Yash Kumar, M.D. F.A.C.S.
410-848-2203

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Sex (circle): Male or Female Date of Birth (MM/DD/YYYY) _____ SSN: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Email Address: _____ Marital Status: (circle) Single Married Divorced Widowed

Employer's Name: _____ Job Title: _____ Department: _____

Insurance Policy Holder's Name: _____ SSN: _____

Relationship: _____ Address (If not the same):_____

Home Phone: _____ Cell Phone: _____

Employer: _____ Employer Address: _____

## EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

## PRIMARY CARE PHYSICIAN

Last Name: _____ First Name: _____ Office Number: _____

Office Address: _____

## INSURANCE INFORMATION

By signing below, I acknowledge and certify that I have provided a copy of my insurance card(s), primary and secondary if applicable, most current and correct sponsor/ employer information and contact numbers. I also certify that all contact and personal information is correct.

Signature of Subscriber/Beneficiary _____ Date: _____

## AGREEMENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This disclosure contains information regarding the privacy of your personal health care information. Please read it carefully before signing.

By signing this disclosure, I acknowledge and agree that Yash Kumar, M.D. may use or disclose my medical information for the purpose of my treatment, or for obtaining payment for services rendered. I am aware that Yash Kumar, M.D., his authorized representative/agents, may disclose my medical information to a business associate for the same reasons, and that the business associate will be bound by all appropriate legal/ regulatory restrictions for use of this information.

Signature of Patient or Representative _____ Date: _____

## AUTHORIZATION AND RELEASE OF INFORMATION

I hereby authorize Yash Kumar, M.D. and or his authorized representative/agents to apply for benefits on my behalf for services rendered by Yash Kumar, M.D. In addition, I also authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original.

Signature of Subscriber/Beneficiary _____ Date: _____

## AUTHORIZATION TO PERMIT RELEASE OF INFORMATION TO OTHER INDIVIDUALS/ DESIGNEES

The Federal Government restricts this office and Yash Kumar, M.D. from discussing your health information and condition with other family members or persons without your specific written permission. If you wish to permit such, please indicate the individual or individuals by name and relationship below:

Name (First, Middle and Last Name) _____ Relationship _____
Name (First, Middle and Last Name) _____ Relationship _____

Signature of Patient _____ Date: _____

## MEDICAL AND SURGICAL HISTORY

### ALLERGIES TO MEDICATIONS (Please list name and reaction

Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____

### CURRENT MEDICATION LIST (including over the counter medications and supplements)

Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____
Medication Name: _____ Strength: _____ Frequency: _____

## Please Circle Yes or No for the Following Questions:

Have you been diagnosed, experienced, or have a history of any of the following?

Yes No Allergy or reaction to Latex products?

Yes No Diagnosed with sleep apnea? If yes, do you use CPAP? Yes No

Yes No Do you have a pacemaker or implanted defibrillator (ACID)?

Yes No Diagnosed or tested positive for a blood borne infection such as Hepatitis or HIV?

Yes No You or a family member experienced a serious reaction to anesthesia, i.e. Malignant Hyperthermia?

Yes No Tested positive or diagnosed with Tuberculosis (TB)?

Yes No Smoke? If yes, how many packs per day? _____ How many years _____ Quit in _____

Yes No Treated for a DVT or Pulmonary Embolism (blood clots in your legs or lungs)?

Yes No Had a blood transfusion? If yes, did you experience an adverse reaction? Yes No

Please circle all conditions/diagnoses you are being treated for, have had, or surgeries performed:

| Nervous | Heart | Lungs | Digestive/Kidney | Blood | Surgical Procedures |
|---|---|---|---|---|---|
| Stroke | High Blood Pressure | Asthma | Stomach Ulcer | Anemia | Tonsilectomy/Adnoidectomy |
| Seizure | Heart Attack | COPD | Indigestion | Low White Cell | Appendix Removed |
| Migraines | Palpitations | Sleep Apnea | Hiatal Hernia | Sickle Cell Anemia | Gall Bladder Removed |
| Parkinson's | Atrial Fibrillation | Tuberculosis | Colitis | HIV | Colonoscopy |
| MS | CHF | Seasonal Allergies | Diverticulosis | High Cholesterol | Upper Endoscopy (EGD) |
| Alzheimer's | Valve Disease | Pancreas/Endocrine | Constipation | Lyme's Disease | Cataract Surgery |
| Psychiatric | Orthopedic | Diabetes | Diarrhea | MRSA | Inguinal Hernia Repair |
| Anxiety | Arthritis | Pancreatitis | Hemorrhoids | Cancer | Umbilical Hernia Repair |
| Depression | Painful/Trick Joints | Thyroid Problems | Abdominal Pain | Bladder | Joint Replacement |
| Fatigue | Gout | Metabolic Syndrome | Gall Stones | Breast | Joint Arthroscopy |
| Dementia | Osteoporosis | Immune System | Liver Disease | Colon | Spinal Surgery |
| Bipolar | Kyphosis/Scoliosis | Fibromyalgia | Jaundice | Prostate | Coronary Stent Placement |
| ADD/ADHD | Chronic Joint Pain | Rheumatoid Arthritis | Hepatitis | Skin | Open Heart Bypass |
| Alcoholism | Chronic Back Pain | Lupus | Kidney Stones | Uterine | Hysterectomy/ Tubes Tied |
| Addiction | | | Kidney Failure | Other: _____ | Prostatectomy |

OTHER CONDITIONS OR SURGERIES NOT LISTED: _____