Jay Medical and Rehab Works, PC Sanjay Nariani, MD

3457 Lawrenceville – Suwanee Road, Suite C Suwanee, GA 30024 678-714-8522

Date: _____

First Name: _____ Last Name:_____ Date of Birth: _____ __M __S __D __W Sex: M__ F__ S.S. Number: _____ Address:
_____ City:
_____ State:_____ Zip Code:_____ Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Emergency Contact:
Name: _____ Phone: _____ Address:
_____ City:
_____ State: _____ Zip Code: _____

Insurance Information:
Company Name: _____ Policy No.: _____
Primary Policy Holder S.S. Number: _____
Billing Address: _____

Consent for Treatment: I hereby consent to allow Dr. Nariani and associates of Jay Medical Rehab Works, PC to medically examine and treat me or my child and order tests that are medically for managing the condition. I agree to let Jay Medical file insurance for payment. I will be responsible for any balances left unpaid by the insurance.

No Show Policy: I understand, acknowledge and agree that any time I miss an appointment without giving 24 hour advance notification, Jay Medical will assess a $25 no show fee for office visit and $50 for procedures/test. This will be paid prior to next visit.

Signature of Patient or Parent: _____

How Did You Hear About Us? _____

JAY MEDICAL & REHAB WORKS

3463 Lawrenceville- Suwanee Road, Suite 109
Suwanee, GA 30024

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies, but acknowledgement could not be obtained because:

- ☐ Individual Refused to Sign
- ☐ Communication Barriers Prohibited Obtaining the Acknowledgement
- ☐ An Emergency Situation Prevented Us from Obtaining Acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

_____

Jay Medical and Rehab Works, PC

3463 Lawrenceville- Suwanee Road, Suite 109
Suwanee, GA 30043
678-714-8522

Name: _____ Date of Birth_____ Age_____

Reason For Visit:_____

DRUG ALLERGIES

_____

_____

_____

_____

_____

_____

CURRENT MEDS

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsion	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

☐ Headache	☐ Lactose intolerance	☐ Depression
☐ Shortness of breath	☐ Gallbladder disease	☐ Gout
☐ Heart palpitations	☐ Prostate disease	☐ Scarlet fever
☐ Heart murmur	☐ Bowel irregularity	☐ Chronic rashes
☐ Chest pain	☐ Incontinence	☐ Rheumatic fever
☐ Dizziness/Fainting	☐ Sexual/Menstrual dysfunction	☐ Mumps
☐ Peripheral vascular disease	☐ Venereal disease	☐ Measles
☐ Allergies/Hay fever	☐ Frequent infections	☐ Rubella
☐ Asthma	☐ Hepatitis	☐ Polio
☐ Bronchitis	☐ Anemia	☐ Diphtheria
☐ Pneumonia	☐ Arthritis	☐ Tetanus
☐ Ulcer	☐ Osteoporosis	☐ Other
☐ GI disorder	☐ Nervousness	☐ Other

WOMEN ONLY: Pregnant? ☐ Yes ☐ No Planning pregnancy? ☐ Yes ☐No

MEN ONLY: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ☐ Yes ☐No
How often does this occur? ☐Frequently ☐ Sometimes ☐ Rarely

HABITS

☐ Smoke: Pack daily_____
How long? _____
Interested in stopping? _____

☐ Exercise routine: _____
_____
_____

☐ Coffee: Cups daily_____
Other caffeine _____

☐ Alcohol: Type _____
Amount _____

☐ Diet: Salt intake_____
Fat intake_____

☐ Sleep: Difficulty falling asleep_____
Continuity disturbances_____
Snoring_____
Early morning awakening _____
Daytime drowsiness_____
Other_____