Krunal J. Mehta M.D.

(v.3.1)

130 W. Route 66 Suite 214 Glendora, CA 91740

Patient Information			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -	

Would you like to access your personal medical records online? ☐ Yes ☐ No If yes, please enter your email address.

E-mail Address:_____

By signing page 4, you acknowledge that you have read and agree to comply with the Patient Portal Consent and User Agreement, which has been provided to you.

Gender ☐ M ☐ F	Social Security #	Preferred Language	Driver's License
Marital Status ☐Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	Preferred Contact ☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal	Ethnicity ☐ Hispanic or Latino ☐ White ☐ Asian ☐ American Indian ☐ Other ☐ Prefer not to answer	Race ☐ American Indian or Alaskan ☐ Asian ☐ African American/Black ☐ Native Hawaiian/Other ☐ White ☐ Prefer not to answer
Referred by	Insurance ☐	Internet ☐	Friend/Family ☐	Other ☐

Responsible Party (Guarantor) ☐ Same as patient			
First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -	

Social Security #	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)			
First Name	Last Name	MI	Relationship to Patient
Address	City	State	Zip
Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -	

Pharmacy Information			
Preferred Pharmacy	Name	Address	Phone

Advanced Directives			
☐No Advance Directive	☐Do Not Resuscitate	☐Durable Power of Attorney	☐Living Will
Power of Attorney:			

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Allergies

List anything that you are allergic to (medications, foods, bee strings, etc.) and how each affects you.

☐ No Known Allergies	
ALLERGY	**REACTION**
1.	
2.	
3.	

Medications

Please list all the medications you are taking (including prescribed drugs and over the counter drugs, such as vitamins or any supplements.

☐ I do not take any medications		
DRUG NAME	**STRENGTH**	**FREQUENCY TAKEN**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medical History – Check if you ever experienced the following conditions and year of onset.

Condition	Year	Condition	Year
☐None		☐ Hepatitis – Type	
☐Acid Reflux		☐ Heart Disease	
☐ Anemia		☐ High Cholesterol	
☐ Anxiety		☐ High Blood Pressure	
☐ Arthritis		☐ HIV	
☐ Asthma		☐ Kidney Disease	
☐ Back Pain		☐ Liver Disease	
☐ Bowel Disease		☐ Migraine Headache	
☐ Blood Clots		☐ Seizure Disorder	
☐ Bleeding Disorder		☐ Sleep Apnea	
☐ Cancer – Type		☐ STD	
☐ Chest Pain		☐ Stroke	
☐ COPD		☐ Thyroid Disorder	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

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Surgical History – Check if have received the following procedures, and year performed.

Surgical Procedure	Year	Surgical Procedure	Year
☐ None		☐ Hip Replacement	
☐ Angioplasty		☐ Hysterectomy	
☐ Angioplasty w/stent		☐ Kidney Biopsy	
☐ Appendectomy		☐ Knee Replacement	
☐ Arthroscopy Knee		☐ LASIK	
☐ Back Surgery		☐ Liver Biopsy	
☐ Bowel resection		☐ Oophorectomy	
☐ Breast Biopsy		☐ Pace maker	
☐ CABG (heart bypass)		☐ Prostate biopsy	
☐ Carpal Tunnel Release		☐ Prostate resection	
☐ Cataract extraction		☐ Thyroid surgery	
☐ Cesarean section		☐ Tonsillectomy	
☐ Colostomy		☐ Organ Transplant - type	
☐ D and C		☐ Tubal Ligation	
☐ Gall bladder removal		☐ Vasectomy	
☐ Gastric Bypass		☐ Other	
☐ Hemorrhoidectomy		☐ Other	
☐ Hernia Repair			

Family History – Check if family member(s) has had any of the following conditions

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other
Alcoholism	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood clot	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐
Cancer- type	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Mental Health Disorder	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Rheumatoid disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

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IMMUNIZATION HISTORY

IMMUNIZATION	MOST RECENT DATE
☐ Chickenpox	
☐ Flu Shot	
☐ Gardasil/HPV	
☐ Hepatitis A	
☐ Hepatitis B	
☐ Meningococcus	
☐ MMR (Measles, Mumps, Rubella)	
☐ Pneumonia	
☐ Tdap (Tetanus and pertussis)	
☐ Zostavax (Shingles)	

Adult Health Maintenance – Check if applicable

Exam	Date	Normal	Abnormal
☐ Last PAP Smear		☐	☐
☐ Last Mammogram		☐	☐
☐ Colonoscopy		☐	☐
☐ FOBT (stool card for hidden blood)		☐	☐
☐ Eye Exam		☐	☐
☐ Hemoglobin A1C Testing		☐	☐
☐ Kidney Disease Screening		☐	☐
☐ Cholesterol Screening		☐	☐
☐ Bone Density Scan (DEXA Scan)		☐	☐

Social History

Employment Status ☐Employed ☐ Student ☐Retired ☐Other

Employer:

Tobacco Use ☐ No	☐Daily ☐Weekly ☐Socially Former/Year quit:	☐Chewing ☐Cigar ☐Pipe ☐Cigarette ☐ Vape
Alcohol Use ☐ No	☐Daily ☐Weekly ☐Socially Former/Year quit:	☐Beer ☐ Wine ☐Liquor ☐Other
Caffeine Use ☐ No	☐Daily ☐Weekly ☐Socially Former/Year quit:	☐Tea ☐Coffee ☐Soda ☐Other
Exercise ☐ No	☐Moderate ☐Vigorous ☐Sedentary Days/Week:	

I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the KRUNAL J. MEHTA M.D. INC. to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I furthermore agree to pay legal interest, collection expenses, and attorneys' fee incurred to collect any amount I may owe. I also hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Acknowledgement of Notice of Privacy Practices: I acknowledge that I have received a copy of Krunal J. Mehta M.D. Inc. Notice of Privacy Practices. This notice describes how Krunal J. Mehta M.D. Inc. may use and disclose my protected health information, certain restrictions in the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who No-Show more than two (2) times in a 12-month period, may be subject to a $25.00 fee for office appointment No Show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (626-335-4129).

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

Patient Name (Please Print): Date of birth:

Signature of Patient or Patient Representative: Date: