

PATIENT INFORMATION

TODAY'S DATE _____ Referring Physician _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MI _____

Date of Birth _____ Social Security # _____ Sex: M () F ()

Marital Status: Married () Single () Divorced () Widowed () Other _____

Home Phone _____ Cell Phone _____ Email _____

Work Phone _____ Employer _____

Address _____

House # and Street _____ City _____ State _____ Zip Code _____

This address is for billing and insurance purposes. Please be specific.

INSURANCE

PRIMARY INSURANCE _____ ID# _____

Primary Insured _____ Date of Birth _____ Relationship _____

Second Insurance _____ ID# _____

Primary Insured _____ Date of Birth _____ Relationship _____

For HIPPA purposes another person who can discuss my account on my behalf _____

Relationship _____ Phone number _____

In case of Emergency notify: Name _____ Relationship _____

Day Phone _____ Cell Phone _____ Work Phone _____

CO-PAYMENT IS DUE AT TIME OF SERVICE--STATEMENT OF RESPONSIBIITY--OFFICE POLICY

I have given this office my correct insurance information. I agree that it is solely my responsibility to notify the office of changes in coverage, address, and telephone numbers. Should the information provided be incorrect, I agree to be responsible for any and all amounts billed to me. I also understand and agree that I am responsible for services that my insurance plan does not cover, including out of plan services. Moreover, I understand that I will be charged for late cancellation of appointments or "no-shows" as well as a \$10.00 invoicing fee for non-payment of my co-payment at time of service. Finally, in signing this document I give this office permission to release my medical records to my insurance carrier upon their request.

PLEASE PROVIDE INSURANCE CARD. Date _____

Patient or Responsible Party Signature

Patient Health History

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of Last Physical Exam _____

What is the reason for this visit? _____

Race _____ Ethnicity _____ Preferred Language _____

Check symptoms you currently have or have had in the past year.

<p>GENERAL</p> <p><input type="checkbox"/> Change in weight Loss or Gain (circle one)</p> <p><input type="checkbox"/> Change in moles Describe: _____</p> <p><input type="checkbox"/> Sore that won't heal</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Rash/itching/dryness</p> <p><input type="checkbox"/> Change in hair Describe: _____</p> <p><input type="checkbox"/> Change in nails Describe: _____</p> <p>EYE/EAR/ NOSE/THROAT</p> <p>Eyes:</p> <p><input type="checkbox"/> Change in vision Describe: _____</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Redness</p> <p><input type="checkbox"/> Tearing</p> <p><input type="checkbox"/> Double Vision</p> <p>Ears:</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Tinnitus</p> <p><input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Discharge</p> <p>Nose:</p> <p><input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> Nosebleed</p> <p>Mouth:</p> <p><input type="checkbox"/> Change in teeth Describe: _____</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Hoarseness</p>	<p>Throat:</p> <p><input type="checkbox"/> Difficulty swallowing (dysphagia)</p> <p><input type="checkbox"/> Lumps</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Throat pain</p> <p><input type="checkbox"/> Throat stiffness</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Blood</p> <p><input type="checkbox"/> Sputum Color _____ Quantity _____</p> <p><input type="checkbox"/> Dyspnea</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Tuberculosis/TB</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> High BP</p> <p><input type="checkbox"/> Low BP</p> <p><input type="checkbox"/> Murmurs</p> <p><input type="checkbox"/> Orthopnea</p> <p><input type="checkbox"/> Nocturnal dyspnea</p> <p><input type="checkbox"/> Swelling of ankles (edema)</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Irregular Heart Beat (palpitations)</p> <p><input type="checkbox"/> Leg Cramps (claudication)</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Vein Inflammation (thrombophlebitis)</p>	<p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> Change in appetite Loss or Gain (circle one)</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Lactose Intolerance</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Liver/gallbladder problems</p> <p><input type="checkbox"/> Jaundice/hepatitis</p> <p>MUSCLE/JOINT/BONE</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Swelling/bruising</p> <p><input type="checkbox"/> Joint stiffness</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Cramps</p> <p><input type="checkbox"/> Proximal weakness</p> <p><input type="checkbox"/> Functional limit</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> Excessive hunger (polyphagia)</p> <p><input type="checkbox"/> Excessive thirst (polydipsia)</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> Excessive sweating (diaphoresis)</p> <p><input type="checkbox"/> Thyroid problem</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Skin color change Describe: _____</p> <p><input type="checkbox"/> Excess hair growth</p>	<p>NEURO/PSYCHOLOGY</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Depression</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Painful urination (dysuria)</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Nocturia</p> <p><input type="checkbox"/> Excessive urination (polyuria)</p> <p><input type="checkbox"/> Change in urination Describe: _____</p> <p><input type="checkbox"/> Lack of bladder control/incontinence</p> <p><input type="checkbox"/> Urinary Tract Infection</p> <p><input type="checkbox"/> Kidney stones</p> <p>REPRODUCTIVE</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Breast pain</p> <p><input type="checkbox"/> Breast discharge</p> <p>Women only:</p> <p><input type="checkbox"/> Pregnancy complication</p> <p><input type="checkbox"/> Currently pregnant</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p>Date of last: Period _____ Pap Smear _____ Mammogram _____ # of children _____</p> <p>OTHER _____</p>
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Check conditions you currently have or have had in the past year.

<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendix</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Breast Lump</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Psychiatric Care</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Suicide Attempt</p> <p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid Fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Vaginal Infections</p> <p><input type="checkbox"/> Venereal Disease</p>
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Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:		Maternal/ Paternal
					Disease	Relationship to you	
Father					<input type="checkbox"/>	Arthritis	M / P
Mother					<input type="checkbox"/>	Asthma	M / P
Brothers					<input type="checkbox"/>	Cancer	M / P
					<input type="checkbox"/>	Chemical Dependency	M / P
					<input type="checkbox"/>	Diabetes	M / P
					<input type="checkbox"/>	Gout	M / P
Sisters					<input type="checkbox"/>	Hay Fever	M / P
					<input type="checkbox"/>	Heart Disease	M / P
					<input type="checkbox"/>	Strokes	M / P
					<input type="checkbox"/>	High Blood Pressure	M / P
Children					<input type="checkbox"/>	Kidney Diseases	M / P
					<input type="checkbox"/>	Tuberculosis	M / P
					<input type="checkbox"/>	Other	M / P

MEDICATIONS	List medications you are currently taking. Provide Details. Name, strength, directions, and date when medication was started.		PREGNANCY HISTORY	
	Year of Birth	Sex of Birth	Complications, if any	

ALLERGIES To medications or substances	

HEALTH HABITS Check (✓) which substances you use and describe how much you use	
<input type="checkbox"/>	Caffeine
<input type="checkbox"/>	Tobacco PPD: _____ Years: _____
<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	Other
<input type="checkbox"/>	Other

SURGERIES		DATE	OUTCOME	OCCUPATIONAL CONCERNS	
HOSPITALIZATIONS / SERIOUS ILLNESSES / INJURIES		DATE	OUTCOME	Check (✓) if your work exposes you to the following	
				<input type="checkbox"/>	Stress
				<input type="checkbox"/>	Hazardous Substances
				<input type="checkbox"/>	Heavy Lifting
				<input type="checkbox"/>	Other
				<input type="checkbox"/>	Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

_____ Signature	_____ Date
_____ Reviewed By	_____ Date

Shyamali Singhal, MD, PhD

NOTICE TO CONSUMERS

**Medical doctors are licensed and regulated
by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov**

I understand that the physician is licensed and regulated by the Medical Board of California.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHYAMALI SINGHAL, MD, PhD

I understand that, under the Health Insurance Probability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily activities of Shyamali Mallick Singhal, M.D., Ph.D.

As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Shyamali Mallick Singhal, M.D., Ph.D. Duties

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:

US Department of Health & Human Services
202-619-0257
Toll Free: 1-877-696-6775