Patient Registration

Today's Date: ____________________________ **Date of Birth**: ____________________________

Patient Name: ____ ☐ Male ☐ Female

Last First MI

Address: ____ **City**: ________________________ **State**: ____ **Zip**: __________

Email: ____ **Primary Phone**: __________________ **Secondary Phone**: ___________

Pharmacy name & address: ____ **City:** ____________________ **State:** _____

Height: ______________ **Weight:** ____________

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor/Student

Race: ☐ Black, African American ☐ Asian ☐ White ☐ American Indian ☐ Alaska Native ☐ Other ☐ Declined

☐ Native Hawaiian, Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Other ______________________________

Patient Employed By: ____ **Occupation**: _____________________________________

Employer Address: ____ **Phone Number:** _________________________________

Emergency Contact: ____ **Relationship**: _____________________ **Phone**: ______________

Spouse Employed By: ____ **Occupation**: _____________________________________

Employer Address: ____

Referred by: ____ **Primary Care Physician**: _________________________________

Does your insurance require referrals and/or precertification? ____

<u>Insurance Information:</u>

Primary Carrier: ____ **Secondary Carrier:** _______________________________________

Identification Number: __________________________________ **Identification Number:** ____________________________________

Name of Insured: ____ **Name of Insured:** ____

Employer: ____ **Employer:** ____

Group Name/Number: __________________________________ **Group Name/Number:** ___________________________________

Insured Date of Birth: __________________________________ **Insured Date of Birth:** ___________________________________

Relationship to Insured: _________________________________ **Relationship to Insured:** __________________________________

Patient Name: ______________________________ **Date of Birth**: ____________________

PAST MEDICAL HISTORY

Allergies: ____

Current Medications and Dosage: ☐ None

____
____
____

Medical Conditions: ☐ None

____
____
____

Do you take blood thinners, aspirin, or motrin/ibuprofen type medications? ☐ Yes ☐ No

Do you take any herbal supplements? ☐ Yes ☐ No Please List: ______________________________

Previous Operations/Hospitalizations: ☐ None

______________________________ Date: __________
______________________________ Date: __________
______________________________ Date: __________

FAMILY HISTORY

Does anyone in your family have any of the following conditions?

Diabetes ☐ Mother ☐ Father **High Blood Pressure** ☐ Mother ☐ Father **Arthritis** ☐ Mother ☐ Father **Cancer** ☐ Mother ☐ Father

Gout ☐ Mother ☐ Father **Tuberculosis** ☐ Mother ☐ Father **Heart Disease** ☐ Mother ☐ Father **Rheumatic Fever** ☐ Mother ☐ Father

Anemia ☐ Mother ☐ Father

Do you smoke? ☐ Yes ☐ No If Yes, how many packs/cigarettes do you smoke per day? _______ For How long? __________

Have you ever smoked? ☐ Yes ☐ No If Yes, how many packs/cigarettes per day? _______ For how long? __________

Do you drink alcohol? ☐ Yes ☐ No If Yes, How many drinks per day/week? ______________________________

Have you ever used intravenous drugs? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you have now or have you had in the past 6 months had any problems related to the following?

GENERAL ☐ Fever ☐ Weight Loss ☐ Fatigue

EYES, VISION ☐ Visual Changes ☐ Glasses

EARS, NOSE, THROAT ☐ Hearing loss ☐ Sinus problems

HEART, CARDIOVASCULAR ☐ Chest pain or pressure ☐ Arrhythmia or palpitations ☐ Shortness of breath ☐ Peripheral edema ☐ Blood clots ☐ Varicose Veins ☐ Cramping in thighs

RESPIRATORY ☐ Cough ☐ Shortness of breath ☐ Wheezing

GASTROINTESTINAL ☐ Abdominal pain ☐ Heartburn ☐ Bloody stool

GENITOURINARY ☐ Frequent urination ☐ Urgency

MUSCULOSKELETAL ☐ Joint pain or swelling ☐ Restricted motion ☐ Musculoskeletal pain

SKIN & INTEGUMENTARY ☐ Rashes ☐ Sores ☐ Blisters ☐ Growths ☐ NEUROLOGICAL Numbness or tingling sensations ☐ Sensation loss ☐ Burning

PSYCHIATRIC ☐ Nervousness, anxiety ☐ Depression

ENDOCRINE ☐ Heat or cold intolerance ☐ Excessive thirst

HEMATOLOGIC/LYMPHATIC ☐ Abnormal bleeding ☐ Easy Bleeding ☐ Enlarged nodes

ALL/IMMUN ☐ Allergic reaction ☐ Recurrent infections

☐ I certify that the above information is accurate, complete and true.

☐ I authorize Center of Excellence for Pain & Regenerative Medicine and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

☐ I give my consent for Center of Excellence for Pain & Regenerative Medicine to retrieve and review my medication history. understand that this will become part of my medical record.

☐ I acknowledge that I have had the opportunity to review Center of Excellence for Pain & Regenerative Medicine Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

☐ I authorize the Center of Excellence for Pain & Regenerative Medicine to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) may be referred to. I also authorize Center of Excellence for Pain & Regenerative Medicine to release any information required in obtaining procedure authorization or the processing of any insurance claims.

☐ I understand that Center of Excellence for Pain & Regenerative Medicine will not release my Protected Health Information to any other party (including family) without my completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility.

Patient Name: ______________________________ Signature: _________________________ Date: __________________

Notice of Privacy Practices Patient Acknowledgement
Authorization for Use/Disclose of Protected Health Information (PHI)

Patient Name ____ Date of Birth ___________________

Acknowledgement of Privacy Notice
The practice's Notice of Privacy Practices is available online at roshninpatelmd.com. The Notice provides in detail the uses and disclosures of my PHI (Protected Health Information) that may be made by this practice. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all PHI at, or controlled by, this practice. I understand I can obtain this practice's Notice of Privacy on request.

Authorization for Use/Disclose of Protected Health Information (PHI)
I authorize the use and disclosure of all health information for the purpose of treatment, payment and Health Care Operations. I authorize Dr. Roshni Patel and her staff to use these disclosures of my health information without limitation. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that any revocation does not apply to disclosures or use of PHI that have occurred prior to my revocation. In addition, I authorize disclosure of my PHI to the following individual(s):

____

List any person(s) that you are allowing this office to communicate with regarding your PHI

Patient Manner of Contact In general the HIPAA Privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. I understand that verbal request is an acceptable authorization for the use of any alternate contact method, number and/or location as well as to change in the manner listed below (i.e. if patient leaves message with contact number and/or location, other than listed below). I understand that this practice calls to confirm appointments at the number I give.

**** I Wish To Be Contacted in The Following Manner**

________ NO RESTRICTION (Okay to contact home and/or work and leave detailed message)
________ Restricted Method of Contact (Check all that apply)
________ Home ONLY Message To Return Call To Doctor's office
________ Work ONLY Message To Return Call To Doctor's office
________ Other ____

I understand that by signing this form I am confirming my receipt of the Notice of Privacy Practices; authorization for method of contact; and authorization for use and/or disclosure of my PHI.
Signature ____ Date ___________________________

Relationship to Patient, if signed by a personal representative i.e. parent, legal guardian, etc
____

Center of Excellence for Pain & Regenerative Medicine
OFFICE POLICIES

Dr. Roshni N. Patel and staff are dedicated to providing you with the best possible care and services. We have adopted the following financial policies in order to minimize confusion or misunderstanding between our patients and practice.

Participating Insurance

You must provide us with accurate insurance information and allow us to photocopy your insurance card. Any co-payments are due at the time of service. You are ultimately responsible for knowing the requirements and coverage limitations of your own insurance policy. If a referral is required by your plan, it must be presented prior to services. You must ensure that the referral is made to the correct doctor, that it has not expired and that the number of visits have not expired. If you receive services without obtaining a required referral, you will be financially responsible for such services.

Self-Paying Patients

Payments for services are due when services are rendered. If we do not participate in your insurance plan, we will be happy to help you process your claim, and/or provide you with an itemized bill, once all fees are paid.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to pay for services not covered by my insurance plan, if I have not obtained and presented a valid referral at the time services are rendered. I agree to pay for services and tests not covered by my insurance plan's regulations and procedures. I also request that this information to apply to any/all insurance(s).

Patient Full Name ____

____ **Date** ______________________

Signature of Patient/Parent or Guardian

HIPAA PRIVACY RESTRICTION QUESTIONNAIRE

Patient Name:____ Date of Birth: ______________________________

May we send statement and reminder cards to your home? ☐ Yes ☐ No

If not, What address should be used?____

May we call you at home? ☐ Yes ☐ No phone______________________________

May we call you at work ? ☐ Yes ☐ No phone______________________________

If no to either of the above, what number should we call? ______________________________

May we leave messages(including laboratory results) on your answering machine ? ☐ Yes ☐ No

May we send you a fax ? ☐ Yes ☐ No

Fax number______________________________

May we send you an appointment reminder via text message? ☐ Yes ☐ No

Phone number______________________________

May we contact you via e-mail? ☐ Yes ☐ No

E-mail address____________________________________

May we speak to another individual regarding your treatment ? ☐ Yes ☐ No

HIPAA CONTACTS

Your Personal contacts that may access your protected health information

Name:	Relation:	Name:	Relation:
Name:	Relation:	Name:	Relation:
Name:	Relation:	Name:	Relation:

Treating Physician List

Patient Information

First Name ________________________ **Last Name**__________________________________

Treating Physician Information

Physician Name: ____

Specialty: ____

Practice Name: ____

Phone: ____

Physician Name: ____

Specialty: ____

Practice Name: ____

Phone: ____

Physician Name: ____

Specialty: ____

Practice Name: ____

Phone: ____

Physician Name: ____

Specialty: ____

Practice Name: ____

Phone: ____