☐ R. Swamy Venuturupalli, MD
☐ D. Wallace, MD
☐ S. Mahajan, MD

ATTUNE HEALTH
Autoimmune and Inflammation Care and Research

Update Forms

Date	**Patient Registration**	New ☐	Add ☐	Change ☐

Personal Information

Patient Name (Last, First, MI)		**Address**	
Social Security#		**City, State**	**Zip Code**
Date of Birth	**Sex** M ☐ F ☐	**Home Phone**	**Work Phone**
Marital Status Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐		**Cell Phone**	
Primary Language		**E-Mail Address**	
Primary Care Physician First Name Last Name		**Referred** First Name Last Name	

Employment Information

Employment Status
Full Time ☐ Part Time ☐ Self Employment ☐ Not Employed ☐ Retired (Date) ☐ Student ☐

Name of Employer/Union/Guild	**Occupation**
Employer Address	**Employer City, State, ZIP**

Additional Information

Driver's License State/ID	**Mother's Maiden Name**	**Place of Birth City & State**	**Pharmacy**
Driver License ID#/ID#	**Patient's Maiden Name**		**Pharmacy Phone & Fax#**

Emergency Contact

Name	**Relationship**	**Home Phone**	**Work Phone**
Address, City	**State, Zip Code**	**Legal Guardian** Yes ☐ No ☐	**Cell Phone**

Guarantor Information

Name of Person who is Financially Responsible for the Patient		**Relation to Patient**
Employer	**Social Security Number**	**Date of Birth**

Please Continue on Back

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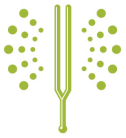

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Insurance Information

Subscriber Name		**Subscriber DOB**	**Subscriber SSN**
Primary Insurance	**PPO/POS/HMO** ☐ ☐ ☐	**Subscriber ID#**	**Phone Number**
Member Effective Date	**Relationship to Subscriber**	**Group#**	**Group Name**
Primary Insurance Claim Address			
Subscriber Name		**Subscriber DOB**	**Subscriber SSN**
Secondary Insurance	**PPO/POS/HMO** ☐ ☐ ☐	**Subscriber ID#**	**Phone Number**
Secondary Insurance Claim Address			
Member Effective Date	**Relationship to Subscriber**	**Group#**	**Group Name**

Insurance Information (Medicare Patients Only)

Subscriber ID#	**Relationship to Subscriber**	**Part A Eff Date**	**Part B Eff Date**
Have you assigned your benefits to a HMO? ☐ **Yes** ☐ **No**			**(If Yes) Medical Group Name**

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

SIGNATURE: _____ **DATE:** _____

Please provide your insurance card(s) and driver's license to the receptionist along with this form.

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UPDATED MEDICAL HISTORY (RETURN PATIENTS) DATE:

Name: _____ DOB: _____

Pharmacy information (name and phone number)

Name:	**Phone:**	**Fax.**

List all hospitalizations and surgeries

1.	5.
2.	6.
3.	7.
4.	8.

List all medication allergies if any:

1.	**4.**
2.	**5.**
3.	**6.**

Current Medication List (include dosage and how many tablets do you take a day)

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Name and Phone number of Primary care Doctor: _____

Date of last Physical with PCP	
Date of last eye exam	
Date of last Bone Density	
Date of last Pap smear (female)	
Date of last Mammogram (female)	
Date of last Colonoscopy	
Date of last Tuberculosis test	
Date of last Flu vaccine	

Social History: **Have you ever smoked**? Yes☐No☐

Check below: Do you smoke?

Smoker	☐	Some a day smoker	☐	Former smoker	☐	Never smoker	☐	Quit date _____

Check below: Do you drink alcohol?:

Never	☐	Occasional	☐	moderate	☐	Heavy	☐

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Check below: **Any caffeine?:**

None ☐	Occasional ☐	Moderate ☐	Heavy ☐

Family History: List all medical issues:

Mother	**Father**	**Paternal GM**	**Paternal GF**	**Maternal GM**	**Maternal GF**

Sister	**Brother**	**Other:**	**Other:**	**Other:**	**Other:**

Notes or questions for the doctor:

1._____

2._____

3._____

4._____

5._____