Patel, Ramanan, & Associates

Patient Registration Form

Patient Information

Social Security Number	Last Name	First Name	Middle Initial	Suffix

Street Address/Mailing Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Gender ❒Male ❒Female

Date of Birth	Email Address	Preferred Language ❒English ❒Chinese ❒Spanish ❒Other __________

Race
❒Asian ❒American Indian or Alaska Native ❒African American ❒Native Hawaiian ❒Hispanic or Latino ❒Not Hispanic or Latino ❒Other Pacific Islander ❒White ❒More than One Race ❒Unreported/Refuse of Report

Marital Status	Employed	Student
❒S ❒M ❒D ❒W	❒Full Time ❒Part Time ❒Retired ❒Not Employed	❒Full Time ❒Part Time ❒Not a Student

Employer Name	Employer Address

Emergency Contact Information

Emergency Contact Name	Date of Birth	Gender ❒Male ❒Female	Phone Number

Insurance Information

Primary Insurance Company	Effective Date	Expiration Date

Claims Address	City	State	Zip

Subscriber (Policyholder) Name	Date of Birth	Social Security Number

Patient Relationship to Subscriber ❒Self ❒Parent ❒Spouse ❒Other	ID Number	Group Number	Co-Pay

Group Name (Employer)	Employer Address

Guarantor Information

Guarantor (Financially Responsible Person) Name	Date of Birth	Social Security Number

Street Address/Mailing Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Patient's Authorization

I_______________________________________, hereby authorize Patel, Ramanan, and Associates to apply for benefits on my behalf for covered the services rendered. I requested payment to be made directly to Patel, Ramanan, and Associates or to the party who accepts assignment. I certify that the information for this or any related claim, to the above named billing agent. This authorization may be revoked by either me or above named carrier at any time in writing. PAYMENT AT THE TIME OF SERVICE IS THE PATIENT'S RESPONSIBILITY.

Signature of Patient of Beneficiary____ Date: ________________

Patel, Ramanan, & Associates

Health History

(Confidential)

Patient Information

Name		Today's Date
Date of Birth	Age	Date of Last Physical

Medical Problems (check conditions you currently have or have had in the past)

	Current	Past		Current	Past		Current	Past
❒Acid Reflux	❒	❒	❒Diabetes	❒	❒	❒Liver Disease/Hepatitis	❒	❒
❒Alcoholism	❒	❒	❒Diverticulosis	❒	❒	❒Lyme Disease	❒	❒
❒ADHD/ADD	❒	❒	❒Emphysema/COPD	❒	❒	❒Menstrual Problems	❒	❒
❒Anemia	❒	❒	❒Epilepsy/ Seizure Disorder	❒	❒	❒Migraine/ Tension Headaches	❒	❒
❒Anxiety/Depression	❒	❒	❒Fatigue	❒	❒	❒Miscarriage	❒	❒
❒Arthritis	❒	❒	❒Glaucoma	❒	❒	❒Mononucleosis	❒	❒
❒Asthma	❒	❒	❒Hay Fever/ Allergies	❒	❒	❒Osteoporosis	❒	❒
❒Back Pain	❒	❒	❒Heart Attack	❒	❒	❒Prostate Problem	❒	❒
❒Bleeding Disorders	❒	❒	❒Heart Disease	❒	❒	❒Sexual Dysfunction	❒	❒
❒Breast Lump(s)	❒	❒	❒Heart Murmur	❒	❒	❒Sleep Disorder	❒	❒
❒Cancer	❒	❒	❒High Blood Pressure	❒	❒	❒Stomach Ulcers	❒	❒
❒Chronic Cough	❒	❒	❒High Cholesterol	❒	❒	❒Stroke	❒	❒
❒Constipation	❒	❒	❒HIV Positive/AIDS	❒	❒	❒Thyroid Problem	❒	❒
❒Diarrhea	❒	❒	❒Kidney Diseases/Stones	❒	❒	❒Urinary Problem	❒	❒

Allergies **(to substances or medications)**

Surgeries **(list all surgeries you have ever had and dates)**

Medication **(list current medications, dosages, times per day)**

Pharmacy Name:

Habits **(check those that apply)**

❒Alcohol Type ___________________ Amount _________________	❒Smoke Packs daily ________________ Interested in stopping? ❒Y ❒N Quit? ❒Y ❒N When? ______________________	❒Sleep: Difficulty falling sleep ❒ Early morning awakening ❒ Daytime Drowsiness ❒	❒ Coffee/Caffeine #cups daily? ________ ❒Illicit Drugs ❒ Exercise Routine ❒Other

Family History **(check those that apply)**

Disease	**Family Member(s) (mother, father, grandmother…)**
❒ Cancer (Include type with family member)	
❒ Diabetes	
❒High Blood Pressure	
❒High Cholesterol	

❒ Heart Disease/ Attack (Age:)	
❒ Stroke (Age:)	
❒ Alcohol/Chemical Dependency	
❒ Mental Illness	
❒ Other	

Vaccine/ Exam/ Test (list the year of your last)

Tetanus vaccine	Pneumonia vaccine	Rectal/stool exam	Mammogram
Flu vaccine		Cholesterol	Pap Smear

Patel, Ramanan & Associates

Waldorf Location
3575 Old Washington Road, Suite A
Waldorf, Maryland 20602
Phone: (301) 645-9650
Fax: (301) 645-0774

Clinton Location
7501 Surratts Road, Suite 307
Clinton, Maryland 20735
Phone: (301) 856-9366
Fax: (301) 856-9368

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 READ DOCUMENT CAREFULLY

The Health Insurance Portability & accountability Act of 1996 (HIPPA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health Care Operations.

- Treatment means providing, coordination or managing health care and related service by one or more health care provider. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing and collection activities and utilization review. An example of this would be sending a bill to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review

We may also create and distribute de-identified information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be interest to you.

Any other uses and disclosures will be made only with you written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following Rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The Right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction, If we agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The Right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The Right to inspect and copy your protected health information.
- The Right to amend your protected health information.
- The Right to receive an accounting of disclosures of protected health information.
- The Right to obtain a paper copy of this notice from us upon request.

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Dear Patient,

Patel, Ramanan, & Associates is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Patel, Ramanan, & Associates provides patients with the HIPAA Privacy Notice of Privacy Rights.

While not required to receive treatment at Patel, Ramanan, & Associates we are obligated under federal regulations to ask you to sign an acknowledgement of the HIPAA Privacy Notice being made available to you.
Thank you.

RECEIPT OF HIPAA PRIVACY NOTICE
I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Patel, Ramanan, & Associates may use and disclose my protected health information. I understand that Patel, Ramanan, & Associates reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

Printed Name________________________________ Date________________________

Signature of Patient Parent/Guardian____

Please answer the following questions:
May we contact you via email? Yes____ No______
Email address: _____________________________
Which telephone number would you prefer us to use? _______________________________________
Can we leave a message on your answering machine/ voicemail? Yes___ No___
Can we leave a message with a family member? Yes____ No_____
If yes, name of household member ____

I understand it is my responsibility to call the office for test results if I have not received a communication after one week.

Office use only: (to be completed only when a patient declines to sign acknowledgement.)
______Check here if patient declined to sign acknowledgement
Staff signature: ______________________________________ Date: __________________________
Refusal to sign acknowledgement does not prevent the patient from continuing to be treated. (To be filed in patient's records.)