Cary Medical Clinic, PC

550 New Waverly Place, Suite #105
Tel 919 233 2022 Cary, NC 27518 Fax 919 233 2212

(PLEASE PRINT CLEARLY)

Patient Information

Name ____________________ (Last Name / First Name / Middle Initial) Home Phone # ____________

Address ____________________ Cell Phone # ____________

City ____________ State ____________ Zip ____________

Soc Sec # ____________ Email address ____________

Sex M F Age ______ Birthdate ____________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Employers Name ____________________ Work Phone ____________

Parent, Spouse, or Partner Full Name ____________________

Employers Name ____________________ Work Phone ____________

Who may we thank for referring you ? ____________________

In case of emergency who should be notified ____________________ Phone ____________

Primary Insurance

Insurance Company ____________________

Policy ID # ____________________ Group # ____________

Please Fill-out **ALL INFORMATION** if policy holder is other than Self

Policy Holder Name ____________________ (Last Name / First Name / Middle Initial)

Relation to Patient ____________ Date of Birth ____________ Sex M F Soc. Sec.# ____________

Secondary Insurance

Insurance Company ____________________

Policy ID # ____________________ Group # ____________

Policy Holder Name ____________________ (Last Name / First Name / Middle Initial)

Allergy Alert

Are you allergic to any medicine? YES ☐ NO ☐ Don't Know ☐

If yes, write the medication here ____________________

FINIANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that Cary Medical Clinic will make all attempts possible to collect from my current insurance carrier as long as correct insurance card(s) are presented BEFORE treatment. After 120 days, I may receive a bill if my insurance does not respond.

Signature ____________________ Date ____________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize for Cary Medical Clinic to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payers or other involved in processing and collecting of claims in accordance with the HIPPA Patient Confidentiality Act of 1996.

Signature ____________________ Date ____________

THANK YOU FOR BEING A PATIENT AT CARY MEDICAL CLINIC.

CHART # ____________

CARY MEDICAL CLINIC
550 NEW WAVERLY PLACE - SUITE 105
CARY, NC 27518

DR. NEELU AGARWAL **DR. ABHAY AGARWAL**

PATIENT QUESTIONNAIRE

DATE

NAME:	DATE OF BIRTH
OCCUPATION / EMPLOYMENT	HIGHEST LEVEL OF EDUCATION

REASON FOR VISIT

HOSPITALIZATIONS

IF YOU HAVE BEEN IN A HOSPITAL OVERNIGHT - STATE THE YEAR - ILLNESS / OPERATION (PLEASE START WITH THE MOST RECENT EVENT)

YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION

PAST MEDICAL & FAMILY HISTORY

PLEASE CHECK IF YOU (SELF) OR ANY BLOOD RELATIVE HAS ANY OF THE FOLLOWING CONDITIONS -

	SELF	RELATION		SELF	RELATION
01) RECENT WEIGHT LOSS			17) KIDNEY / BLADDER PROB.		
02) MIGRAINE HEADACHES			18) NEUROLOGICAL		
03) EPILEPSY / CONVULSIONS			19) ARTHRITIS		
04) EYE DISEASE			20) OSTEOPOROSIS		
05) HEARING DISORDER			21) CANCER - TYPE:		
06) RECURRENT-NOSE BLEEDS					
SINUS / THROAT INFECT(S)			22) BLEEDING DISORDER		
07) ANGINA - CHEST PAIN			23) BLOOD TRANSFUSIONS)		
08) HEART ATTACK			24) ANEMIA		
09) HIGH BLOOD PRESSURE			25) DIABETES		
10) STROKE			26) THYROID		
11) HIGH CHOLESTEROL			27) ALCOHOL OR DRUG ABUSE		
12) HEART VALVE DISORDER			28) MENTAL ILLNESS		
13) LUNG DISEASE			29) DEPRESSION		
14) STOMACH ULCER			30) PSORIASIS		
15) BOWEL PROBLEMS			31) HAIR LOSS □ PROGRESSIVE □ RECENT		
16) LIVER DISEASE/ HEPATITIS			32) ACCIDENT - MAJOR		

LIST ALL MEDICATIONS YOU TAKE

MEDICATION	DOSE	TIMES/DAY

DO YOU NOW OR HAVE EVER CONSUMED -

CIGARETTES	Y	N	PACK / DAY ____ #YRS ____
ALCOHOL	Y	N	DRINKS / WK ____________
COFFEE / TEA	Y	N	CUPS / DAY ____________
STREET DRUGS	Y	N	TYPE ________________
EXERCISE	Y	N	_______ Min/day _______ Times/week

THE LAST TIME YOU HAD A - (YEAR)

FLU VACCINE	____	TETANUS SHOT	____
HEPATITIS VACCINE	____	PNEUMONIA SHOT	____
T.B. TEST	____	RECTAL EXAM	____
STOOL BLOOD TEST	____	EYE EXAM	____
DENTAL EXAM	____	COLONOSCOPY	____
CHOLESTEROL TEST	____	*(result)*	____

DRUG ALLERGIES

DRUG	REACTION

FOR WOMEN ONLY

DATE OF LAST PERIOD _________

ARE YOU USING BIRTH CONTROL Y N

TYPE: ____________________

NUMBER OF PREGNANCIES ______

NUMBER OF BIRTHS ______

NUMBER OF ABORTIONS ______

NUMBER OF MISCARRIAGES ______

YEAR OF LAST -

____	PAP TEST	□ NORMAL	□ ABN
____	BREAST EXAM	□ NORMAL	□ ABN
____	MAMMOGRAM	□ NORMAL	□ ABN

THE LAST TIME YOU HAD A COMPLETE PHYSICAL DATE: ____________________

*** PLEASE NOTE THAT ANY COMPLETE PHYSICAL DONE BEFORE YOUR INSURANCE CONTRACT PLAN COVERAGE WILL BE BILLED DIRECTLY TO PATIENT***

DO YOU HAVE ANY OTHER PROBLEM FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? - PLEASE LIST THEM

ARE YOU HAVING ANY SYMPTOMS THAT YOU WOULD LIKE TO DISCUSS? PLEASE LIST THEM

Chart # _______________

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Neelu Agarwal, MD **Abhay Agarwal, MD**

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Patient Chart# _______________

Patient Name ____ Phone # ___________________

Address ____

City ________________________ State _____________________ Zip Code __________________

Date of Birth _____ /_____ / _____ SS# _________________________________

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Facility **TO RELEASE** Records ____

Full Address ____

Phone # ________________________________ Fax # _____________________________

Dates of Treatment Needed ____

Party **TO RECEIVE** Records Cary Medical Clinic

Full Address 550 New Waverly Place Suite 105 Cary, NC 27518

Phone # 919-233-2022 Fax # 919-233-2212

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I authorize Cary Medical Clinic to obtain/release my personal health records concerning my illness and/or treatment including HIV/STD, drug and alcohol abuse. I understand that I may revoke this authorization at any time except for release that has already been made. All releases will be handled discretely in compliance with the HIPAA Patient Confidentiality guideline for healthcare providers.

Signature ____ Date ________________________

Witness ____ Date ________________________