

Last Name	First Name	Age	Date

**FAMILY AND INSURANCE INFORMATION**

Patient's Last Name	First Name	Date of Birth	Age	Social Security #	Male / Female

Address	City	Zip Code	Phone

E-mail Address	Cell Phone

Spouse's Last Name	First Name	Date of Birth	Social Security #	Married / Single

Address	Phone	City	State	Zip Code

E-mail Address	Cell Phone

Employer	Address	Phone

Spouse's Employer	Address	Phone

Emergency Contact	Phone	Relationship

Who referred you to our office?

**Assignment of Benefits:** I understand that I am financially responsible for all the charges for services rendered by Vinaya K. Gavini, M.D. including the balance remaining after the payment of possible insurance benefits.

**“No-show” policy:** If you fail to cancel and fail to show up for the appointment, we may charge your account \$25 “no-show” charge. I am aware of this policy and agree to pay such charges.

\_\_\_\_\_

**Signature of Patient**

\_\_\_\_\_

**Date**

Last Name	First Name	Age	Date

**Patient Questionnaire**

1. Briefly describe your symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. When did your symptoms start? Date \_\_\_\_\_
  
3. On a scale of 0-10 (10 being the worse) rate your symptoms Rating \_\_\_\_\_
  
4. Have your co workers complained about your performance? Yes \_\_\_\_\_ No \_\_\_\_\_
  
5. Do you feel uncomfortable in social settings? Yes \_\_\_\_\_ No \_\_\_\_\_
  
6. Have you lived in a home built before 1960? Yes \_\_\_\_\_ No \_\_\_\_\_
  
7. How was your work/school performance? Good \_\_\_\_\_ Poor \_\_\_\_\_

**ASRS-vLI QUESTIONNAIRE**

**(Please check the answer that best describes how you have felt or conduct yourself)**

		Never	Rarely	Sometimes	Often	Very Often
1.	How often do you have trouble wrapping up the final details of a project once the challenging parts have been done?					
2.	How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3.	How often do you have problems remembering appointments or obligations?					
4.	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5.	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6.	How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7.	How often do you make careless mistakes when you have to work on a boring or difficult project?					
8.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9.	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10.	How often do you misplace or have difficulty finding things at home or at work?					
11.	How often are you distracted by activity or noise around you?					
12.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13.	How often do you feel restless or fidgety?					
14.	How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15.	How often do you find yourself talking too much when you are in social situations?					
16.	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17.	How often do you have difficulty waiting your turn in situations when turn taking is required?					
18.	How often do you interrupt others when they are busy?					

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**NEW PATIENT QUESTIONNAIRE**

Instructions: Please fill out as completely as possible. All information will be kept confidential.

**Health Status:**

Are you under treatment for any illness / condition?		
Have you had any allergic reactions to Food or bee stings? Please List:	<input type="checkbox"/> N	<input type="checkbox"/> Y
Have you had any hospitalizations?	<input type="checkbox"/> N	<input type="checkbox"/> Y
Please list:		

**Please list any medical problems:**


**Family History:**

Please list any blood relatives who have had the following illnesses.

Illness	Relative
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Blood Disease	
Psychiatric conditions	
Asthma/Allergies	
ADD / ADHD	
Other	

**List any other problems:**


**List Behavior Psychiatric Problems:**


**List the medications you are taking:**


**List any Drugs use (Marijuana, Cocaine, etc.)**


**List how many drinks you consume in a week:**


## Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

### Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care.

### Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law

### Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Representative, Print Name and Relationship

\_\_\_\_\_  
Date