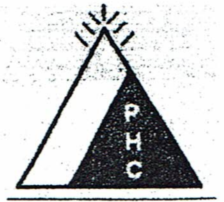


PINNACLE HEALTH CENTER

PRITI T MODI F.A.C.P.

1608 TULLY ROAD, MODESTO, CA 95350

P: (209) 409-8589 f: (209) 409-8691

DEAR ____________________________,

A very warm welcome to you! We thank you for selecting our office to care for your health.

Our goal is to provide you with the highest quality medical care in a gentle, efficient and pleasant manner.

Please complete the enclosed forms, and return forms during your appointment. If you have medical insurance, please bring your card with you to your visit. If you have an HMO please make sure that Priti Modi MD is the primary care physician listed on your card. If you are a cash pay patient please be aware new patient consults are $100 and follow-up appointments are $75, please note cost of visit is due at the time of visit.

Our office is located is 1608 Tully Road in between > Briggsmore Avenue and Granger Avenue.

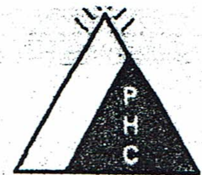
Your appointment is scheduled for:

____

If you have any questions, please call at your convenience. We are looking forward to meeting you.

Welcome!

Dr. Priti T. Modi & staff



Patient Registration Information

Patient Demographics - Please complete the following information regarding the patient being seen today.

Patient Name:	Address:
Date of Birth:	City, ST:
SSN:	Zip: Country:
Male Female Marital Status: M S W D	Home: Cell:
Language : English / Spanish / Other:	Email:
Hispanic Origin: Yes / No Race:	Employer:
Relation to Guarantor: Self / Other:	Address:
Guarantor:	City, ST:
Patient AKA: Note: *Please list all names used in the past or present*	Zip: Country:
How did you hear about us?	Work Phone:
What is your preferred language for discussing health care?	Retirement Date:

Subscriber Information/Responsible Party - Please complete the following information regarding the person financially responsible.

Name: Relationship to Patient: Same as Patient? ☐	Employer:
Address:	Address:
City, ST:	City, ST:
Zip: Country:	Zip: Country:
Home: Cell:	Work:
SSN: DOB:	☐ Male ☐ Female

Emergency Contacts - Please complete the following information regarding the person(s) to contact in case of an emergency.

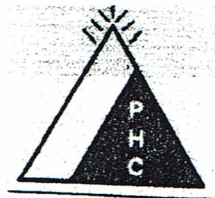
Contact: Relationship:	Contact: Relationship:
Home: Cell: Work:	Home: Cell: Work:

Insurance Information - Please complete the following information regarding the insurance(s) that you wish to use today.

Did you injure yourself on the job? ☐ check here

Insurance -1:	Insurance -2:
Policy /ID No.: Group No.:	Policy /ID No.: Group No.:
Subscriber Name: Relation to Patient: Self / Other:	Subscriber Name: Relation to Patient: Self / Other:

Please provide a picture ID and any insurance cards to the Registration Staff when you return this form. Thank you.



Medical History

Patient Name ______________________ Date of Birth ______________

Reason for Visit Today ______________________

Pharmacy 1)______________________ 2) ______________

Past Medical History (Please check if you have had any of the following)

High Blood Pressure	❑ yes ❑ no	If yes, year of diagnosis ________		
High Cholesterol	❑ yes ❑ no	If yes, year of diagnosis ________		
Diabetes	❑ yes ❑ no	If yes, year of diagnosis ________		
Bone Density Test	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal
Colonoscopy	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal
Heart Stress Test	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal
Heart Catheterization	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal

FOR MALE PATIENTS ONLY

PSA Test	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal

FOR FEMALE PATIENTS ONLY

Mammogram	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal
Pap smear	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal
Colposcopy	❑ yes ❑ no	If yes, year of test ________	❑ normal	❑ abnormal

Number of pregnancies ________ Number of births ________

Date of last menstrual period ______________ Method of birth control ______________

Please list any other medical conditions:

____

____

____

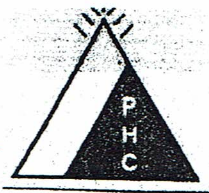
____

____

Past Surgical History

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

continued



Medical History *page 2*

Patient Name ______________________

Family History (Check in the appropriate boxes to identify all illnesses/conditions in your blood relatives)

Relative	Heart Attack	High Blood Pressure	Stroke	Colon Cancer	Breast Cancer	Colon Polyps	Prostate Cancer	Other Illness or Condition	Age if living	Age of death
Father	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Mother	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Brother	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____
Sister	☐	☐	☐	☐	☐	☐	☐	☐ ________	____	____

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation ______________________________

Exercise Type? ____________ How long? ____ minutes How often? ____ times per week

	Current Use	Past Use	How often per week	How much per day
Smoking				
Caffeine				
Alcohol				
Drug Use				

Allergies (Please list all allergies)

Reaction: Date:

1 ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

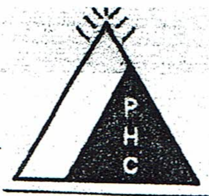
Current Medications

Medication	Reason for taking	Dosage	Times per day	Date Started

continued

Medical History *page 3*

Patient Name ______________________________



Immunizations

Tetanus	❑ yes ❑ no	Date vaccinated ______	Gardasil Series (HPV)	❑ yes ❑ no	Date vaccinated ______
Influenza	❑ yes ❑ no	Date vaccinated ______	Zoster Vaccine	❑ yes ❑ no	Date vaccinated ______
Pneumococcal	❑ yes ❑ no	Date vaccinated ______	Varicella	❑ yes ❑ no	Date vaccinated ______
Hepatitis A Series	❑ yes ❑ no	Date vaccinated ______	Have you had chicken pox?	❑ yes ❑ no	Date vaccinated ______
Hepatitis B Series	❑ yes ❑ no	Date vaccinated ______			

Review of Systems

Please check any of the following that you have experienced in the last 3 weeks.

Constitutional
- ❑ Changes in appetite
- ❑ Fever
- ❑ Recent weight gain (___lbs)
- ❑ Fatigue
- ❑ Night sweats
- ❑ Chills
- ❑ Recent weight loss (___lbs)

Skin/Integumentary
- ❑ Change in a wart or mole
- ❑ Rash
- ❑ Sores that won't heal

Eyes
- ❑ Recent changes in vision
- ❑ Double vision
- ❑ Eye pain

Ear, Nose and Throat (ENT)
- ❑ Loss of hearing
- ❑ Nasal congestion
- ❑ Trouble swallowing
- ❑ Ringing in the ears
- ❑ Seasonal allergies
- ❑ Snoring
- ❑ Cold symptoms
- ❑ Sore throat

Respiratory
- ❑ Wheezing
- ❑ Cough

Cardiovascular
- ❑ Fainting
- ❑ Calf cramps
- ❑ Difficulty breathing on exertion
- ❑ Chest pain
- ❑ Heart rate is fast
- ❑ Varicose veins
- ❑ Irregular heart beat
- ❑ Swelling of extremities

Gastrointestinal
- ❑ Black, tarry stool
- ❑ Constipation
- ❑ Indigestion
- ❑ Bloody stools
- ❑ Heartburn
- ❑ Vomiting

Genitourinary
- ❑ Blood in urine
- ❑ Painful intercourse
- ❑ Urinating at night
- ❑ Menstrual irregularities
- ❑ Painful urination

Musculoskeletal
- ❑ Joint pain
- ❑ Muscle pain

Neurological
- ❑ Numbness
- ❑ Headaches

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Substance abuse

Endocrine
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Excessive urination

Heme/Lymph
- ❑ Easy bruising
- ❑ Enlarged lymph nodes

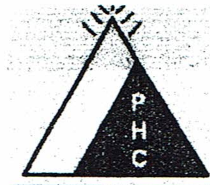
List all other symptoms you are experiencing that you need to discuss:

____

____

____

We will make every effort to discuss your medical concerns at your visit. However, we may need to schedule an additional appointment to adequately address multiple concerns.



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1608 TULLY ROAD, MODESTO CA 95350
P: (209) 409-8589 F: (209) 409-8691

HIPPA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. Administrative Simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

- Unique identifiers for health plans, providers, individual and employers
- Healthcare transactions & code sets for transmitting electronic data
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

All of these rules have been developed by the Department of health & human services and will become final in a staged manner. It will be the policy of PINNALCE HEALTH CENTER to release confidential information with signed consent by home telephone, answering machine, work telephone, voicemail, and cellular phones. Whenever returning telephone calls and the answering machine identifying the residence. Confidential information will NOT be left with an unauthorized person who may answer your telephone.

If you would like to have medical information released to someone other than yourself, please complete the following:

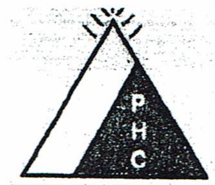
I authorize PINNACLE HEALTH CENTER to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone Yes No
Answering Machine Yes No
Work Telephone Yes No
Voice Mail Yes No
Cellular Phone Yes No

Please List authorized persons:

Spouse/Fiancé: ______________________
Parent/Guardian: ______________________
Other: ______________________

______________________ ______________________ __________
Patient Name Signature Date



PINNACLE HEALTH CENTER

PRIT T. MODI MD, F.A.CP.

1608 TULLY ROAD, MODESTO CA 95350

P: (209)409-8589 F: (209) 409-8691

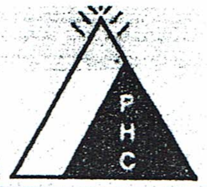
OFFICE/FINANCIAL POLICY

Please be aware our office policies are as follows:

- Make an appointment **every 3 months** for a follow up to continue your medication refills.
  If you are taking controlled medication you will need to pick up triplicate once a month.
- When you need a medication refill, **CALL** your pharmacy and **allow 24 hours** for our office to fax a response back to your pharmacy.
- Bring your medication list to **every appointment**.
- There is **$25.00** charge for completion of forms, please allow **10 business days** for them to be completed.
- Any work excuse note **MUST** be picked up in person, the office staff **WILL NOT** fax to employers.
- If you call the office and a message is left for the doctor, **ALLOW** up to **24 HOURS** for response.

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.
Payment is required at the time of service. We accept cash, check, & credit card.
For patients with private or no insurance, full payment is required at the time of service, $100.00 for new consult, & $75.00 for follow up appointments.
For patients HMO plans, co-payment is required at the time of service. The amount of co-payment varies with different plans. Your are responsible for knowing the co-payment amount.
For patients with PPO plan, payment is required at the time of service until the New Year's deductible has not been met. After that, we require co-payments or liability to be paid at the time of service.
While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.
Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.
If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our billing staff you can make those arrangements by contacting LISA WALKER (209) 529-9529.
Missed appointments: Unless canceled at least 24 hrs in advance, there will be a $25.00 charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in dismissal from the practice.
I have read the above Financial Policy, I have understood it, I agree to it. I have also received a copy of this financial policy.

Name: ____________________________ Signature: _______________________ Date: _____________



Release of Medical Information

Please send records to:

Pinnacle Health Center
Priti Modi MD
1608 Tully Road
Modesto, CA 95350
Ph: 209-409-8589 Fax: 209-409-8691

I, ______________________, with a date of birth, ____________________, give my permission for
(Patient name) (Patient's DOB)

Requesting records from:

Name of Practice: ________________________________

Name of Physician: ________________________________

Fax number: ________________________________

Address: ________________________________

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**
- **This form is only good for 3 months from the date I sign it.**

Patient's Signature ________________________________ Date ____________

Authorized Representative's Signature ______________________ Date ____________

Relationship of Authorized Representative ________________________________