Tri-State Health, Inc.
107 N. Bridge St. Elkton, MD 21921
2288 Pulaski Hwy., Ste. 1 North East, MD 21901
2527 Jacob Tomb Memorial Hwy., Colora, MD 21917
266 S. College Ave. Newark, DE 19711
P: (410) 392-6408 ** (302) 368-2563
F: (410) 392-6409

New Patient Registration

Patient Information:

Last Name: _____ First Name: _____ M.I___

Date of Birth: _____ Social Security Number: _____ Gender: [ ] M [ ] F

Ethnicity: _____ Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____

Emergency Notification:

Person 1 Name: _____

Relationship: _____ Phone Number: _____

Address: _____

Person 2 Name: _____

Relationship: _____ Phone Number: _____

Address: _____

HIPPA Patient Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect, H.I. P.P. A., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe. Tri- State Health Inc. requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Name of Patient or Representative: _____ Birth Date: _____

Date: _____

Signature of Patient or Representative: _____

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Preventative History:

Have you ever had a(n)

Prostate Check	[] Yes	[] No	Date: _____
Mammogram	[] Yes	[] No	Date: _____
Pap Smear	[] Yes	[] No	Date: _____
Colonoscopy	[] Yes	[] No	Date: _____
Dental exam	[] Yes	[] No	Date: _____
EKG/ ECG	[] Yes	[] No	Date: _____

Family History:

Please Circle: Father Mother Sister Brother Other

Alzheimer's_____

Dementia Bipolar_____

Depression Diabetes_____

Kidney Dis. Heart_____

Disease/ CAD High_____

Blood Pressure High:_____

Cholesterol Thyroid:_____

Disorder Stroke/ TIA:_____

Cancer: _____

Other:_____

Drug Allergies: List all medication allergies:

Medication:_____Reaction:_____

Medication:_____Reaction:_____

Medication:_____Reaction:_____

Medication:_____Reaction:_____

Signature of Patient or Representative:_____

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Food Allergies: List all food allergies.

Food:_____Reaction:_____

Food:_____Reaction:_____

Food:_____Reaction:_____

Food:_____Reaction:_____

Medical History: (check the items that apply to you, currently, or in the past)

[] None	[] Peripheral Vascular Disease	[] Blood Disorders	[] Anxiety
[] Gallstones	[] Heart Murmur	[] Diverticulitis	[] TMJ
[] Osteoporosis	[] Pneumonia/Bronchitis	[] Allergies	[] Scarlet Fever
[] Kidney Disease/Failure	[] Ulcerative Colitis	[] Stomach Ulcer	[] Thyroid
[] Glaucoma/Cataracts	[] Hepatitis	[] Diabetes	[] Osteoarthrosis
[] Pancreatitis	[] Cirrhosis of Liver	[] Drug Use	[] Depression
[] High Blood Pressure	[] Sleep Apnea	[] Enlarged Prostrate	[] COPD
[] Hearing loss	[] HIV/ AIDS	[] Migraines	[] Anemia
[] Paralysis	[] Reynaud's Syndrome	[] Colon Polyps	[] Asthma
[] Atrial Fibrillation	[] Lupus	[] TB	[] Heartburn
[] Heart Attack	[] Rheumatic Fever	[] Neuropathy	[] Reflux
[] Parkinson's Disease	[] Rheumatoid Arthritis	[] Sciatica	
[] Vitamin B-12 Deficiency	[] Psoriasis	[] Kidney Stone	

Medical History:

Surgical History: (Please list all surgeries and/ or procedures along with date of occurrence)

_____

_____

Cancer History: (Detail any family history and/ or blood disorders, including aunts, uncles, cousins, grandparents and Immediate family):

_____

_____

Signature of Patient or Representative:_____

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Exercise: [] Yes_____ [] No_____

Tobacco Use: [] Yes [] No [] Former Smoker Packs a Day _____

Alcohol Use: [] Yes [] No [] Occasional a Social [] Heavy Drug/ IV Drug

Drug/IV Drug Use: [] Yes_____ [] No

Medication List:

Please list any medications you are currently taking prescribed by any doctor:

Name of Medication Strength/ Dosage Frequency

_____
_____
_____
_____
_____
_____
_____

Please list any Additional Physicians you see: (Include Phone # and reason for visit)

_____
_____
_____
_____
_____
_____
_____
_____

Are you Pregnant [] Yes [] No N/A

Note :- According to office policy, fees for medical records are $ 0.75 per page and time required to print is approximately 72 hours to one week

Signature of Patient or Representative:_____

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PHARMACY CONTRACT

Muhammed Niaz, M.D.

266 S. College Ave
Newark, DE 19711
Phone: (302) 368-2563
Fax: (302) 368-3445

107 N. Bridge St.
Elkton, MD 21921
Phone: (410) 392-6408
Fax: (410) 392-6409

This is an agreement between_____(the patient) and Dr. Muhammed Niaz and his practice, Tri-State Health INC. The patient here after agrees to fill all controlled prescriptions at the following pharmacy. Failure to do so without notifying the office will result in possible discharges from the practice.

I_____agree to only utilize:

Pharmacy Name:_____

Signature: _____

Date: _____Witness: _____

A $25.00 no show fee will be charged for appointments not cancelled 24 hours in advance of the scheduled appointment time.

Patient Signature: _____

Date: _____

Signature of Patient or Representative:_____

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POLICY REGARDING CONTROLLED SUBSTANCES PRESCRIPTION

Please note our office has to evaluate your past medical history, diagnostic procedures, all prior labs and pharmacy profile for the past year. Also we need to review your information on Crisp website and review your records from previous physicians' offices and hospitals including any surgical procedures done in the past.

All of this information may need extensive time and use of resources. So, it may not be possible to give any controlled medicine on your first visit. Once we receive all of the relevant information, the physician will then be able to make a decision whether he/she could prescribe any controlled medication for you.

_____ _____
Patient Signature Date

_____ _____
Witness Date

Signature of Patient or Representative:_____

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Tri-State Health Inc. Office Policy's

CO- PAYMENT

- Co-pays are expected at the time of service. I understand that failure to pay my co-pay upfront may result in my visit being rescheduled.

REFERRALS

- The office required a 72 hour notice to complete all referrals. Failure to inform the office within 72 hours prior to the appointment may result in the incompletion of this referral. The office requires the patient be seen within the last 6 months to get a referral from the office

MEDICATION REFILLS

- Prescriptions refills take 24-46 hours to be called in and it is my duty to notify the office when I have enough medications left.

NEW PATIENTS

- I understand that as a new patient I need to have Dr. Muhammed Niaz selected as my PCP with my insurance company if it is required by my policy. If my insurance fails to pay for the visit, I will be held accountable for the balance occurred.

COMMUICATION

- It is my responsibility to update my personal and insurance information at each visit otherwise critical information regarding my healthcare, appointments, etc. can be missed.

WALK INS

- Walk ins will be fit in between scheduled patients unless it is an emergency.

LATE ARRIVALS TO APPOINTMENTS

- I understand that if I am more than 15 minutes late I have missed my scheduled appointment time I can either reschedule my appointment or wait until the next available appointment time.

DIAGNOSTIC/ LAB RESULTS

- Results will not be discussed over the phone unless Dr. Niaz specifically says that he will call you. It is my responsibility to complete all requested tests and schedule follow up appointments to review them with the doctor.

Signature of Patient or Representative:_____

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FEES FOR MEDICAL RECORDS

Please note that there are fees of 75 cents per page to copy your medical records. Fees must be paid in advance before printing the records.

RELEASE OF MEDICAL INFORMATION

Please note that medical records could be released to insurance companies to request authorization of any treatment, procedure or other medical care needs as they might occur from time to time. Please also note that medical records could be released other physicians for consultation or other medical care needs.

I agree to and understand the office policies of Tri-State Health Inc. stated above.

Patient Signature:_____ Date:_____

Consent to Treatment

1. I _____ (patient name) give permission for Tri-State Health Inc. to give me medical treatment.

2. I allow Tri-State Health Inc. to file for insurance benefits to pay for the care I receive.

   I understand that:
   - Tri-State Health Inc. will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

   - I have the right to discuss all medical treatments with my clinician.

Signature of Patient or Representative:_____

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3. I understand:
   - I have the right to refuse any procedure or treatment.

   - I allow Tri-State Health Care to acquire my medical related information from other health care facilities including but not limited to, hospitals, pharmacies, Prescription Drug Monitoring Programs, labs and other diagnostic tests and imaging, and other health care providers etc.
   - Tri-State Health also has the right to release your medical information to other health care providers and facilities related to your treatment as needed, including hospital, physicians and diagnostic and therapeutic, behavior and mental treatment centers etc.
   - You may be subjected to urine toxicologist and testing can be send to toxicology lab which can send the bill to your insurance companies and if the insurance company deny payment then the bill will be transferred to you.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____ _____

Print name Date

Signature of Patient or Representative: _____