



EXTENDED ARM PHYSICIANS, INC

Doctors of Internal Medicine – Board Certified

Leon N Davis, MD

Kanini Z Rodney, MD

Patient Information – Please print clearly

Patient First Name	Patient Middle Name		Patient Last Name	
Social Security #	Birth Date (mm/dd/year)		Age	
	/ /			
Street Address	City	State	Zip Code	Home Phone #
Physician Requesting Visit	Marital Status	Driver's License #		Work Phone #
Patient Employer	Occupation (Indicate if student)			
Employer Address	City	State		Zip
Here to see	Dr. Davis <input type="checkbox"/>		Dr. Rodney <input type="checkbox"/>	
Spouse /Guardian First Name	Spouse/ Guardian Middle Name		Spouse/ Guardian Middle Name	
Emergency Contact (Other Than Spouse)	Relationship		Phone #	
			- -	
Alternate Contact (Other Than Spouse)	Relationship		Phone #	
			- -	

We request all patients to show their insurance or managed care membership card and the driver's license, so that we may make copies for our permanent records.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account. Payment is expected at the time of service.

PAYMENT AND RELEASE OF INFORMATION

I, _____, hereby authorize Extended Arm Physicians Inc., to furnish information concerning my present illness to third party payers. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due to him or her as a result of the claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I agree to pay any collection and or attorney fees associated for my failure to pay my debt. A photo static copy of this authorization will be valid as the original.

I hereby authorize Extended Arm Physicians Inc., to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.

Signature of Patient or Guardian: _____

Date: _____



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Insurance Verification Form

To the Patient: The Following Information Is Required In Order For The Office To File Your Insurance. Failure To Provide Complete Information May Result In You Being Required To Pay For Your Visit In Full At The Time Of Service.

Patient First Name	Patient Middle Name	Patient Last Name	Date
			/ /

Primary Policy Holder Information

First Name	Middle Name	Last Name	DOB	SSN
			/ /	

Relationship To Patient: _____

Secondary Policy Holder Information

First Name	Middle Name	Last Name	DOB	SSN
			/ /	

Relationship To Patient: _____

Name of Primary Insurance Carrier	Name of Secondary Insurance Carrier

Group No: _____

ID Number: _____

Effective Date: _____

Are you covered by MEDICARE? _____

Are you covered by MEDICAID? _____

Mailing Address

Group No: _____

ID Number: _____

Effective Date: _____

Are you covered by MEDICARE? _____

Are you covered by MEDICAID? _____

Mailing Address

Contact Person: _____

Phone Ext: _____

Benefits

Co Pay _____

Deductable _____

X-Ray _____

Lab _____

Pre-existing condition clause: _____

INS. VER. BY	Date
_____	_____
_____	_____
_____	_____
_____	_____



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Patient Notice

(Request for Limitations and Restrictions of PHI)

HIPPA (Health Insurance Portability & Accountability Act of 1996; a Federal Law) requires Healthcare organizations to comply with specific rules (Notice of Privacy Practices) regarding your Preferred Health Information . (PHI)

With my consent, Extended Arm Physicians Inc. may use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operations. (TPO) Please refer to Extended Arm Physicians Inc.'s Notice of Privacy Practice for a more complete description of such uses and disclosures. **Please Note: The practice is not required to agree to your request. Please see Notice of Privacy Practice for more information regarding such requests.**

Patient First Name	Patient Middle Name	Patient Last Name	Date of Birth
			/ /

Address	Apt #	City	State	Zip

I authorize Extended Arm Physicians Inc. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Please check **Yes** or **No** and Write Telephone Number(s)

Home Telephone (H)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number: _____
Ans. Machine (Home)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Work Telephone (W)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number: _____
Voice Mail (Work) (VM)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cell Phone (C)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number: _____
Voice Mail (Cell) (VM)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pager (P)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number: _____
Email (E)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Email: _____

We will try and honor you above request. However, if you DO NOT give us a telephone number, we will not be able to contact you with lab results. Therefore, you will have to schedule an office visit appointment to discuss your results, whether normal or abnormal.

Please list names of people we can discuss your medical care:

Spouse: _____

Parent: _____

Other (Name): _____

Relationship: _____

Signature: _____

Date: _____

Patient / Parent / Legal Guardian



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Patient Health History

In order to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of the form. The information will be entered into the computer and you are welcome to a copy of the report if you wish.

Social Security Number: _____

Appointment Date: ____/____/____

Patient First Name	Patient Middle Name	Patient Last Name	Gender	Date of Birth
			Male / Female	/ /

Pharmacy Preference (Include Location and Phone Number)

Name of Primary Care (Family) Physician _____ Phone Number: _____

Name of Referring Physician _____ Phone Number: _____

Current Medications: Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) No Yes **If yes, please list below include dosages**

Medication Name		

Medication Allergies: Are you allergic to ANY medications? No Yes. **If yes, please list below**

Name of Medication	Type of Medication

Non-Medication Allergies: Are you allergic to seafood? No Yes. **If yes, what reaction do you have?**

Are you allergic to things that touch your skin, such as latex, tape, metal? No Yes latex tape metal

Past Health History: Have you ever been **DIAGNOSED** with any of the following problems

Cancer (type) _____ No Yes
What Year? _____

Nose and Sinus:
Nasal Allergies _____ No Yes
What Year? _____

Heart and Blood Vessels:
High/Elevated Cholesterol _____ No Yes
What year? _____

Lungs and Respiratory
Tuberculoses _____ No Yes
What year? _____

Stomach and Digestive:
Duodenal Ulcer _____ No Yes
What Year? _____

Hepatitis _____ No Yes
What year? _____

Stomach Ulcer _____ No Yes
What Year? _____

Kidney and Gender Problems:
Renal Failure _____ No Yes

Are you pregnant _____ No Yes



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Mental and Emotional:

Depression No Yes

What year? _____

Anxiety No Yes

What year? _____

Allergies, Immune & Infectious Problems:

HIV No Yes

What year? _____

Infectious mononucleosis No Yes

Blood and Lymph Problems:

Anemia No Yes

What Year? _____

Glands, Hormones and Sugar Control:

Diabetes No Yes

What year? _____

Thyroid deficiency No Yes

What year? _____

Thyroid Excess No Yes

What year? _____

SURGERIES AND HOSPITALIZATIONS:

Have you had problems with anesthesia (being numbed or put to sleep)?

High fever Trouble with intubation (placement of breathing tube)

Have you had surgery? No Yes

If yes list types and when they were done

Have you ever been hospitalized for non-surgical reasons? No Yes

If yes list types and when they were done

FAMILY HISTORY

MEDICAL PROBLEM	MOTHER	FATHER	BROTHER	SISTER
Specific Anesthesia Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss Before Age 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss Before After 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose and Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart and Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs and Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain and Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood and Lymph Node Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other				



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SOCIAL HISTORY

What is or was your occupation? _____

Check if retired

Have you used tobacco in any form? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please complete the following:			Do you consume alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please complete the following:		
Type of Tobacco	From Year	To Year	Type of Alcohol	From Year	To Year
Cigarettes per day _____					
Other: (List Type)					

Are you exposed to second hand smoking? No Yes

Do you use drugs recreationally? No Yes If yes. please list _____

REVIEW OF SYSTEMS Mark YES or NO and CHECK any of the following **SYMPTOMS** you have had recently

General Health Problems No Yes
 fever sleeping problems unintentional weight loss

Head or Face Problems No Yes
 headache face pain

Eye Problem No Yes
 blurred vision double vision loss of vision

Ear Problem No Yes
 hearing loss dizziness ringing

Mouth and Throat Problem No Yes
 change in voice snoring sore throat ulcers

Neck Problem No Yes
 Neck masses or lumps pain swollen glands

Heart or Circulation Problem No Yes
 blackout or fainting chest pain irregular heartbeat
 bluish or discoloration of lips or fingernails leg cramps
 swelling of ankles

Lung or respirator problems No Yes
 freq non productive cough freq. productive cough

Stomach Problems No Yes
 abdominal pain diarrhea heartburn nausea
 vomiting

Bones Joint and Muscles No Yes
 pain in the back painful jobs stiffness
 swelling of joints

Brian or Nervous System Problems No Yes
 change in alertness loss of bladder control
 numbness loss of consciousness seizures
 severe face pain weakness

Problems with Glands and Hormones No Yes
 feel cold all the time feel hot when others do not
 increased appetite increased fatigue
 neck has enlarged unwanted weight change

Problem with Blood or Lymph nodes No Yes
bleeds excessively after injury bruises easily

Problem with Allergies No Yes
 food intolerance freq. sneezing hives
 post nasal drainage severe reaction to insect bites

What is the main reason you are seeing the doctor?

