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: _____