

DRS. LAHIRI & MESIBOV, LLC

Patient Name: _____ Date of Birth: _____

Address/City/State/Zip: _____

Home Phone: _____ Leave message?

Cell Phone: _____ Leave message?

Work Phone: _____ Leave message?

Marital Status: _____ Social Security Number: _____

Employer Name: _____ or School Name: _____

Emergency Contact: _____ Phone: _____

Relation: _____

Preferred Pharmacy Name: _____ City: _____

Race (Please circle one): Asian American Indian/Alaska Native Native Hawaiian/Other Pacific
African American White Other: _____

Ethnicity (Please circle one): Hispanic/Latino Not Hispanic/Latino Other: _____

Primary Language: _____ Translator Needed?

Email Address: _____ Patient Portal: YES NO

Insurance Information

1. Primary Insurance Name: _____

Subscriber Name: _____ Subscriber DOB: _____

ID#: _____ Group #: _____

Relation: _____

2. Secondary Insurance Name: _____

Subscriber Name: _____ Subscriber DOB: _____

ID#: _____ Group #: _____

Relation: _____

I authorize Drs. Lahiri & Mesibov, LLC to release any medical information including information about prescriptions, test results, appointment times, appointment scheduling, and billing to the following individuals: (Personal contacts only. No Physicians.) **PLEASE LIST NAMES AND RELATIONSHIP.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I do not authorize any medical information to be released or discussed with anyone other than myself.

Patient Signature: _____ Date: _____

Medical History

Current Medications:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Medical Problems: (Example: Hypertension)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Surgeries, Date of Surgery: (Example: Appendectomy, 1995)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Family History: (Examples: Heart Attack – Father, Breast Cancer – Sister, Type 2 Diabetes – Mother)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Social History:

Are you: Single _____ Married _____ Divorced _____ Widowed _____

Number of children: _____

Your Occupation: _____

Your Spouse's Occupation: _____

Do you smoke? Yes _____ No _____

If yes, how many packs/day? _____ For how many years? _____

Do you drink alcohol? Yes _____ No _____ # of drinks /week _____

Do you take any illicit drugs? Yes _____ No _____

If yes, please describe: _____

Are you on any kind of special diet? Yes _____ No _____

If yes, please describe: _____

Do you exercise regularly? Yes _____ No _____

If yes, please describe the exercise you do and how often. (Example: Walk 30 minutes, 5 days/week.)

Do you have allergies to or have you ever had an adverse reaction to any medication? Please list and describe. (Example: Penicillin – rash)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Patient: _____ Age: _____

DRS. LAHIRI & MESIBOV, LLC

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Notice of Privacy Practices, and I have been provided an opportunity to review it.

NAME _____ **BIRTHDATE** _____

SIGNATURE _____ **DATE** _____

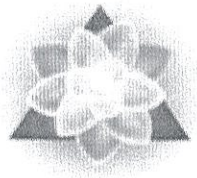
DRS. LAHIRI & MESIBOV, LLC
118 CENTRAL PARK SQUARE
LOS ALAMOS, NM 87544
(505) 662-4798

CANCELLATION POLICY

Drs. Lahiri and Mesibov, LLC requires 24 hours notice for all cancellations. All cancellations made in less than 24 hours and all missed appointments without notice will be charged a fee. For all new patient and complete physical appointment cancellations or missed appointments, there will be a \$50 fee. All other cancellations or missed appointments will incur a \$25 fee.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____



DRS. LAHIRI & MESIBOV, LLC

Aparamita Lahiri, MD
Endocrinology

David Mesibov, MD
Family Practice

Tracy B. Martin, PA-C
Family Practice

Consent to Treat Form

1. I _____ (patient name) _____ (DOB) give permission for **Drs. Lahiri & Mesibov** to give me medical treatment.
2. I allow **Drs. Lahiri & Mesibov** to file for insurance benefits to pay for the care I receive.
3. I understand that:
 - ◇ **Drs. Lahiri & Mesibov** will have to send my medical record information to my insurance company.
 - ◇ I must pay my share of the costs.
 - ◇ I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
4. I understand that:
 - ◇ I have the right to refuse any procedure or treatment.
 - ◇ I have the right to discuss all medical treatments with my clinician.

Patient's Signature

Date

Print Patient's Name

Parent or Guardian Signature
(for children under 18)

Date

Print Guardian's Name

This consent form remains valid until one year from the date of signature, unless effectively revoked in writing by the individual before that date.

DRS. LAHIRI & MESIBOV, LLC
118 CENTRAL PARK SQUARE
LOS ALAMOS, NM 87544
PHONE (505) 662-4798 FAX (505) 661-9637

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____ Phone: _____

Alternate Names (Maiden, etc.): _____

Release from: _____ Send to: _____

Release copies of the following: (Please initial all applicable areas.)

____ All medical records ____ Abstract of medical records(past 3 yrs.)
____ Immunization Records ____ Test Results
____ Other _____

For the purpose of: (check one)

____ Continuing Care ____ Personal Copy (fee may apply)
____ Insurance Claim ____ Legal Claim
____ Disability Determination ____ Endocrine Consultation
____ Other _____

This authorization is in effect for the following time period. Upon conclusion of this time period, this authorization is automatically revoked.

Time Period: _____ to _____

Patient/Legal Guardian Signature: _____ Date: _____