The Leela Center for Integrative Medicine at Huntington Hospital

New Patient Registration

Patient Information

First Name	Last Name	MI	Nickname	DOB / /

Address	City	State	Zip

Home Phone Number	Alternate Phone Number (☐ Cell or ☐ Work)

E-mail Address

Gender ☐ M ☐ F	SSN	Preferred Language

Marital Status	Preferred Contact	Ethnicity	Race
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Email	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline	☐ American Indian of Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Insurance Information

Please give your insurance card to the receptionist.

Primary Insurance	Secondary Insurance
Policy(ID) no.	Policy(ID) no.
Group no.	Group no.
Policy Effective Date	Policy Effective Date
Policy Holder (Guarantor) Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Policy Holder (Guarantor) Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Complete below if patient(self) is not the Guarantor.

Guarantor First Name	Guarantor Last Name	Guarantor DOB

Guarantor Address	City	State	Zip

Guarantor Phone No.	Guarantor SSN	Relationship to Patient

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed: _____ _____ _____ _____

Emergency Contact

Name of local friend or relative *not* living at the same address.

First Name	Last Name	Relationship to Patient	
Address	City	State	Zip
Home Phone Number	Alternate Phone Number (☐ Cell or ☐ Work)		

Release of Information

I hereby give permission to the person(s) listed below to receive all information about the care of the above named patient.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. In the event of default, I agree to pay all costs of collections and attorney fee. I also authorize The Leela Center for Integrative Medicine or insurance company to release any information required to process my claims. I further agree that a scanned copy of this agreement shall be as valid as the original.

X_____ _____

Patient/Guardian Signature *Date*

New Patient Medical History

Past Medical History

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
Example: *High Cholesterol*	*2000*	Other(s):	

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

Other Physicians and Specialists

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

Physician Name	*Specialty*	*Physician Name*	*Specialty*

Medication or Food Allergies and/or Intolerances

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

Medications, Vitamins and Herbal Supplements

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

Social, Educational and Work History

Work Status (circle one): ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student	Current or Prior Occupation: Hours worked per week:
What type of exercises do you perform, duration & frequency?	
In what type of residence do you live (i.e., house, assisted living, nursing home)?	

Do you drink alcohol? ☐ Y ☐ N	What type of alcohol?	No. of drinks per week?
Are you a current smoker? ☐ Y ☐ N	If you smoke, how many packs per day?	
Are you a former smoker? ☐ Y ☐ N	If so, what year did you quit?	No. of years you smoked?
	On average, how much did you smoke per day?	
Are you sexually active: ☐ Y ☐ N	How many partners have you had during the past 12 months?	
	Are you concerned that you may have been exposed to HIV? ☐ Y ☐ N	

Family Health History

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Mother's Father: (Your Grandfather)				
Mother's Mother: (Your Grandmother)				
Father's Father: (Your Grandfather)				
Father's Mother: (Your Grandmother)				
Children:				
Children:				
Children:				

Other Relatives:				

Review of Systems

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

- ❑ ***Place an "X" in the box to the left if you have none of the above.***

Disease Prevention and Health Maintenance

Please indicate which health screening tests are up to date.

Are you up to date on the following:

Mammogram ☐Y ☐N	*Female Only*	Eye Exam ☐Y ☐N	
Pap Smear ☐Y ☐N	*Female Only*	Dental Exam ☐Y ☐N	
Colonoscopy ☐Y ☐N			

HIPAA CONFIDENTIALITY AGREEMENT

Health Insurance Portability and Accountability Act

I hereby give my consent for *The Leela Center for Integrative Medicine* 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 The Leela Center for Integrative Medicine describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Leela Center for Integrative Medicine 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 Dr. Alexis Anvekar at 50 Bellefontaine St #307, Pasadena, Ca 91105.

With this consent, The Leela Center for Integrative Medicine 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, The Leela Center for Integrative Medicine 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, The Leela Center for Integrative Medicine 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 The Leela Center for Integrative Medicine 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 The Leela Center for Integrative Medicine 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, The Leela Center for Integrative Medicine may decline to provide treatment to me.

_____ _____/_____/_____

Signature of Patient or Legal Guardian Date

_____

Print of Patient or Legal Guardian Name

The Leela Integrative Medicine Center
50 Bellefontaine St # 307
Pasadena, CA 91105
Phone: 626.795.0411 Fax: 626.795.0080

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
_____

Please disclose the following information: (mark all that apply)

- ☐ Complete Health Record(s)
- ☐ Progress Notes
- ☐ Labs
- ☐ Health Summary
- ☐ Radiology/Ultrasound Reports
- ☐ Physical Exam
- ☐ Shot/Medication Records
- ☐ Other _____

Covering the period(s) of health care From(Date) _____ To(Date) _____

I hereby authorize the release of my records from and to the following providers:

REQUEST FROM:	**REQUEST TO:**
PROVIDER:	**PROVIDER:**
Alexis Anvekar, MD.	_____
Address:	Address:
50 Bellefontaine St, Suite 307	_____
Pasadena, Ca 91105	_____
Phone:	Phone:
(626) 795-0411	_____
Fax/secure email:	Fax:
(626) 795-0080/ erika@leelacenter.com	_____

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

X _____ ___/___/___

Patient and/or Legal Guardian Signature Date

The Leela Integrative Medicine Center
50 Bellefontaine St # 307
Pasadena, CA 91105
Phone: 626.795.0411 Fax: 626.795.0080

Patient Name: _____
DOB: _____

This page left blank for any special information you would like to share that was not addressed on the above forms: