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 Spouses 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** __________________________

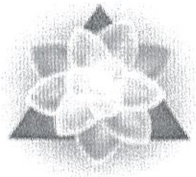
DRS. LAHIRI & MESIBOV, LLC
118 CENTRAL PARK SQUARE
LOS ALAMOS, NM 87544
(505) 662-4798

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 Date
(for children under 18)

____

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: ____________________________
____
____
Phone:_____________ Fax: ____________

Send to:
Drs. Lahiri & Mesibov
118 Central Park Square
Los Alamos, NM 87544
Phone: 505-662-4798 Fax: 505-661-9637

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

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

For the purpose of: (check one)

_____ Continuing Care
_____ Insurance Claim
_____ Disability Determination
_____ Personal Copy (fee may apply)
_____ Legal Claim
_____ 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:__________