Anita Gupta, M.D.

Sunshine Walk-In Clinic

Patient Name:
(Print) _____

Date of Birth: _____ **Sex:** _____ **Race:** _____

Have you ever had a problem with the following?

	Yes	No
Heart	____	____
Lungs	____	____
Stomach	____	____
Liver	____	____
Kidney	____	____
Anemia	____	____
Diabetes	____	____
Mental Illness	____	____
Cancer	____	____
Bleeding Disorder	____	____
Other	____	____

Explain all Yes Answers

_____

_____

Current Medications (dosage/frequency)

_____

_____

_____

_____

_____

_____

Surgical History

_____

_____

_____

_____

_____

Allergies to Medications

_____

Family History

	Yes	No
Heart	____	____
Blood Pressure	____	____
Diabetes	____	____
Bleeding Disorder	____	____
Cancer	____	____
Other	____	____

Explain all Yes Answers

_____

_____

_____

_____

Social History

Occupation: _____

Smoking History: ☐ Never ☐ Previous ☐ Current ☐ Chew only

If Current, How much? _____ per day

If Previous, Year quit? _____

Alcohol History: ☐ None ☐ Rarely ☐ Moderate ☐ Heavy

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Number of Children? _____

Height _____ Weight _____

General	**Yes**	**No**
Change in Appetite	____	____
Change in weight	____	____
Chills, fever, sweat	____	____

Head	**Yes**	**No**
Frequent headaches	____	____
Recent trauma	____	____

Vision	**Yes**	**No**
Double Vision	____	____
Reading Glasses	____	____
Change in vision	____	____

Ear Nose and Throat	**Yes**	**No**
Loss of hearing	____	____
Ringing in ears	____	____
Gum Problems	____	____
Bleeding	____	____
Nose Bleed	____	____
Hoarseness	____	____
Difficulty Swallowing	____	____
Morning cough	____	____
Toothache	____	____

Respiratory	**Yes**	**No**
Difficulty Breathing	____	____
Cough	____	____
Shortness of breath	____	____
Coughing up blood	____	____

Heart	**Yes**	**No**
Chest Pain	____	____
Heart beating fast	____	____
Difficulty breathing during activities	____	____

Digestive System	**Yes**	**No**
Abdominal pain	____	____
Nausea	____	____
Vomiting	____	____
Bloating	____	____
Diarrhea	____	____
Constipation	____	____
Blood in stool	____	____
Frequent belching	____	____

Urinary System - Men	**Yes**	**No**
Penile discharge	____	____
Difficulty urinating	____	____
Blood in urine	____	____

Allergies	**Yes**	**No**
None/Normal	____	____
Hay Fever	____	____
Other (explain)	____	____

Urinary System - Women	**Yes**	**No**
Regular Periods	____	____
Menopausal	____	____
Hysterectomy	____	____
Vaginal discharge	____	____
Difficulty urinating	____	____
Blood in urine	____	____

Muscles and Bones	**Yes**	**No**
Pain	____	____
Weakness	____	____
Joint Swelling	____	____
Backache	____	____
Degenerative disease	____	____

Nervous System	**Yes**	**No**
Dizziness	____	____
Loss of consciousness	____	____
Seizures	____	____
Blackouts	____	____
Nervous exhaustion	____	____
Numbness and Tingling	____	____

Emotional Status	**Yes**	**No**
Nervous	____	____
Mood changes	____	____
Depression	____	____
Insomnia	____	____

Skin	**Yes**	**No**
Normal	____	____
Rash	____	____
Non-healing lesion	____	____
	____	____

Endocrine and Glands	**Yes**	**No**
Thyroid	____	____
Heat Intolerance	____	____
Cold Intolerance	____	____
Diabetes	____	____
Excessive thirst	____	____
Excessive hunger	____	____
Excessive urination	____	____

Blood and Lymph System	**Yes**	**No**
Anemia	____	____
Easy Bruising	____	____
Easy Bleeding	____	____
Swollen Glands	____	____

Other (Explain)

_____

_____

_____

_____

Patient Information

Patient Name: _____ Age: _____ Date of Birth: _____

Address: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternate Phone: _____

Patient's SSN: _____ Sex: Female ____ Male ____

Patient's Employer: _____ Phone: _____

Primary Insurance Information

Primary Insurance Company: _____ Effective Date: _____

Group Number: _____ Policy Number: _____ Member ID: _____

Is Patient the also the Primary Insured? Yes ___ No ___ *If "No" pease provide us with the following:*

Primary Insured's Name: _____ Relationship: _____

Primary's Employer: _____ Primary's SSN: _____

Primary's Date of Birth: _____ Phone: _____

Secondary Insurance Information

Secondary Insurance Company: _____ Effective Date: _____

Group Number: _____ Policy Number: _____ Member ID: _____

Is Patient the also the Primary Insured? Yes ___ No ___ *If "No" pease provide us with the following:*

Primary Insured's Name: _____ Relationship: _____

Primary's Employer: _____ Primary's SSN: _____

Primary's Date of Birth: _____ Phone: _____

Please describe the reason for your visit: _____

_____

If due to an injury, please provide the following:

Body Part: _____ Left ____ Right ____

Date of injury _____ Injured at: Home ____ Work ____ Other: _____

Details of event: _____

_____

How did you hear about us?

Referred by Doctor: _____ Internet ____ Yellow Pages ____

Sign ____ Friend _____ Other _____

I authorize the release of all medical information necessary to process this claim and is pertinent my medical care. I assign all medical and/or surgical benefits to Sunshine Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I agree to be financially responsible for all charges. I have read this information and understand it.

Signature: _____ Date: _____

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may be changed. If we change our notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and healthcare operations as described in our notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

I hereby instruct and direct my Insurance Company to pay by check /electronic funds to name and address above.
If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me-and-mail it to the name and address above.

A photocopy of the-Assignment shall be considered as effective and valued as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

I understand that I am responsible for any deductibles, co-pays and/or fees not otherwise covered by my insurance company. I further understand that any past due amounts may be subject to collection fees and/or court costs.

Print Name: _____DOB:_____

Signature:_____Date:_____