☐ R. Swamy Venuturupalli, MD
☐ D. Wallace, MD
☐ S. Mahajan, MD
☐ D. Scaramangas, MD
☐ C. Lee, MD

ATTUNE HEALTH
Autoimmune and Inflammation Care and Research

Date		New ☐	Add ☐	Change ☐

Patient Registration

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

Please Continue on Back

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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._____