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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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:_____		

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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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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.