FRONTLINE MEDICAL CENTER
WILKINSON J. NINALA M.D.

PATIENT REGISTRATION **INTERNAL MEDICINE**

PATIENT NAME FIRST MIDDLE LAST				DATE OF BIRTH
HOME ADDRESS		CITY	STATE	ZIP CODE
OCCUPATION EMPLOYED ☐ RETIRED ☐ STUDENT ☐	SOCIAL SECURITY NO.	MARITAL STATUS ☐ **S** ☐ **M** ☐ **D** ☐ **W**	SEX	HOME PHONE
EMPLOYER	E-MAIL	WORK PHONE		CELL PHONE
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE		
RACE:				

SUBSCRIBER/ POLICY HOLDER INFORMATION

FIRST NAME LAST NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
HOME ADDRESS	CITY	STATE	ZIP CODE
PRIMARY INSURANCE COMPANY NAME	ID OR POLICY NUMBER		GROUP NUMBER
INSURANCE COMPANY ADDRESS	SOCIAL SECURITY NO.		DATE OF BIRTH
SECONDARY INSURANCE COMPANY NAME	ID OR POLICY NUMBER		GROUP NUMBER
INSURANCE COMPANY ADDRESS	SOCIAL SECURITY NO.		DATE OF BIRTH

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claim, to the above named billing agent.

1. I agree to have my insurance company, Medicare or third-party payment program make payments directly to WILKINSON J NINALA M.D.
2. I agree to let my doctor(s) and the office of WILKINSON J NINALA M.D. submit claims and required treatment information to my Insurance company, Medicare or other third party payment program for my care and receive payments directly.
3. I understand that I must pay all charges, co-payments and deductibles that are not covered by my insurance company, Medicare or third party payment program.

Patient Signature (or person authorized to sign for patient) _____

Relationship to Patient_____ Date_____

_____

Authorized Staff Signature Date

Account

WILKINSON J NINALA M.D.

Health History

NAME: _____

Medical information

Please list any **MEDICATIONS** you are currently taking, Prescribed or over the Counter:

Medication	Dosage	Route	Frequency

Any Allergies to Medication or Food (list reactions)**:** _____

Preferred Pharmacy: _____ **Phone Number:** _____

Address: _____

Past Medical History:_____

If **YOU** or a **FAMILY MEMBER** has had any of the following, please **CIRCLE** and indicate which family member where applicable.

ADD/ADHD	Type 1 or 2 Diabetes	Respiratory Disease
Anemia	Fractures	Skin Disease
Allergies/ Hay Fever	Gynecological Disease	Stomach/Colon Disease
Asthma	High Blood Pressure	Stroke
Arthritis	High Cholesterol	Seizure Disorder
Anxiety/ Depression	Heart Attack	Thyroid Disease
Alcoholism	Kidney Disease	Sexually transmitted Disease
Blood Clots	Liver Disease	Osteopenia/ Osteoporosis
Cancer, Type(s)_____	Neurological Disease	Other _____
Dementia		

Please List Any **SURGERIES** you have had and include the month/year.

_____

Social Information

Tobacco Use:

- Do You Smoke Yes ☐ No ☐
- How many Cigarettes per day:_____
- No. of years smoking:_____
- Have you quit before? _____
- **Alcohol use:**
- Do you drink Alcohol? Yes ☐ No ☐ If yes, how many drinks per occasion/day/month:_____
- **Drug Use:** Any History of illegal drug use? Yes ☐ No ☐ What Type? _____

AUTHORIZATION FORM

WILKINSON J NINALA M.D.

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **WILKINSON J NINALA M.D.** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits **WILKINSON J NINALA M.D.** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire when written notice is provided by me.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **WILKINSON J NINALA M.D.**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: **WILKINSON J NINALA M.D.** University Boulevard East Suite 37, Silver Spring, MD 20903.

Signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Patient's Name | Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

PATIENT CONSENT FORM

WILKINSON J NINALA M.D.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **WILKINSON J NINALA M.D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **WILKINSON J NINALA M.D.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

WILKINSON J NINALA M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **WILKINSON J NINALA M.D.**

With this consent, **WILKINSON J NINALA M.D.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **WILKINSON J NINALA M.D.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **WILKINSON J NINALA M.D.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **WILKINSON J NINALA M.D.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **WILKINSON J NINALA M.D.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **WILKINSON J NINALA M.D.** may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Legal Guardian | Print Patient's Name | Date

_____

Print Name of Patient or Legal Guardian, if applicable
