver Disease ☐ Stomach Ulcers ☐ Gastric Reflux/GERD
NEUROLOGIC ☐ Multiple Sclerosis ☐ Epilepsy/Seizures ☐ Parkinson's ☐ Alzheimer's ☐ Drug Abuse/Alcohol Dependence	RESPIRATORY ☐ Asthma ☐ Bronchitis/Emphysema ☐ Pneumonia
BLOOD DISORDER ☐ Anemia ☐ Bleeding Disorder ☐ History of blood clots (e.g. pulmonary embolism and/or DVT)	OTHER CONDITIONS: _____ _____ _____

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List previous hospitalizations, major surgeries, serious injuries and approximate dates:

Surgery/Injury/Hospitalization Date

_____
_____
_____
_____

MEDICATIONS: List all medications you are taking and dosages (prescription and all over-the-counter drugs):

Medication Dosage (e.g. mg) **Times/day**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

External treatment History consent (Do you allow the doctor to see the medications that your other doctors had put you on?)

☐ No ☐ Yes

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ALLERGIES: List medication, food, latex and environmental allergies and describe reaction(s):

☐ No known drug allergies

Allergen _____ Reaction _____

_____

_____

_____

_____

_____

FAMILY HISTORY:

List any health problems in your immediate family:

	Age	Medical Problems	If Deceased: Cause & Age at Death
Father :			
Mother:			
Siblings:			
Children:			

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Tel: 408.370.0200
Fax: 408.370.0202

Shamala Mohanasundaram, MD
FAMILY MEDICINE

SOCIAL HISTORY:

Alcohol Screen:

Did you have a drink containing alcohol in the past year?

☐ Yes ☐ No

How often did you have a drink containing alcohol in the past year?

☐ Never (0 point) ☐ Monthly or less (1 point) ☐ 2 to 4 times a month (2 point)
☐ 2 to 3 times a week (3 points) ☐ 4 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point) ☐ 3 or 4 drinks (1 point) ☐ 5 or 6 drinks (2 points)
☐ 7 to 9 drinks (3 points) ☐ 10 or more drinks (4 points)

How often did you have 6 or more drinks on one occasion in the past year?

☐ Never (0 point) ☐ Less than monthly (1point) ☐ Monthly (2points) ☐ Weekly (3 points)
☐ Daily or almost daily (4 points)

Total Points: _____

Tobacco Use/Smoking:

Are you a:

☐ Current smoker ☐ Former smoker ☐ Nonsmoker ☐ Light tobacco smoker ☐ Heavy tobacco smoker

Drugs:

Have you used drugs other than those for medical reasons in the past 12 months?

☐ Yes ☐ No

Household:

Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Not Answered

SHAMALA MOHANASUNDARAM, MD

555 Knowles Drive, Suite 109

Los Gatos, CA 95070

PAYMENT POLICIES

ALL CO-PAYS AND BALANCES HAVE TO BE PAID IN FULL AT THE TIME OF OFFICE VISIT.

MISSED APPOINTMENTS/LATE ARRIVALS

Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be billed to you directly, not your insurance.

. FOR ESTABLISHED PATIENTS

- **NO SHOW AND NO CALL TO RESCHEDULE WITHIN 48 HOURS OF APPOINTMENT WILL BE CHARGED $50 for Office Visit and $75 for Well Visit.**
- A patient who **arrives 15 minutes after the appointment time** is considered late arrival and will have to reschedule his/her appointment.

Please help us serve you and other patients efficiently by arriving on time for your scheduled appointments. Giving us a call to reschedule on time will enable us to accommodate other patients who are in need of urgent care.

Thank you.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party: _____

Date: _____

LOS GATOS MEDICAL GROUP
Family Medicine & Urgent care
M.SHAMALA, MD
FAMILY PRACTICE

555 Knowles Drive, Ste # 109
Los Gatos, CA 95032
Tel: 408. 370 0200
Fax: 408.320 0202

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations
&
Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my health care, M.SHAMALA, M.D., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been presented with a copy of M.Shamala, M.D.'s Notice of Privacy Practices (hereto forth referred to as "the Notice"), detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that M.Shamala, M.D., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that M.Shamala, M.D., reserves the right to change the Notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should M.Shamala, M.D., change the Notice substantively, she will send a copy of any revised Notice to the address I've provided, whether by U.S. mail or email.

I request the following restriction(s) concerning the use or disclosure of my personal medical information:

_____

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M.SHAMALA, MD
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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. Further, I permit a copy of this authorization to be used in place of the original

Signature of patient or parent/guardian if minor _____ Print Name _____ Date _____

If not signed by patient, please indicate relationship to patient (e.g., spouse):

Relationship: _____

HIPAA Addendum for eEHX

We may also share protected health information with your other healthcare providers in order for him or her to treat you. This information is shared electronically, in a restricted, secure format.

You may request that this office not provide electronic access to your protected health information to other healthcare providers. Opting out will stop this office from sharing your health information electronically with all other healthcare providers. However, this will not stop your other doctors and healthcare providers from electronically sharing your health information. Note that if you stop this office from electronically sharing your protected health information, it may not be available, even in an emergency. Denying this access to your healthcare providers may make it more difficult for doctors and healthcare providers to coordinate your care. This could have an adverse effect on the quality and efficiency of your healthcare services.

If you do Opt Out, we may share your health information with other healthcare providers for the purposes of your treatment, and to coordinate your care.

Signature of patient or parent/guardian if minor _____ Print Name _____ Date _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of the Notice, please document the date and time the Notice was presented to patient and sign below.

Presented on (date and time): _____