

Diabetes, Thyroid and Endocrinology of Northern Ohio

Vikram Kumar M.D., F.A.C.E.

Please present your insurance card, list of medication and Drivers license and Copayment at the front desk

Date: _____ Time: _____

First Name: _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell _____

Social Security #: _____

Birthdate: _____ Age: _____ Sex: M F Marital Status: S M D W

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Employer: _____ Work Phone: _____

Employer's address: _____

Occupation : _____

Emergency Contact _____ Relationship: _____

Phone #: _____ May we leave information with this person: Y N

Referring Physician _____

Responsible Party Information:

FIRST NAME: _____ MI _____ LAST NAME _____

ADDRESS _____ CITY, STATE, ZIP _____

PHONE #: _____ BIRTHDATE _____ Social Security #: _____

EMPLOYER _____ ADDRESS _____

WORK PHONE: _____

If covered by Medicare, complete this section:

MEDICARE PRIMARY? YES NO ARE YOU EMPLOYED? YES NO

MEDICARE NUMBER(include letter) _____

Insurance Information

PRIMARY INSURANCE INFORMATION: _____

ADDRESS: _____ PHONE: _____

POLICY HOLDER: _____ ID # _____ GROUP # _____

SECONDARY INSURANCE: _____

ADDRESS: _____ PHONE: _____

POLICY HOLDER: _____ ID # _____ GROUP # _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF MY BILL, IN A TIMELY FASHION.

I authorize the release of my medical information necessary to process this claim and I authorize payment of medical benefits to the providing physician directly for services rendered.

Patient's Signature _____ Date: _____

Reason for visit: _____

MEDICAL HISTORY

When was your last physical Exam (estimated)? _____ Physician's Name: _____

Are you under treatment? _____ if yes, please describe: _____

Previous hospitalizations or surgery? _____ if yes, please describe and provide dates: _____

Current Medications: _____

Do you smoke? _____ Use alcohol? _____ Use cocaine or other drugs? _____

Do you have any drug allergies? _____ If yes, to what: _____

For women: Date of: Last menstrual period _____

Last mammogram _____

Last PAP smear _____ normal abnormal

Write "yes" next to any of the following you have had:

- | | | | |
|-----------------|----------------------|----------------------------|----------------------------|
| Anemia _____ | Back Problems _____ | Bleeding Tendency _____ | Sinus Trouble _____ |
| Asthma _____ | Blood Disease _____ | Circulatory Problems _____ | Stroke _____ |
| Anorexia _____ | Chemotherapy _____ | High Blood Pressure _____ | Thyroid Problems _____ |
| Arthritis _____ | Chicken Pox _____ | Skin Rash _____ | Tonsillitis _____ |
| Cancer _____ | Heart Murmur _____ | Migraine Headaches _____ | Tuberculosis _____ |
| Diabetes _____ | Heart Disease _____ | Shortness of Breath _____ | Ulcer _____ |
| Epilepsy _____ | Hepatitis _____ | Pneumonia _____ | Venereal Disease _____ |
| Glaucoma _____ | HIV/AIDS _____ | Prostate Problem _____ | Mumps/ Measles _____ |
| Hernia _____ | Kidney Disease _____ | Psychiatric Care _____ | Any other conditions _____ |
| Herpes _____ | Liver Disease _____ | Respiratory Disease _____ | _____ |
| Jaundice _____ | Pacemaker _____ | Rheumatic Fever _____ | _____ |