Yatish Goyal, MD, Inc.
Medina Hospital South Medical Bld.
970 E. Washington St., Suite 4D
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330-725-7277
330-723-1254 fax
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Welcome to our Practice

Please complete the new patient forms. If possible, please fax or email them 2 days before your scheduled appointment.

Please arrive 15 minutes before your scheduled appointment.

What to bring:
Photo ID.
Insurance Cards & Traditional Medicare Card
All medications currently prescribed to you, include any that are "as needed".

If your insurance company requires you to list a primary care physician, please contact them and have this updated.

Co-pays are required at the time of service.

Self-pay patients - Payment is required at the time of service. Please contact us for applicable fees.

Kindly provide us with 24 hr. notice if you will be unable to keep your appointment.

No show/No call fees: $10.00 for regular appointment
$25.00 for physical appointment

We require a 24 hour notice for medication refills.

We appreciate the trust you have placed in our office for your medical care. We value our patients and their families. If you have any questions or concerns, please contact our office and a staff member will be happy to assist you.

Please Print

Last Name, First Name:
_____

Address:
_____

City: State: Zip Code:
_____ _____ _____

Email Address: _____

Home Phone:_____ Cell:_____ Marital Status:_____

Birth Date:_____ Sex:_____ Social Security #:_____

Patient Employer: _____

Occupation:_____ Phone:_____ Ext:_____

This is not an authorization to release medical/health information

Emergency Contact:_____

Relationship:_____ Phone:_____

Living Will: Yes____ No____ Power of Attorney: Yes____ No____

Power of Attorney Name & Phone:

Name:_____

We are required by HIPAA to have your permission before releasing medical/health information.

May we leave a message at your home with other residents? Yes___ No____

May we leave a message on answering machine/voicemail? Yes__ No____

Who may we talk to about any medical/health concerns:

Name:_____ Relationship:_____

Phone:_____

Insurance Information:

Ins. Company:_____ Policy Holder:_____

ID #:_____ Group #:_____

Policy Holder Birth date:_____ Co-Pay:_____

Ins. Company:_____ Policy Holder:_____

ID #:_____ Group #:_____

Policy Holder Birth date:_____ Co-Pay:_____

I authorize Dr. Goyal's office to submit any and all health care information, which may include drug, alcohol, and HIV status to my health insurance plan for their review and processing of claims. I understand that my insurance plan may not cover some services and I am financially responsible for these services. I further understand that referrals and authorizations should be initiated by my own request in order to comply with my insurance plan requirements. I authorize payment to be made directly to Yatish Goyal, M.D., Inc.

Signature:_____

Date:_____
This form will be updated annually.
Name:_____ Date:_____

Social History:

Cigarette Smoking: Yes__ No__ No. of years:_____ Packs per day: ___
Year quit: _____

Coffee/Tea ___ cups per day

Alcohol Use: Yes__ No__ Rare__ Occasionally__ Daily__ Quantity: _____
Beer ___ Wine___ Other____

Recreational Drug Use: Yes____ No____

Family Medical History: Please list any high blood pressure, heart disease, diabetes, or cancer. Please note living or deceased.

Father:_____

Mother:_____

Brothers:_____

Sisters:_____

Please circle the number & indicate which blood relative suffered any of the following conditions:

1. Epilepsy
2. Migraine
3. Mental Illness
4. Glaucoma
5. Diabetes
6. Thyroid Disease
7. Hay Fever
8. Asthma
9. Anemia
10. Bleeds easily
11. Osteoporosis
12. Arthritis
13. Heart Disease
14. Stroke
15. Hypertension
16. Lipid Disorder
17. Alcoholism
18. Hepatitis
19. Cancer

_____

_____

_____

Name: _____

Medical History:

Current Medications and dosage that you are taking:

1._____
2._____

3._____
4._____

5._____
6._____

7._____
8._____

9._____
10._____

11._____
12._____

Drug or Latex Allergies:

_____

_____

Hospital Admission or Surgical Procedures: List year and Illness
(Do not include pregnancy)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Vaccine: Year of last

Tetanus/TD:_____ Flu:_____ TB:_____ Hepatitis:_____

Test/Exam: Year of last Cholesterol:_____ Eye:_____ Diab Eye: _____

Name:_____

Medical History: Mark (C) for current problem. Check & indicate age when you had any of the following.

___ Decreased Hearing
___ Ringing in ears
___ Ear infections
___ Dizzy/Fainting
___ Failing Vision
___ Nose bleeds
___ Sinus trouble
___ Sore throat
___ Hoarseness-prolonged
___ Hay fever/Allergies
___ Pneumonia/Pleurisy
___ Bronchitis/Chronic cough
___ Asthma/Wheezing
___ Shortness of breath
___ on exertion ___lying flat
___ Chest pain
___ High blood pressure
___ Heart murmur
___ Irregular pulse
___ Palpitations
___ Leg pain while walking
___ Varicose veins
___ Cold numb feet
___ Loss of appetite (recent)
___ Difficulty swallowing
___ Heartburn ___Peptic ulcer
___ Nausea/Vomiting
___ Abdominal pain-chronic
___ Gall bladder trouble
___ Diarrhea ___ Constipation
___ Diverticulitis
___ Chrons/Colitis
___ Bloody or tarry stools
___ Hemorrhoids ___ Hernia

___ Urination-Overactive bladder
___ Overnight >than twice
___ More than 8 times/24 hrs.
___ Urgency to urinate __with leakage
___ Decreased force/flow __ painful
___ Stress incontinence- urine leakage with exercise/movement
___ Urine infections- frequent
___ Sexually transmitted disease
___ Weight loss ___ Weight gain
___ Anemia ___ Bruise easily
___ Blood transfusions
___ Cancer ___ fatigue
___ Diabetes
___ Thyroid
___ Seizures ___ Stroke
___ Tremor/hand shaking
___ Numbness/Tingling
___ Headache - frequent
___ Back pain-recurrent
___ Bone fx/Joint injury
___ Osteoporosis
___ Foot pain ___Gout
___ Rashes ___Hives
___ Psoriasis ___ Eczema
___ Difficulty sleeping
___ Difficulty concentrating
___ Depression ___ Nervousness
___ Agitation ___ Memory loss
___ Moodiness
___ Suicidal thoughts
___ Phobias
___ Feelings of worthlessness
___ Rheumatic fever ___Scarlet fever

___ Chicken pox
___ Polio ___ Mumps
___ Measles
___ German Measles
___ Tuberculosis
___ Herpes
___ Aids/HIV
___ Exercise
___ Hair loss

Females: Please complete the following

Menstrual Flow: Regular ____ Irregular ____ Pain/Cramps ____
Date of last period: _____ Pain/bleeding during/after intercourse_____
Number of Pregnancies:___ Live Births___ Miscarriages____ Abortions_____
Birth control method:_____ Name of Birth control pill _____
Flushing/Menopause_____ Date of last pap_____ Normal___ Abnormal___

Date of last Mammogram_____ Normal ____ Abnormal ___
Date of last Colonoscopy_____ Normal ____ Abnormal ___
Date of last Fecal Occult _____ Normal ____ Abnormal ___
Date of last Cologuard _____ Normal ____ Abnormal ___
Name of COVID 19 Shot _____
Dates of COVID 19 Shots 1st Shot _____ 2nd Shot _____