

**EAST COAST RHEUMATOLOGY, PLLC
PREM C. CHATPAR, M.D., LLC AND ASSOCIATES**

877 Stewart Avenue
Garden City, New York 11530
(516) 745-0202

524 Old Country Rd
Plainview, New York 11802
(516) 931-3988

5 East Main Street
Huntington, NY 11743
(631) 629-4588

PATIENT INFORMATION

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____ CELL PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT/NEAREST RELATIVE: _____

D.O.B.: ___/___/___ AGE: ___ STATUS: S M W D EMAIL ADDRESS: _____

EMP. NAME: _____ S.S # _____ SEX: _____ **Referring M.D. or P.C.P** _____

**RESPONSIBLE PARTY (INSURED) INFORMATION
(IF SAME, WRITE SAME)**

NAME: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

D.O.B.: ___/___/___ S.S # _____ SEX: _____

EMPLOYER: _____ PATIENT RELATIONSHIP: _____

INSURANCE INFORMATION

PLEASE SHOW US ANY INSURANCE CARDS YOU HAVE, AND **FILL IN THE FOLLOWING INFORMATION:**

PRIMARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID #: _____

SECONDARY:

INSURANCE NAME: _____ INSURED PARTY: _____

ADDRESS: _____ INS. ID #: _____

- 1.) I hereby authorize the practice of PREM C. CHATPAR, M.D., LLC to furnish any and all records pertaining to medical history, services, rendered or treatment given to me or my dependents for purposes of review, investigation, or evaluation of claims.
- 2.) I agree that any services that are rendered by PREM C. CHATPAR, M.D., LLC, OR HIS ASSOCIATIES beyond the normal scope of medical care will be billed additionally. This additional charge will be incurred for Disability Reviews, Insurance Examination Statements, Social Security Evaluations, Disability Evaluations and records requested by counsel, at your request. (A schedule of fees will be made available to you at your request.)
- 3.) I authorize payment of medical benefits to the practice of PREM C. CHATPAR, M.D., LLC.
- 4.) I hereby agree if my insurance carrier does not in any circumstance, reimburse PREM C. CHATPAR, M.D., LLC at contracted rate or honor the claim; I will be responsible in full for payment for all services rendered.
- 5.) I also understand that a \$25.00 no show fee can be charged for cancellation of appointments with less than 24-hour notice.

PATIENT OR AUTHORIZED SIGNATURE (REQUIRED): _____ **DATE:** _____ **2012** NEWPT.115

DEAR PATIENT:

IN ORDER THAT YOUR CONSULTATION BE AS PRODUCTIVE AS POSSIBLE, PLEASE COMPLETE THE BRIEF INFORMATION SHEET BELOW. THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND IS INCLUDED IN YOUR MEDICAL RECORDS. THANK YOU VERY MUCH.

DR. PREM C. CHATPAR AND ASSOCIATES

PLEASE PRINT

NAME:(Last)_____ First)_____

NATURE OF VISIT:_____

WHICH JOINTS HURT? (Please check ALL that apply to you.)

- | | | | |
|------------------------------------|----------------------------------|---------------------------------|------------------------------------|
| <input type="checkbox"/> NECK | <input type="checkbox"/> HANDS | <input type="checkbox"/> HIPS | <input type="checkbox"/> FEET |
| <input type="checkbox"/> JAW | <input type="checkbox"/> WRISTS | <input type="checkbox"/> KNEES | <input type="checkbox"/> TOES |
| <input type="checkbox"/> SHOULDERS | <input type="checkbox"/> FINGERS | <input type="checkbox"/> ANKLES | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> ELBOWS | | | |

PAST HISTORY: (Please check ALL that apply to you.)

- | | | |
|--|---|--|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> STROKE | <input type="checkbox"/> HYPERTENSION |
| <input type="checkbox"/> PSORIASIS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> GOUT | <input type="checkbox"/> MIGRAINE | <input type="checkbox"/> STOMACH ULCER |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> MENTAL ILLNESS | <input type="checkbox"/> GASTRITIS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> OSTEOPOROSIS | |
| <input type="checkbox"/> CONNECTIVE TISSUE DISEASE | | |

PAST SURGICAL HISTORY_____

MEDICATIONS: (Please list ALL medications with dosages.)

ALLERGIES: (Please list ALL allergies.)

(Continued on back of this sheet)

SYMPTOMS AND COMPLAINTS: (Please check ALL that apply to you.)

GENERAL: FATIGUE EYE INFLAMMATION/REDNESS
 FEVER/CHILLS RINGING IN EARS
 WEIGHT LOSS MOUTH ULCERS
 HEAD PAIN DRY MOUTH
 DRY EYES ENLARGED GLANDS

SKIN: LOSS OF HAIR RAYNAUD'S PHENOMENON
 RASH SKIN TIGHTENING
 PHOTOSENSITIVITY SKIN ULCERS
 EYE SWELLING, REDNESS PSORIASIS
OR ITCHING

GASTROINTESTINAL:

DECREASED APPETITE VOMITING/NAUSEA
 SWALLOWING DIFFICULTY DIARRHEA/CONSTIPATION
 BURNING STOMACH PAIN BLEEDING
 ABDOMINAL PAIN JAUNDICE (Yellow skin)

HEART/LUNG:

ANGINA COUGH, PERSISTENT/WHEEZING
 CHEST PAIN LEG SWELLING
 SHORTNESS OF BREATH PREVIOUS HEART ATTACK
(Date: _____)

GENITOURINARY:

BURNING ON URINATION LAST MENSTRUAL PERIOD (_____)
 DISCHARGE MENSTRUAL ABNORMALITIES
 KIDNEY STONE BLOOD IN URINE

BLOOD:

ANEMIA
 OTHER BLOOD DISORDER (Please specify _____)

NEUROMUSCULAR:

SEIZURES MUSCLE WEAKNESS
 NUMBNESS/TINGLING ALTERED SENSATION
 MUSCLE PAIN HEADACHE

PERSONAL HISTORY: (Please complete as fully as possible.)

TYPE OF WORK: _____ NIGHT PAIN _____
DISABILITY: _____ Which joints? _____
STAIRS/CHAIRS: _____ DRESSING/GROOMING: _____
A.M. STIFFNESS: _____ CIGS/DAY: _____
How long? _____ ALCOHOL (oz./week): _____

THANK YOU FOR YOUR PATIENCE AND COOPERATION!

PREM C. CHATPAR, M.D., F.A.C.R.

*Diplomate of the American Board of Internal Medicine
Diplomate of the American Board of Rheumatology*

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Huntington, NY 11743
(631)-629-4588

Dear Patient:

As per HIPPA rules and regulations you are required to inform this office how you wish us to communicate with you in regards to your Personal Health Information (PHI). At times we may need to contact you to confirm your appointment, schedule tests, return your phone calls or to give you results of labs, x-rays, scans or consultations. We are required to follow your written instructions specifically, except where we feel following the instruction would be detrimental to your health or in case of emergency. Please be very specific as to how we are to reach you, where we can leave messages and with whom. Please fill in or circle.

You may/may not call me at home# _____

You may/may not leave a message on my answering machine. You may leave a message with (please circle) no one, my spouse, my children, other

You may/may not call me at work# _____

You may/may not leave a message on my voicemail

You may/may not call me on my cell phone _____

You may/may not leave a message on my cell phone

You may/may not fax me at # _____

You may call my preferred pharmacy for prescriptions at # _____

You may change your decision at any time by filling out a request for change with our office manager at 524 OLD COUNTRY ROAD, PLAINVIEW, NY 11803 or 877 STEWART AVENUE, GARDEN CITY, NY 11530.

Signature of Patient (or Personal Representative)

Date

Printed Name of Personal Representative / Relationship to Patient

Affiliated with the Long Island Osteoporosis and Arthritis Center

Specialists in Osteoporosis and Rheumatic Diseases

PREM C. CHATPAR, M.D., F.A.C.R.

Diplomate of the American Board of Internal Medicine

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DATE: _____

PATIENT NAME: _____

ACCOUNT NO: _____

This is to acknowledge receipt of a copy of the HIPAA Privacy Guidelines from the office of Prem. C. Chatpar, M.D. My signature below confirms the receipt of this information on the above date.

Printed Patient Name

Signature of Patient