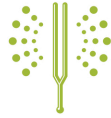


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- C. Lee, MD



ATTUNE HEALTH

Autoimmune and Inflammation Care and Research

Date	<h2 style="margin: 0;">Patient Registration</h2>			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 Partner 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	

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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	

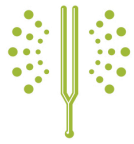
Social History: Have you ever smoked? Yes ...No

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. _____