Expedient Medical, PLLC

SARWAT KHAWAR, MD, FACP

www.expedientmedicalpllc.com

Patient Information:

Name: _____ Date of Birth: ____/____/_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone:(_____)_____ Cell Phone:(_____)_____ Email:_____
SSN:___-____-_____Maiden Name: _____ Age: ____ Sex: M / F Marital Status: S / M / W / D
Race:_____Ethnicity: Hispanic/Latino ---Not Hispanic/Latino ___Language:_____

Employer Name: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____
Employer Phone: (_____)_____ Employer Fax:(_____)_____

Spouse/Emergency Contact Information:

Name: _____ Relationship: _____
*Phone: (_____)_____ **Allowed to share medical information? Y / N*

Insurance Information:

Primary Insurance: _____
ID#: _____Group#: _____
Subscriber: _____ Relationship to Patient: Self / Spouse / Dependent

Secondary Insurance: _____
ID#: _____Group#: _____
Subscriber: _____ Relationship to Patient: Self / Spouse / Dependent

Pharmacy Information:

Pharmacy: _____ Phone#:(_____)_____
Address: _____ City: _____ State: _____ Zip Code: _____

I hereby assign, transfer and set over to Sarwat Khawar M.D., all of 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, M.D. is my primary care physician and therefor I will be 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.*****

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Name: _____ *Date of Birth:* _____

Medical History:

Please list your medical conditions:

Surgical History:

Please list any surgeries and dates that you have had:

Surgery	Date	Surgery	Date

Family History

Please list any physical, mental or substance abuse problems for each family member:

Family Member	Living/Deceased?	Age	Conditions
Father			
Mother			
Brother 1			
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			

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Name: _____ Date of Birth: _____

Allergies:

Please list any medication allergies and your reaction to each:

Medication Allergy:	Reaction:

Current Medications:

Please list all medications/supplements that you are currently taking:

Medication Name	Dosage (mg, mcg, %, etc,)	Directions (daily, twice a day, weekly, etc.)

Social History:

Smoking: Do you smoke? Y / N Did you ever smoke? Y / N If so, how many per day? _____
How long? _____ When did you quit? _____ Do you want to quit? Y / N
Alcohol use: Do you drink alcohol? Y / N If so, how much? _____
Sex at Birth: M / F Sexual Orientation:_____ Gender Identity: M / F
How many children do you have:_____

Preventative Care:

Please indicate your most recent dates for each of the following preventative measures:

Flu Shot: _____ Pneumonia Shot: _____ Pap Smear: _____

Colonoscopy: _____ Mammogram: _____ Bone Density Scan: _____

Previous Physician/Current Specialists:

Please list your previous primary care physician and any current specialists that you have seen:

Physician Name	*PCP or Specialist Type*

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Current Health Questionnaire:

*Please **circle** if you are **currently experiencing** any of the following symptoms:*

ENT: Ear Pain, Discharge

CHEST: Chest Pain, Palpitations, Shortness of Breath on Exertion

RESPIRATORY: Cough, Phlegm, Shortness of Breath, Wheezing

DIGESTIVE: Abdominal Pain, Nausea, Vomiting

URINARY: Pain or Difficulty Urinating

NEUROLOGICAL: Numbness, Tingling, Weakness

MENTAL: Depression, Anxiety

NUTRITIONAL: Change in Appetite, Weight Loss, Weight Gain

INFECTION: Fever, Any Infection