EXPEDIENT MEDICAL PLLC

SARWAT KHAWAR, MD, FACP

WWW.EXPEDIENTMEDICALPLLC.COM

PATIENT INFORMATION:

NAME:______________________________ DATE OF BIRTH:____________________

SOCIAL SECURITY NUMBER: ____-____-____ AGE:________ SEX: M / F / T

MAILING ADDRESS:____

CITY:__________________ STATE:________________ ZIP CODE:________________

PHONE:(___)____-________ MOBILE:(___)____-______ EMAIL: ______________________

OCCUPATION:______________________ EMPLOYER: ________________________

EMPLOYER PHONE: (___)____-______ MARTIAL STATUS: S/M/W/D NUMBER OF CHILDREN:____

EMERGENCY CONTACT INFORMATION:

NAME:____________________ RELATIONSHIP:____________________________

PHONE:(______)______-________ PERMISSION TO CONTACT: Y / N

INSURANCE INFORMATION:

PRIMARY INSURANCE: ____________________ID#:____________GROUP:__________

SUBSCRIBER:______________________ RELATIONSHIP TO PATIENT:________________

PHARMACY INFORMATION:

PHARMACY:______________________________ PHONE:(______)______-________

ADDRESS:________________________CITY:__________STATE:______ZIP CODE:________

I hereby assign transfer and set over to Sarwat Khawar MD all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I have notified my insurance company that Sarwat Khawar MD is my primary care physician and therefore I will e responsible for payment if my insurance carrier does not cover my office visits and procedures. I understand that I am financially responsible for all charges whether, or not, they are covered by my insurance.

PATIENT'S SIGNATURE:__________________________ **DATE:**______________

******** PLEASE BE ADVISED, OUR OFFICE POLICY REQUIRES 24 HOUR NOTICE TO RESCHEDULE OR CANCEL ANY APPOINTMENTS. IF WE DO NOT RECEIVE NOTICE OR YOU DO NOT SHOW FOR YOUR APPOINTMENT, YOU WILL BE CHARGED A FEE OF $50.00********

EXPEDIENT MEDICAL PLLC

SARWAT KHAWAR MD

NAME:______________________________ DATE OF BIRTH:__________________

MEDICAL HISTORY:

PLEASE LIST YOUR MEDICAL CONDITIONS:

SURGICAL HISTORY:

PLEASE LIST ANY SURGERY

SURGERY	DATE

FAMILY HISTORY:

PLEASE LIST ANY PHYSICAL, MENTAL OR SUBSTANCE ABUSE HISTORY FOR SUCH FAMILY MEMBER

FAMILY MEMBER	LIVING/ DECEASED	AGE	CONDITIONS
FATHER			
MOTHER			
BROTHER			
BROTHER			
BROTHER			
SISTER			
SISTER			
SISTER			

EXPEDIENT MEDICAL PLLC

SARWAT KHAWAR MD

NAME:________________________________ DATE OF BIRTH:______________

ALLERGY:	REACTION:

CURRENT MEDICATION:

PLEASE LIST ALL MEDICATIONS/ SUPPLIMENTS THAT YOU ARE CURRENTLY TAKING:

MEDICATION NAME	DOSAGE	DIRECTIONS

SOCIAL HISTORY:

SMOKING: DO YOU SMOKE? Y / N DID YOU EVERY SMOKE? Y / N

HOW LONG?________ WHEN DID YOU QUIT? Y / N DO YOU WANT TO QUIT? Y / N

ALCOHOL: DO YOU DRINK ALCOHOL? Y / N IF SO, HOW MUCH?___________

PREVENTATIVE CARE:

PLEASE LIST ANY CURRENT SPECIALIST THAT YOU CURRENTLY SEE:

PHYSICAN NAME:	SPECIALIST TYPE:

EXPEDIENT MEDICAL PLLC

SARWAT KHAWAR MD

NAME:________________________________ DATE OF BIRTH:______________

CURRENT HEALTH QUESTIONAIRE:

PLEASE CIRCLE IF YOU CIRRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

ENT: EAR PAIN, DISCHARGE FROM EARS

CHEST: CHEST PAIN, PALPATATIONS, SHORTNESS OF BREATH

RESPIRATORY: COUGH, PHLEGM, SHORTNESS OF BREATH, WHEEZING

URINARY: PAIN, DIFFICULTY URINATING

NEUROLOGICAL: NUMBNESS, TINGLING, WEAKNESS

MENTAL: DEPRESSION, ANXIETY

NURITIONAL: CHANGES IN APPETITE, WEIGHT LOSS, WEIGHT GAIN

INFECTION: FEVER, ANY INFECTION