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**Dr.Jaya Sonkar, MD ( Rheumatology)**

**General Consent for Evaluation and Treatment for Patients of JSRHealth**

TO THE PATIENT: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_

Printed Name of Patient or Representative Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JSRHealth

Dr.Jaya Sonkar, MD ( Rheumatology)

21216 NW Suite 230

Cypress, TX 77429

Phone No 612-439-9572 Fax No.314-405-9678



**Patient Rights and Responsibilities**

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

***You have the right to:***

* A personal clinician who will see you on an on-going, regular basis.
* Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
* A second medical opinion from the clinician of your choice, at your expense.
* A complete, easily understandable explanation of your condition, treatment and chances for recovery.
* The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
* Confidential management of communication and records pertaining to your medical care.
* Information about the medical consequences of exercising your right to refuse treatment.
* The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
* Be free from mental, physical and sexual abuse.
* Humane treatment in the least restrictive manner appropriate for treatment needs.
* An individualized treatment plan.
* Have your pain evaluated and managed.
* Refuse to participate as a subject in research.
* An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
* The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
* The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

***You are responsible for:***

* Knowing your health care clinician’s name and title.
* Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
* Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
* Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
* Signing a “Release of Information” form when asked so your clinician can get medical records from other clinicians involved in your care.
* Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
* Telling your clinician about any changes in your condition or reactions to medications or treatment.
* Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
* Following your clinician’s advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
* Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
* Paying copayments at the time of the visit or other bills upon receipt.
* Following the office’s rules about patient conduct; for example, there is no smoking in our office.
* Respecting the rights and property of our staff and other persons in the office.

**Patient Signature:**

**Date:**

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**Dr.Jaya Sonkar, MD (Rheumatology)**

**21216 NW Freeway Suite 230**

**Cypress, TX 77429 Phone No. 612-439-9572 Fax No. 314-405-9678**

**HIPPA AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | | |
| Previous Name: | | | | | | |  | | | | Social Security #: | | | |  | | | | | |
| I request and authorize | | | | | | | | | |  | | | | | | | | | | to |
| release healthcare information of the patient named above to: | | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | |  | | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | | Zip Code: | | |  | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 🞎 Yes 🞎 No | | | | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. | | | | | | | | | | | | | | | | |
| Patient Signature: | | | | | | | |  | | | | | Date Signed: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | |
| THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED. | | | | | | | | | | | | | | | | | | | | |

Credit Card Payment Authorization

You authorize charges to your credit card. You will be charged the amount indicated below on the day of service. A receipt for each payment will be provided to you and the charge will appear on your credit card statement.

I authorize    JSR HEALTH PLLC to charge my

(Cardholder’s Name) (Merchant’s Name)

Credit Card indicated below for $ on the day of service.

Billing Information

Billing Address Phone #

City, State, Zip Email

Card Details

* Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name    Account/CC Number    Expiration Date /

CVV

Zip Code

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify

JSR HEALTH PLLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE

NAME

DATE

# Notifier:

1. **Patient Name: C. Identification Number:**

**Advance Beneficiary Notice of Non-coverage (ABN)**

**NOTE:** If Medicare doesn’t pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** below.

|  |  |  |
| --- | --- | --- |
| **D.** | **E. Reason Medicare May Not Pay:** | **F. Estimated Cost** |
|  |  |  |

# WHAT YOU NEED TO DO NOW:

* + Read this notice, so you can make an informed decision about your care.
  + Ask us any questions that you may have after you finish reading.
  + Choose an option below about whether to receive the **D.** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

|  |
| --- |
| **G*.* OPTIONS: Check only one box. We cannot choose a box for you.** |
| * **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. * **OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. * **OPTION 3.** I don’t want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay. |

# H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

|  |  |
| --- | --- |
| **I. Signature:** | **J. Date:** |

# CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov.](mailto:AltFormatRequest@cms.hhs.gov)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

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Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Doctors Care and UCI Medical Affiliates.

# Self-Pay Policy

* If you are a self pay patient, you will be required to pay for the office visit before services are rendered.
* In addition, any remaining balance on your account will be collected at discharge.

# Insurance Policy

* If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
* If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service. Non-covered services and supplies may include medical supplies, durable medical equipment, medications, x-ray supplies, and labs you receive at any Doctors Care facility.
* If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Doctors Care, you will be responsible for the balance due.
* Deductibles, co-payments, and coinsurance will be collected before services are rendered.
* In special cases, we may need your help in contacting your insurance company for the payment of your services.

# Workers Compensation Policy

* If you are a workers' compensation patient, it is our policy to bill your employer or the workers' compensation carrier for services rendered.
* If you are covered under workers' compensation, we will accept the payments by the workers' compensation carrier as per contracted rates based on the mandated SC state fee schedule.
* If payment is denied from your workers' compensation carrier, a claim will be submitted with your private insurance on file. Should the private insurance deny the claim, you will become responsible for the entire balance of your services.
* It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

# X-Ray Policy

* If you require an x-ray on today's visits, the x-ray will be sent out to a Radiologist for a second opinion for quality assurance purposes.
* You will be responsible for the cost of this service if your insurance company chooses not to cover it.

# Overdue and Credit Balances

* All over-due patient balances will be sent to collections.
* All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
* Credit balances under $15 which are the patient’s responsibility shall be administered in accordance with South Carolina state law.

# Divorce or Custody Case Policy

* The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the check out associate or front desk.

Your cooperation is greatly appreciated.

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| **Dr.Jaya Sonkar, MD ( Rheumatology)**  **21216 NW Suite 230**  **Cypress, TX 77429**  **Phone No 612-439-9572**  **Fax No. 314-405-9678** | | | | | | | | | | | | Original Date: | | | | |  | | | |
| Dates Revised: | | | | |  | | | |
|  | | | | | | | | | | | |  | | | | | | | | |
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| HEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | |  | | | | | 🞎 M 🞎 F | | DOB: | | |  | | | | | | | |
| Marital status: | | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed | | | | | | | | | | | | | | | | | | |
| Previous or referring doctor: | | | | |  | | Date of last physical exam: | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Childhood illness: | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio | | | | | | | | | | | | | | | | | |
| Immunizations and dates: | | | | 🞎 Tetanus | |  | 🞎 Pneumonia | | | |  | | | | | | | | | |
| 🞎 Hepatitis | |  | 🞎 Chickenpox | | | |  | | | | | | | | | |
| 🞎 Influenza | |  | 🞎 MMR Measles, Mumps, Rubella | | | | | | |  | | | | | | |
| List any medical problems that other doctors have diagnosed | | | | | | | | | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | | | | | | | 🞎 | | Yes | 🞎 | No |
|  | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | | | | | | | | | | |
| Name the Drug | | | Strength | | | Frequency Taken | | | | | |
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| Allergies to medications | | | | | | | | | | | |
| Name the Drug | | | Reaction You Had | | | | | | | | |
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| HEALTH HABITS AND PERSONAL SAFETY | | | | | | | | | | | |
|  | | | | | | | | | | | |
| All questions contained in this questionnaire are optional and will be kept strictly confidential. | | | | | | | | | | | |
| Exercise | 🞎 Sedentary (No exercise) | | | | | | | | | | |
| 🞎 Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | |
| 🞎 Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | |
| 🞎 Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | |
| Diet | Are you dieting? | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | 🞎 | Yes | 🞎 | No |
| # of meals you eat in an average day? | | | | | | | | | | |
| Rank salt intake | 🞎 Hi | | 🞎 Med | 🞎 Low | | | | | | |
| Rank fat intake | 🞎 Hi | | 🞎 Med | 🞎 Low | | | | | | |
| Caffeine | 🞎 None | 🞎 Coffee | | 🞎 Tea | 🞎 Cola | | | | | | |
| # of cups/cans per day? | | | | | | | | | | |
| Alcohol | Do you drink alcohol? | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, what kind? | | | | | | | | | | |
| How many drinks per week? | | | | | | | | | | |
| Are you concerned about the amount you drink? | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you considered stopping? | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever experienced blackouts? | | | | | | | 🞎 | Yes | 🞎 | No |
| Are you prone to “binge” drinking? | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you drive after drinking? | | | | | | | 🞎 | Yes | 🞎 | No |
| Tobacco | Do you use tobacco? | | | | | | | 🞎 | Yes | 🞎 | No |
| 🞎 Cigarettes – pks./day | | | 🞎 Chew - #/day | 🞎 Pipe - #/day | | 🞎 Cigars - #/day | | | | |
| 🞎 # of years | 🞎 Or year quit | | | | | | | | | |
| Drugs | Do you currently use recreational or street drugs? | | | | | | | 🞎 | Yes | 🞎 | No |
| Have you ever given yourself street drugs with a needle? | | | | | | | 🞎 | Yes | 🞎 | No |
| Sex | Are you sexually active? | | | | | | | 🞎 | Yes | 🞎 | No |
| If yes, are you trying for a pregnancy? | | | | | | | 🞎 | Yes | 🞎 | No |
| If not trying for a pregnancy list contraceptive or barrier method used: | | | | | | | | | | |
| Any discomfort with intercourse? | | | | | | | 🞎 | Yes | 🞎 | No |
| Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | | | | | | |  |  |  |  |
| 🞎 | Yes | 🞎 | No |
| Personal Safety | Do you live alone? | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have frequent falls? | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have vision or hearing loss? | | | | | | | 🞎 | Yes | 🞎 | No |
| Do you have an Advance Directive or Living Will? | | | | | | | 🞎 | Yes | 🞎 | No |
| Would you like information on the preparation of these? | | | | | | | 🞎 | Yes | 🞎 | No |
| Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | | | | | | |  |  |  |  |
| 🞎 | Yes | 🞎 | No |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FAMILY HEALTH HISTORY | | | | | | | |
|  | | | | | | | |
|  | Age | | Significant Health Problems |  | Age | | Significant Health Problems |
| Father |  | |  | Children | 🞎 M 🞎 F |  |  |
| Mother |  | |  | 🞎 M 🞎 F |  |  |
| Sibling | 🞎 M 🞎 F |  |  | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | 🞎 M 🞎 F |  |  |
| 🞎 M 🞎 F |  |  | Grandmother Maternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandfather Maternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandmother Paternal |  | |  |
| 🞎 M 🞎 F |  |  | Grandfather Paternal |  | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MENTAL HEALTH | | | | |
|  | | | | |
| Is stress a major problem for you? | 🞎 | Yes | 🞎 | No |
| Do you feel depressed? | 🞎 | Yes | 🞎 | No |
| Do you panic when stressed? | 🞎 | Yes | 🞎 | No |
| Do you have problems with eating or your appetite? | 🞎 | Yes | 🞎 | No |
| Do you cry frequently? | 🞎 | Yes | 🞎 | No |
| Have you ever attempted suicide? | 🞎 | Yes | 🞎 | No |
| Have you ever seriously thought about hurting yourself? | 🞎 | Yes | 🞎 | No |
| Do you have trouble sleeping? | 🞎 | Yes | 🞎 | No |
| Have you ever been to a counselor? | 🞎 | Yes | 🞎 | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| WOMEN ONLY | | | | |
|  | | | | |
| Age at onset of menstruation: | | | | |
| Date of last menstruation: | | | | |
| Period every \_\_\_\_\_ days | | | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | 🞎 | Yes | 🞎 | No |
| Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ | | | | |
| Are you pregnant or breastfeeding? | 🞎 | Yes | 🞎 | No |
| Have you had a D&C, hysterectomy, or Cesarean? | 🞎 | Yes | 🞎 | No |
| Any urinary tract, bladder, or kidney infections within the last year? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine? | 🞎 | Yes | 🞎 | No |
| Any problems with control of urination? | 🞎 | Yes | 🞎 | No |
| Any hot flashes or sweating at night? | 🞎 | Yes | 🞎 | No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | 🞎 | Yes | 🞎 | No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | 🞎 | Yes | 🞎 | No |
| Date of last pap and rectal exam? | | | | |
|  | | | | |
| MEN ONLY | | | | |
|  | | | | |
| Do you usually get up to urinate during the night? | 🞎 | Yes | 🞎 | No |
| If yes, # of times \_\_\_\_\_ | | | | |
| Do you feel pain or burning with urination? | 🞎 | Yes | 🞎 | No |
| Any blood in your urine? | 🞎 | Yes | 🞎 | No |
| Do you feel burning discharge from penis? | 🞎 | Yes | 🞎 | No |
| Has the force of your urination decreased? | 🞎 | Yes | 🞎 | No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | 🞎 | Yes | 🞎 | No |
| Do you have any problems emptying your bladder completely? | 🞎 | Yes | 🞎 | No |
| Any difficulty with erection or ejaculation? | 🞎 | Yes | 🞎 | No |
| Any testicle pain or swelling? | 🞎 | Yes | 🞎 | No |
| Date of last prostate and rectal exam? | 🞎 | Yes | 🞎 | No |
|  | | | | |
| OTHER PROBLEMS | | | | |
|  | | | | |
| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 🞎 | Skin | 🞎 | Chest/Heart | 🞎 | Recent changes in: |
| 🞎 | Head/Neck | 🞎 | Back | 🞎 | Weight |
| 🞎 | Ears | 🞎 | Intestinal | 🞎 | Energy level |
| 🞎 | Nose | 🞎 | Bladder | 🞎 | Ability to sleep |
| 🞎 | Throat | 🞎 | Bowel | 🞎 | Other pain/discomfort: |
| 🞎 | Lungs | 🞎 | Circulation |  |  |

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**REGISTRATION FORM**

**Section I:** **Patient Information Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I Prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The best time to contact me is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ A.M. ⬜ P.M. on my ⬜ Home phone ⬜ Work phone ⬜ Cell phone

Date of Birth:\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Box: ⬜ Minor ⬜ Single ⬜ Married ⬜ Widowed ⬜ Separated ⬜ Divorced

If Student, Name of School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ FT ⬜ PT

Spouse or Parent’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you like to receive our e-newsletter? ⬜ Yes ⬜ No

**Logo

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**Section II Responsible Party**

Relationship to Patient: ⬜ Self ⬜ Spouse ⬜ Parent ⬜ Other

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section III Insurance Information**

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins Co Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins Co. Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ⬜ Yes ⬜ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins Co Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins Co. Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_