

Darius Peikari, M.D.

Internal Medicine

Thank you for selecting Darius Peikari, M.D., PA for your healthcare needs. Please fill out the enclosed paperwork and bring it in with you when you come for your appointment. Also, be sure to bring your insurance card(s), driver's license, the medications you are on and any medical records from your prior physician. If you need to cancel or reschedule your appointment, please call us as soon as possible.

Our office building is located on the northwest corner of Coit Road and 15th street and is easy to find since it is connected to the hospital (Medical Center of Plano) by a pedestrian walkway over Coit Road. Our suite is located on the fourth floor of the building.

If you have any questions or need additional information, please do not hesitate to call our office at (972) 964-7800 or visit our web site at www.dariuspeikari.com.

We look forward to meeting you!

*4001 W. 15th Street • Suite 435 • Plano, TX 75093
(972) 964-7800*

Payment/Insurance Agreement

Thank you for choosing the office of Dr. Darius Peikari for your internal medicine needs.

If you are a **PPO PATIENT**, you should select Dr. Peikari as your PCP (Primary Care Physician). You are also responsible for a co-payment as well as meeting a yearly deductible and any out-of-pocket (if applicable) expenses with your insurance plan. If your deductible has been met, you will simply owe a co-payment, which must be paid at the time of service. If your deductible has not been met, you are responsible for the charges up to the amount of your deductible. It is important that you understand that any services rendered that are **NOT COVERED** by your insurance plan will be billed to you. Note: Out-of-pocket expenses do not apply to all PPO health plans.

If you are an **HMO/POS PATIENT**, you are required to select Dr. Peikari as your PCP (Primary Care Physician). If you have not done this, your visit to our office may not be covered and you will be responsible for payment in full. You are also responsible for a co-payment which must be paid at the time of service. It is important that you understand that any services rendered that are **NOT COVERED** by your insurance plan will be billed to you.

If you are a **CASH/SELF PAY PATIENT**, you will be responsible for all charges in full at the time of service, unless prior arrangements have been made with the office manager.

If you have any questions regarding covered services, deductibles, out-of-pocket expenses, etc., please contact the benefits director at your insurance company or your insurance carrier directly for assistance. Every effort is made to verify your insurance coverage on your first visit, but it is impossible for our office to investigate which services are not covered on your behalf, as each plan differs. It is ultimately your responsibility to ensure that any services rendered to you are covered by your particular policy.

Dr. Peikari's office realizes that managed care issues can be very confusing and frustrating at times. If you have any further questions, please feel free to call at (972) 964-7800.

Patient/Legal Guardian Signature

Date

PATIENT REGISTRATION

NAME: (LAST) _____ (FIRST) _____
BIRTHDAY: ___/___/___ AGE: ___ SEX: M / F SSN: ___-___-___
ADDRESS: _____
CITY: _____ STATE: ___ ZIP: _____
TELEPHONE: HOME (___) _____ OFFICE (___) _____
OCCUPATION: _____ DRIVER'S LICENCE#: _____
EMPLOYER: _____ PHONE: (___) _____
BUSINESS ADDRESS: _____
CITY: _____ STATE: ___ ZIP: _____
EMAIL ADDRESS: _____
HOW DID YOU HEAR ABOUT US: _____
IF YOU WERE REFERRED, WHICH PHYSICIAN? _____

RESPONSIBLE PARTY'S INFORMATION

INSURED'S NAME: (LAST) _____ (FIRST) _____
RELATION: _____ DATE OF BIRTH: _____
SOCIAL SECURITY #: ___-___-___ DRIVER'S LICENCE #: _____
INSURED'S ADDRESS (if different): _____
CITY: _____ STATE: ___ ZIP: _____
TELEPHONE: HOME (___) _____ OFFICE (___) _____
INSURED'S EMPLOYER: _____ PHONE: (___) _____
BUSINESS ADDRESS: _____
CITY: _____ STATE: ___ ZIP: _____

PRIMARY INSURANCE INFORMATION

POLICY NAME (HMO/PPO/POS): _____
ADDRESS: _____
CITY: _____ STATE: ___ ZIP: _____
GROUP #: _____ ID #: _____
DO YOU HAVE A SECONDARY INSURANCE CARRIER? _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATION: _____
TELEPHONE: HOME (___) _____ OFFICE (___) _____
MOBILE PHONE/PAGER: (___) _____

I hereby consent to treatment by the physician and staff of Darius Peikari, M.D., PA.
I hereby authorize Darius Peikari, M.D., P.A. to furnish information to insurance carriers concerning me or any of my dependents' illnesses and treatments. I agree to be held legally responsible for the payment of all fees for services rendered to me and my dependents by the physician and staff of Darius Peikari, M.D., PA.

Signature: _____ Date: _____

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Internal Medicine

Name: _____ Sex: M / F Age: ____ Date of Birth: _____

Current Illness (what problem(s) are you seeing the doctor for on this visit): _____

Medical Conditions (list all current and past medical conditions, the dates of onset and the physician [if known])-eg. Asthma, diabetes _____

Surgeries (list any surgery you have ever had [include date, place, surgeon if known])

Other Hospitalizations/Injuries (list anything not covered above) _____

Allergic Reactions (list the medication or other substance [food, bee sting, etc] and type of reaction)

Medication List (include drug name, dosage, and number of times per day taken-include non-prescription drugs, vitamins, herbal supplements, Tylenol, etc.) _____

Do any of the above medicines cause any bothersome side effects? Which ones? Describe the effect.

Please list the date you received the following immunizations: Tetanus _____ Hepatitis B _____

Polio _____ Flu _____ Measles _____ Pneumococcal _____ Hepatitis A _____

Occupational exposures? To what substances? _____

Women Only: Age of onset of menstruation: ____ Menses are (circle one): REGULAR / IRREGULAR

Number of Pregnancies: ____ How many children: ____ Age at menopause: ____

Are you currently seeing a gynecologist? YES / NO Doctor's Name: _____

Family History (List current age or age at death, health/medical conditions and cause of death if known)

Mother: _____

Father: _____

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Brother(s)/Sister(s) [include names]: _____

Children [include names]: _____

Have you ever been married? YES / NO How many times: _____ Marital Status Now: S M D W

Current Occupation: _____ What are your duties: _____

If retired, what date: _____ Former Occupation: _____

What is the extent of your education: _____

Do you exercise? YES / NO Type: _____ How often: _____

Have you smoked cigarettes/cigar/pipe? YES / NO How many packs per day? _____ How many years have you smoked? _____ If you quit, what year? _____ Do you use chewing tobacco/snuff: YES / NO

Do you drink liquor/beer/wine? YES / NO How many drinks per day? _____

What alcoholic products? _____

Are you on any diet or do you have dietary restrictions: _____

How many cups of coffee do you drink daily? _____ How many soft drinks? _____

Health Maintenance:

When was your last comprehensive physical exam: _____ Last PAP (if applicable): _____

Last time that blood work was drawn/what type of blood work: _____

Last Mammogram (if applicable): _____ Last colon screening/what type: _____

Last cholesterol check: _____ Last Bone Density test: _____

Last Prostrate exam/ Prostrate blood test (PSA) (if applicable): _____

Body Systems Review

YES NO Do you have any of the following? (list current symptoms only, add previous symptoms/concerns to the medical history above)

Change in weight? Over what time period? _____

Problems with your eyes/ears/mouth/throat (hearing aides, glasses, dentures, etc.) _____

Fainting spells, seizures, recurrent headaches, strokes, nervous, mental disorders _____

Lung problems (Asthma, bronchitis, etc) _____

Chest pain/tightness/discomfort, irregular heart beats, high blood pressure, pacemaker

Stomach problems, jaundice, intestinal bleeding, ulcers, indigestion, reflux, gall bladder or pancreas conditions _____

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- Kidney stones, kidney problems, bladder, prostate, reproductive organs, sexual problems

- Hormone imbalance (diabetes, thyroid, etc.) _____
- Cancer, tumor, lymph gland disorder, skin disorders, hair loss, unexplained fever _____

- Anemia or other blood disorders _____
- Arthritis/Gout, bone/joint problems _____
- Sleeping difficulty/snoring _____
- Chronic infection or venereal disease _____

Please list any other symptoms not listed above or explain any of the above in more detail: _____

Please do not email this back to our office.

Also, remember to bring the following items to your office visit:

- These forms completed to the best of your ability
- Your insurance card(s)
- Your driver's license
- Any medical records/xray reports from previous physicians
- All of your medications

Thank you for your patience and again we look forward to seeing you here.

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