Duke Ahn, M.D.

ProHealth Partners Patient Information Sheet

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security #_____

Sex: __M __F Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Language _____ Interpreter Required: □ Yes □ No

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial _____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION (*please print*)

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security #_____

Billing Address _____ City, State, Zip _____

Group or Policy #_____ Cert. or Member #_____ Local Union #_____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security #_____

Billing Address _____ City, State, Zip _____

Group or Policy #_____ Cert. or Member #_____ Local Union #_____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Pharmacy Information/ePrescribing (*please print*)

Pharmacy Name _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): _____ Date: _____

Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.
Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
Fill status of notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.
By signing the consent form you are agreeing that Sherif Labatia, M.D./ProHealth Partners can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Sherif Labatia, M.D/ProHealth Partners to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Emergency Contact Information

Please list two people who do not live with you that we may call in case we are unable to reach you and we have an urgent matter to discuss with you**.**
Note: NO CONFIDENTIAL INFORMATION SHALL BE DISCLOSED, SIMPLY TO REQUEST TO HAVE YOU CONTACT OUR OFFICE.

Emergency Contact Name	Relationship	Phone Number

Authorization to Communicate Patient's Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name of Person Authorized to received information	Relationship to patient	All	Medical	Appt. Only	Billing Only

Office No Show Policy

In order to assure the best appointment availability to our patients, we ask that you notify us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule the appointment. Failure to give us 24 hours notice will result in a $25.00 No Show fee.

Copayments, Deductibles and Share of Cost

Please note that we have a contractual agreement with your insurance company that states we are required to charge you for any deductibles, copayments and out of pocket share of cost. As a courtesy to our patients, we will bill your insurance company for services rendered in our office, however, we do ask that copayments, out of pocket share costs and deductibles that are due. Be paid at the time of service. We are no longer able to bill for these items. Any special arrangements must be made in advance with the office manager or provider.

Informative Required Information

Advance Directive given: □ Yes □ No Initials:____ TB Risk Assessment given: □ Yes □ No Initials:_____

Signature (Patient or Parent of Minor): _____ Date: _____

Identification Policy

In effort to comply with HIPAA regulations, our office requires that you present a Picture ID and your Insurance Card at every visit.

Patient Printed Name: _____ Date of Birth: _____

Signature (Patient or Parent of Minor): _____ Date: _____