Mayur C. Patel, M.D., Inc.
Diplomate American Board of Internal Medicine

2625 W. Alameda Ave
Suite 506
Burbank, CA 91505-4816
Office: 818-843-5864

Registration (please print):

Date: ____________________ Home Phone: (____)_______________ Cell: (____)_______________

Patient:____
(Last Name) (First Name) (Middle Name)

Date of birth: _______________ Age:_____ Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Responsible Party (if a minor):____

Address:____ City:______________________

State:____________ Zip Code:________________ E-Mail:____________________________________

Employer / School:____

Employer / School Address:____

Occupation:____ Work phone: (____)__________

Spouse (or responsible party) Name:____________________________ Birth date:__________________

Business Name and Address:____

Occupation:____ Work phone: (____)__________

Who is responsible for this account?____________________ Relationship to the patient:____________

Social Security #:____________________________ Spouse's Social Security #:_____________________

Do you have medical insurance? ☐ Yes ☐ No ⇨ If yes,

Name of Primary Insurer:_____________________ Policy holder:______________________________

Contract #:____________________ Group #:_______________ Subscriber #:_____________________

Name of Secondary Insurer (if any):___________________ Policy holder:_________________________

Contract #:____________________ Group #:_______________ Subscriber #:_____________________

☐ Medicare ☐ Medicaid Claim ID #:____

If Welfare, your number:_____________________________ County of: ___________________________

In case of emergency, who should be notified?:____________________ Phone:____________________

How did you learn of our practice?:____

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Diplomate American Board of Internal Medicine

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with_______________________________________
Name of Insurance Company (ies)

And assign directly to **MAYUR C. PATEL, M.D., INC.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare / Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **MAYUR C. PATEL, M.D., INC.** for any services furnished to me by that provider.

To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Center for Medicare and Medicaid services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_______________________________________ _______________________
Signature of Beneficiary, Guardian or Personal Representative Date

_______________________________________ _______________________
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

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MEDICAL HISTORY

Date:_______________

Name:____________________________________ **Date of Birth:**_____________________

Allergies to Medications, X-Ray Dyes, or Other Substances:____________________________________

Past Medical History: Please circle if you are *being or have been* treated for any of the following:

Arthritis	Asthma	Ulcers	Kidney Disease/Stones	Blood Clots
Diabetes	Pneumonia	Anemia	High Blood Pressure	Migraine
Cancer	Tuberculosis	Polyps	Gallbladder Disease	Gout
Heart Disease	Hay Fever	Liver Disease	Alcohol Abuse	Anxiety
Rheumatic Fever	Allergies	Thyroid Disease	Substance Abuse	Depression
HIV/AIDS	Hepatitis	Colitis	Skin Disease	Other____________
Blood Disorders			Venereal Diseases	

Have you ever had:

Stress Test Y N If yes, date_____
Flex Sig. Y N If yes, date_____
Endoscopy Y N If yes, date_____
Cardiac Cath Y N If yes, date_____
Colonoscopy Y N If yes, date_____

When was your last:

Cholesterol Check____________ Stool Check for Blood_____________ Prostate Check____________

Review of Systems: Please circle if you are *currently* having any of the following:

General:

Weight Loss / Gain, Fever, Sleep Apnea, Loss of Appetite, Rash, Fatigue
Anxiety, Depression, Sleep Disturbance, Sleepiness During Daytime, Chills, Insomnia
Easy Bruising, Skin Lesions, Other____

Neurological:

Headaches, Numbness, Changes in Hearing, Changes in Vision, Last Eye Exam_______
Tingling, Dizziness, Lightheadedness, Changes in Gait

Cardiovascular:

Chest Pain, Palpitations, Heart Murmur: Do you take antibiotics before dental exams? Y N
Shortness of Breath, Swollen Ankles

Respiratory:

Wheezing, Shortness of Breath, Nasal Discharge? Y N If yes, color_________
Painful Breathing, Cough? Productive? Y N If yes, color_________

Gastrointestinal:

Indigestion, Rectal Bleeding, Black / Tarry Stools, Change in Bowel Habits, Heartburn, Reflux
Abdominal Pain, Nausea, Vomiting, Hemorrhoids

Genitourinary:

Frequency, Burning with Urination, Getting up During the Night to Urinate
Urgency, Changes in Sex Drive, Incontinence: stress or urge
Erectile Dysfunction

Musculoskeletal:

Bone Pain, Joint Pain, Muscle Aches, Arthritis

Notes:____
____
____
____
____

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MEDICAL HISTORY

Gynecologic and Obstetric History

Age at onset of periods:____________ Frequency:__________ Length of Periods:____________
Pregnancies:______________________ Births:______________ Miscarriages:________________
Are you using birth control? Y N If yes, which method?__________________________________

Do you have any of the following:
Prolonged Bleeding Abnormal Bleeding
Leakage of Urine Pelvic Pain Abnormal Discharge History of abnormal Pap Smear

When was your last: Pap Smear____________ Mammogram____________________
Period____________ Breast Check___________ DEXA Scan (bone density)________

Operations:____
____
____

Hospitalizations(Other than for surgery):____________________________________
____
____

Lifestyle

	Yes	No	
Do you wear seatbelts?	____	____	If no, why not?____________________________
Do you wear a bike helmet?	____	____	____n/a If no why not?_____________________
Do you exercise regularly?	____	____	If yes, type & duration per week________________
Do you smoke / chew tobacco?	____	____	If yes, how many packs per day?________________
Do you drink alcoholic beverages?	____	____	If you, how much per week?____________________
Do you drink tea?	____	____	If you, how many cups per day?_________________
Do you drink coffee?	____	____	If yes, how many cups per day?_________________
Do you wish to be tested for AIDS?	____	____	
Do you have a living will?	____	____	
Have you had blood transfusions?	____	____	

Immunization History: Have you had any of the following?

Hepatitis A	Y N Date:__________	Hepatitis B	Y N Date:__________
Pneumovax	Y N Date:__________	Flu	Y N Date:__________
Tetanus	Y N Date:__________	Other	____________________

Past Family History: Have any members of your family (parents, grandparents, & siblings) ever had any of the following?

Illness	Family Member(s)	Age Diagnosed
Cancer	____________________	__________
Hypertension (High Blood Pressure)	____________________	__________
Heart Disease	____________________	__________
Diabetes	____________________	__________
Strokes	____________________	__________
Mental Disease (Anxiety/Depression)	____________________	__________
Drug or Alcohol Addiction	____________________	__________
Glaucoma	____________________	__________
Bleeding Diseases	____________________	__________
Other:__________________	____________________	__________

Mayur C. Patel, M.D., Inc.

Diplomate American Board of Internal Medicine

MEDICAL HISTORY

Name:	DOB:	Date:

To better serve your healthcare needs, Mayur C. Patel, M.D., Inc. practice uses an electronic health record (EHR). This will not only include your chart contents, but your medication needs as well. Whether it is a one-time prescription or your daily medication, your prescriptions will be transmitted to your pharmacy with the EHR.

In order to meet your prescription needs, we ask that you provide us with your four (4) favorite pharmacies. Put the one you use the most at the top. This will ensure that your prescriptions are sent to the most convenient location for you to pick them up. Since we use the EHR, you may not receive a paper prescription.

Thank you for your information and cooperation in making this transition.

FAVORITE PHARMACY INFORMATION

Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		

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ADULT HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	Date:

1. ACTIVE PROBLEMS

1. List any illnesses for which you are now being treated at this office or any other physician's office.

2. PAST MEDICAL HISTORY

1. Have YOU ever had any of the following problems?

YES	NO	PROBLEM	MONTH/YEAR	YES	NO	PROBLEM	MONTH/YEAR
☐	☐	Arthritis/Rheumatism/Gout/ Lupus	/	☐	☐	Stomach Trouble/Ulcers	/
☐	☐	Asthma (wheezing)	/	☐	☐	Bowel Trouble/Colitis	/
☐	☐	Hay Fever/Sinus Trouble	/	☐	☐	Any type of Cancer/Tumor	/
☐	☐	Emphysema/Bronchitis/ Constant Cough	/	☐	☐	Epilepsy (fits, seizures, convulsions)	/
☐	☐	Pneumonia/Pleurisy	/	☐	☐	Stroke or Paralysis	/
☐	☐	Rheumatic Fever/Heart Murmur	/	☐	☐	Thyroid Disorders/Goiter	/
☐	☐	Coronary Artery Disease/Heart Attack/Angina	/	☐	☐	High Blood Pressure/ Hypertension	/
☐	☐	Enlarged Heart/Congestive Heart Failure	/	☐	☐	Venereal Disease (Syphilis, Gonorrhea, Chlamydia) or PID	/
☐	☐	Tuberculosis	/	☐	☐	HIV Infections/AIDS	/
☐	☐	Blood Clots in your Legs or Lungs	/	☐	☐	Yellow Jaundice/Hepatitis/ Liver Cirrhosis	/
☐	☐	Diabetes (sugar)	/	☐	☐	Kidney or Bladder Trouble	/
☐	☐	Anemia (low, weak blood)	/	☐	☐	Osteoporosis	/
☐	☐	Bleeding Tendency/Unusual Bruising	/	☐	☐	Migraine Headaches	/

2. List hospitalizations, starting with most recent:

Illness/Injury (Location)	Onset/Injury Date	Hospital/Location/Physician

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ADULT HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	Date:

3. PAST SURGICAL HISTORY

1. List any surgeries YOU have had and the date.

SURGERY	HOSPITAL	DATE

4. FAMILY HISTORY

1. Check (Ö) relationship as indicated

	Relationship	Age if Living	Age at Death	Illness and/or cause of death
☐	Father			
☐	Paternal Grandfather			
☐	Paternal Grandmother			
☐	Paternal Aunt 1			
☐	Paternal Aunt 2			
☐	Paternal Uncle 1			
☐	Paternal Uncle 2			
☐	Mother			
☐	Maternal Grandfather			
☐	Maternal Grandmother			
☐	Maternal Aunt 1			
☐	Maternal Aunt 2			
☐	Maternal Uncle 1			
☐	Maternal Uncle 2			
☐	Brother 1			
☐	Brother 2			
☐	Brother 3			
☐	Brother 4			
☐	Sister 1			
☐	Sister 2			
☐	Sister 3			
☐	Sister 4			
☐	Son 1			
☐	Son 2			
☐	Son 3			
☐	Son 4			
☐	Daughter 1			
☐	Daughter 2			
☐	Daughter 3			
☐	Daughter 4			

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ADULT HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	Date:

5. SOCIAL HISTORY

Marital Status: ☐Married ☐Single ☐ Widowed ☐Divorced ☐Separated	Use seat belt: ☐Yes ☐No
Working Status: ☐Full-time ☐ Part-time ☐ Retired ☐ Not Working	Use sunscreen: ☐Yes ☐No
How many cigarettes do you smoke each day? ☐ Pipes? ☐ Cigars?	Fire alarm at residence: ☐Yes ☐No
Number of years smoking:	Have you ever used narcotics or other addictive drugs? ☐Yes ☐ No
Year quit smoking:	Do you consider your diet adequate? ☐Yes ☐ No
How much beer do you drink each day? ☐ Hard Liquor? ☐Wine?	Do you feel you receive adequate sleep? ☐Yes ☐ No
Did you ever drink more than you do now?	Are you regularly exposed to any chemicals, toxins, poisons, fumes, smoke, or radioactive material at home or work? ☐Yes ☐ No
Year quit drinking:	Do you regularly participate in any strenuous physical activity or exercise program? ☐ Yes ☐ No

6. ALLERGIES

Have you ever had an allergic reaction to any medication? ☐ Yes ☐No
If yes, list medications and reaction:

MEDICATION	REACTION	WHEN?

List any non-mediciation allergies:

NON-MEDICATIONS	REACTION	WHEN?

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ADULT HEALTH QUESTIONNAIRE

7. MEDICATIONS

List all drugs or medications you use regularly
(Include birth control pills and non-presceiption items –-laxatives, pain pills, cold tables, etc.)

Medication Name	Dose	Times Daily	Reason	Medication Name	Dose	Times Daily	Reason

8. IMMUNIZATIONS

IMMUNIZATIONS		YEAR
Influenza	☐YES ☐NO	
Pneumonia	☐YES ☐NO	
Tetanus	☐YES ☐NO	
Hepatitis B	☐YES ☐NO	

9. ADVANCED DIRECTIVES

Do you have an advance directive/living will?
☐ YES ☐ NO
If you have an advance directive/living will, will you provide this office a copy for your medical record?
☐ YES ☐ NO
If you would like information regarding advance directives please ask the nurse of your doctor.

10. HEALTH MAINTENANCE REVIEW

	Date of Last		Date of Last
Physical Exam		Stool Blood Test	
Breast/GYN Exam		Prostate Exam	
Mammogram		Blood Transfusion	
Cholesterol Test		TB Test	

NURSING COMMENTS/REVIEW OF IMMUNIZATIONS:

HAVE YOU COMPLETED ALL SECTIONS AND ANSWERED ALL QUESTIONS?

Please list any additional problems or special concerns about your health which you would like to discuss with your doctor:

☐ Other

INTERPRETER ONLY

(Please Print)

Name:____________________ Agency:____________________

Telephone:____________________ Language:____________________

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No Show / Cancellation Policy

Effective: January 1, 2017

Your scheduled appointment is a specific time that is reserved for you to spend time with your physician / provider. It is very important for you to be on time or cancel 24 hours prior to this reserved time if you are unable to make your appointment. Prior notification allows our staff to fill these reserved time slots with patients that are waiting for appointments.

We understand that situations arise that require you to cancel an appointment, but we require a 24 hour notice of cancellation or you will be charged a $25.00 no show / cancellation fee. Therefore, if you do not show up to your appointment and have not called to cancel 24 hours prior, you will be charged a $25.00 no show/ cancellation fee. These charges cannot be billed to any insurance company and will be considered self-pay and billed directly to you.

Please understand that it is our goal to provide quality care in a timely manner to our patients. In order to achieve this goal we need our patients / families to communicate with our practice so that we utilize our physician / provider's time in the best way possible to meet our patient's needs.

Thank you for your consideration and understanding of this policy.

____________________________________ ______________________________

Patient / Guardian / Patient Representative Signature   Date / Time

____________________________________ ______________________________

Witness Signature   Date / Time

INTERPRETER ONLY

(Please Print)

Name:______________________________ Agency:______________________________

Telephone:___________________________ Language:______________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on ____________________ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fund Raising: We may provide medical information to one of our affiliated fund raising foundations to contact you for fund raising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fund raising materials, we will provide you a description of how you may choose not to receive future fund raising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $__________ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.