OFFICE REGISTRATION FORM

Please **PRINT** and complete all sections below.

Today's Date________________

Last Name: ______________________ First: ________________ MI: ______ Marital Status: S M W D Sep

Date of Birth: ____________ Age: ______ M or F Social Security #________________________

Street Address: ________________________________ City, State, Zip: __________________________

Phone (day):____________________________ Phone Cell: __________________________________

Email Address: ____

In Case of Emergency:
Emergency Contact: __________________________________ Relationship to patient________________

Phone: ______________________________ Cell: __________________________

Insurance Information:

_____Medicare ______Medicaid ______HMO ______PPO _____ Self Pay Copay amount_________

PLEASE NOTE IF YOU HAVE A HMO PLAN YOU WILL NEED AUTHORIZATION

Primary Care physician:

Name: ________________________________ **Phone:** _______________ **Fax:** __________________

Address: ____________________________ **City:** ____________ **State:** ________ **Zip:** ___________

Pharmacy Information:

Local Pharmacy Name: ___________________________ Phone: _____________ Fax:___________

Address: _______________________ City: ______________ State: ________ Zip: ___________

Mail Order Name: ________________________ Phone: __________________ Fax: _____________

Address: ________________________ City: _______________ State: ___________ Zip: ________

Employment information:

Employer ________________________________ Occupation: ____________________________

Address: ________________________________ City, state, Zip: ___________________________

Phone _________________________________

Financial Policy

We are pleased to have you as our patient and we are committed to providing you with the best professional care. Your clear understanding of our financial policy is important to our relationship.

Payments

If you have no insurance, we require payment in full at the time of service and will be accepted by Cash or Card ONLY. All co-pays are due the day of appointment. If you're insurance requires you to pay a co-pay please know this is due every time you are seen at office. If you do not have your co-pay at your appointment it will be rescheduled

We will accept Cash, Visa, Mater Card, Discover and Checks are accepted.

Participating Provider Plans/HMO Plans

We will file claims for patient's whose insurance companies are contracted with us. However, co-pays are due at the time of appointment and for each appointment. Due to all the various HMO and PPO insurance plans now in effect it is a complicated process to remain familiar with every one. We require that all patients seek out all information for providing this information to our office. It is the patient's responsibility to make sure that their primary issue an authorization (for HMO) for each visit.

Commercial and Private Insurance

It is our office policy to bill your insurance carrier as a courtesy to you. You are ultimately responsible to see that the account is paid in full. In order for our office to bill your insurance carrier, you will need to supply our office with all the requested information and current co-pay of your insurance card. Your insurance policy is an agreement between you and your insurance company. You are responsible for all the charges.

Medicare

We are Medicare providers and do accept assignment from Medicare. There may be a balance due from patient after Medicare pays. If you have a secondary insurance, we will submit this for you. You will receive a statement showing any balance due by you.

Medical Assistance or Medicaid

Special procedures are necessary for handling these claims. All patients must show a valid card each time before seeing a doctor. We will also verify eligibility prior to you being seen by the doctor. If ineligible or **you did not provide us with an ID card, your appointment will be rescheduled, as we are required to verify current coverage.**

Collections

We accept Cash, Check, Visa, MasterCard and Discover. If you need to make a payment arrangement due to financial hardship, our business office requires patients to call to make mutually satisfactory arrangements prior to you scheduled appointment.

You must be able to show Insurance Card and a Government ID at time of appointment.

I have read and I understand the above policy.

Print Name: ____________________________________ **Signature:** ____________________________

Relationship (If other than patient signing)_________________________ **Date:**__________________

HHQ(history)

Have any of the following caused you concern lately: (Please circle)

Decreased Appetite	Black, Tarry stool	Joint Pain
Weight Loss	Rectal bleeding	Paralysis
Anemia (low blood)	Diarrhea	Blood in urine
Nausea/Vomiting	Constipation	Rash
Heartburn	Change in size or	Fever
Difficulty swallowing	Shape of stool	Chills
Food sticking	Hallucinations	Vision changes
Gas	Deafness	Nosebleeds
Abdominal pain	Earache	Coughing blood

If Yes, please explain: ____

____

____

Medications (please list all and/or provide list): ______________________________

____

____

Allergies: ____

Past Medical History:

Have you had any of the following past or present (please circle)

High blood pressure	Kidney disease	Colon Polyps
Heart disease	Pancreatic disease	Ulcerative Colitis
Heart attack	Diabetes	Crohn's disease
Emphysema	Gall stones	Hepatitis/Liver disease
Asthma	Cancer (where__________)	Stomach ulcers
Stroke/CVA	Chemotherapy	Diverticulosis
COPD	Radiation	Diverticulitis
Thyroid disease	GERD/Acid reflux	IBS
Anemia		Hemorrhoids
Arthritis		Hernia

Past Surgical History:

Have you had any of the following (please circle)

Peptic ulcer surgery	Colon surgery	Hemorrhoidectomy
Hysterectomy	Gallbladder surgery	Appendectomy
Colonoscopy	Gastroscopy/EGD	Coronary Bypass/CABG
Aortic aneurysm surgery	Cancer (which organ ______________)	
Pacemaker	Defribilator/AICD	

Any other surgery? Please list all ____

____

Family History:

Please indicate if your grandparents, parents, brothers, sisters, and/or children have had the following conditions. Please list who had in the space provided.

High blood pressure ______________ Heart disease __________

Diabetes ______________ Colon polyps ______________

Cancer (where?) ____

Social History:

Please indicate if you currently use or have used the following and how much:

Tobacco No______ PPD _______ Ex-smoker __________

Alcohol No______ Per Day: Beer _____ Wine _____ Other _________

PATIENT NAME AND DOB_________________________________ **DATE:**__________

Satish Patel, M.D., P.A.
5340 Gulf Dr, Ste 105
New Port Richey, FL 34652
Tel: (727) 849-0222 | Fax: (727) 847-7685

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA OMNIBUS RULE NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Satish Patel, M.D., P.A. A copy of this signed and dated document shall be as effective as the original.

____________________________________ __________________
Printed Name of Patient — Date of Birth

____________________________________ __________________
Printed Name of Legal Representative *(if applicable)* — Relationship to Patient

____________________________________ __________________
Signature of Patient *or* Legal Representative — Date Signed

HIPAA

OFFICE USE ONLY

I attempted to obtain the patient's (or legal representative's) signature on this Acknowledgement, but did not do so because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient.
- ☐ The patient refused to sign.
- ☐ The patient was unable to sign because ______________________________.
- ☐ Other *(specify)*: ______________________________________.

Employee Name: ________________________ Signature: ________________________