

NEW PATIENT INSTRUCTIONS

- Please complete the new patient packet in FULL, mail it or bring it back to our office prior to your appointment, COMPLETELY FILLED OUT. FAILURE TO COMPLETE THE PACKET IN FULL WILL DELAY SCHEDULING YOUR APPOINTMENT.
- Insurance card—you MUST have the actual insurance card on the day of your appointment so it can be scanned into our system—insurance cards on phones will NOT WORK!
- If you need to list a doctor per your insurance company, make sure you **CALL YOUR INSURANCE COMPANY AND LIST DR. MAMDANI AS YOUR PRIMARY CARE DOCTOR. FAILURE TO DO THIS WILL RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.**
- Please arrive 5 minutes prior to your appointment to get registered.
- We do require that when our office calls you to confirm your appointment in advance, you must CONFIRM the appointment—failure to do this will result in your appointment being cancelled.

PATIENT SIGNATURE: _____

Patient Information

First Name:	Last Name:	Preferred Name:
Address: City, State, Zip:		
Home Phone: Cell:	Work Phone:	ext:
Date of Birth:	Soc Sec #:	
Email address:		
Sex: Male Female Marital Status: Married Single Other:		
Ethnicity:	Race:	Language:

Emergency Contact Name:
Relationship to Patient:
Phone Number:

Preferred Pharmacy:	
Name:	Location:

Health Insurance:	
Insurance Company Name:	
Insurance Phone Number:	
Insurance Company Address: City, State, Zip:	
Employer:	Group Number:

Please make sure to switch your PCP to Raza Mamdani, M.D. before your visit to our office. Please have all paperwork filled out completely before coming to appointment. Please bring insurance card with you or you will not be seen. Please arrive 15 minutes before the appointment time.

Patient History Form

Medical Problems (Explain “Yes” Answers)

	Yes	No	Explanation
Heart Disease			
Lung Disease			
Kidney Disease			
Strokes			
Seizures			
Bowel Problems			
Problems Urinating			
Diabetes			
High Blood Pressure			
Liver Problems			
Gallbladder			
Blood Clots			
Ulcers			
Cancers			
Thyroid Problems			
Vision/Hearing Problems			
Other Problems			

Surgical History

Reaction to anesthetics: Yes or No Bleeding Problems: Yes or No

[illegible]

Other Hospitalizations

Reason	Date	Physician/Hospital

Medications (Prescribed & Over the Counter)

Name	Dosage	Times Per Day

Allergies

Medications (Drug Name & Type of Reaction):

Food:

Other:

Family Health History

Father: Alive Age: Deceased Age: Cause:

Medical Problems:

Mother: Alive Age: Deceased Age: Cause:

Medical Problems:

Brothers/Sisters: Medical Problems/Causes of death

Children: Boys: Girls:

Medical Problems:

Gynecologic History

Menopausal Status: Pre Menopausal Post Menopausal Going through Menopause

Menstrual Period: Date of Last Period: Periods are: Regular or Irregular

Last Pap Smear: Date Gynecologist:

Last Mammogram: Date

Children: Ages:

All Vaginal Delivers: Yes or No History of Cesarean Section: Yes or No

Total Number of Pregnancies:

Travel History (Recent trips abroad-abroad Last 2 years)

Country	Length of Stay	Dates

Immunizations

Last Tetanus shot: Date: Did you have usual childhood Immunizations: Yes or No

If born after 1956, # of doses of Measles Vaccine: 0 1 2 or Don't Know

Have you had a : Flu Shot in past Yes or No Date of most recent:

Pneumonia Vaccine in Past Yes or No Date of most recent:

Organ Donor Status

Established Organ Donor Interested but not a donor Not Interested

Have a Health Care Proxy Signed? Yes or No

Have a Designees or Power of attorney or Medical decisions? Yes or No

Have a DNR (Do Not Resuscitate Order)? Yes or No

Occupation:

Habits

Tobacco

Never Smoked
Quit Smoking: Age Started Age Stopped: Packs Per day:
Presently Smoke: Packs per day Years:
Smoke Cigarettes Pipe Cigar Chew Tobacco
Tried to quit, Can't Want to quit

Alcohol

Never Drink Quit Drinking
Drink: Weekly (Type and Amount)
Daily (Type and Amount)

Drugs

Never used Drugs
Quit using Drugs
Present Drug user of:
Marijuana Cocaine Heroin PCP
Amphetamines Intravenous Drugs

Exercises

Never Exercise Rarely Exercise
Regularly Exercise: # of days per week

Seat Belts

Always Use Mostly Use Never Use

Sexual History

Marital Status: Married Divorced Single Separated
Number of previous marriages:
Orientation: Heterosexual or Homosexual
Number of partners in last 2 years:
Type of Contraception: Or None

RAZA MAMDANI, MD PC
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**MISSED APPOINTMENTS AND CANCELLATION
AGREEMENT**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Please review and sign our new policy regarding missing an appointment.

-I will be charged \$50 for all no show appointments and Cancellations made less than 24 hours in advance.

-I will be charged \$100 for all no show appointments and Cancellations made less than 24 hours in advance for Annual appointments.

-I agree to pay this amount before being seen for my next Appointment.

-I understand that after 3 consecutive no shows I may be Released from the practice.

Patient's Signature: _____

Date: _____

ABSOLUTELY NO EXCEPTIONS!

PATIENT RESPONSIBILITY FORM

1. **INDIVIDUAL'S FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service. Co-payments are due at time of service.

2. In the event that my health plan determines a service to be "not payable", **I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.**

3. I understand if I have an unpaid balance, I will not be able to make future appointment with the practice until I have paid the balance in full.

Signature

Date