UNIVERSAL HEALTH CARE

AMIT RAJVANSHI, M.D., FAAFP
MAIA KORIOUKHINA, PA-C

121 Congressional Lane
Suite 409
Rockville, MD 20852
Phone: (301) 881-0230
Fax: (301) 770-0207

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

With my consent, Universal Health Care may:

- Use and disclosure of protected health information (PHI) regarding me to carry out treatment, payment and healthcare operations (TPO). Please refer to Universial Health Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.
- Call or e-mail my home or other designated location and leave a message on my voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders and insurance issues. This also includes anything pertaining to my clinical care, including laboratory results among others.
- Mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, including post cards and patient statements.
- I have the right to request Universal Health Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it bound by this agreement.
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Universal Health Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by written request to Universal Health Care.

By signing this form, I am consenting in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Universal Health Care may decline to provide treatment.

Signature of Patient or Legal Guardian	Printed name of Patient or Legal Guardian
Patient Name	Date

Universal Health Care **Patient Registration** **Please Print Legibly**

Name: _____ SS: _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason(s) for your visit today: _____

Current medications: _____

Allergies to medications: _____

Other types of allergies: _____

Physicians currently treating you: _____

Previous or other medical problems: _____

List any previous surgeries or hospitalizations(include number of miscarriages and live births):_____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐Yes ☐ No

Do you smoke? ☐No ☐Yes ☐Cigarettes ☐Pipe ☐ Cigars No. of years _____ How Much? _____
Interested in stopping? Yes ☐ No ☐

Do you regularly drink alcohol? ☐Yes ☐ No How many ounces/beers per day? _____

Do you regularly drink coffee? ☐Yes ☐ No How many cups per day? _____

Are you under a lot of pressure at work? ☐Yes ☐ No Please describe: _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply):

☐Chest pain/pressure/tightening
☐Hypertension
☐Heart attack
☐Stroke
☐Headaches
☐Glaucoma
☐Allergies or Eczema
☐Depression
☐Blood in stool
☐Asthma
☐Dizzy spells
☐Cancer
☐Diabetes
☐Arthritis
☐Difficulty hearing
☐Anemia
☐Memory loss
☐Hemorrhoids
☐Kidney disease
☐Shortness of breath
☐TB/Lung disorder
☐Ulcers
☐Skin Disorders
☐Hepatitis
☐Cataracts
☐Digestive Problems
☐Frequent urinary infections

Hepatitis C risk factor:

☐Blood transfusion prior to 1992
☐IV drug use (1+ times)
☐Contact with blood/bodily fluid
☐Tattoos
☐Shared razor/toothbrush
☐Body piercing

IMMUNIZATIONS

(Year last received, if known)

Smallpox _____
Tetanus _____
Typhoid _____
Polio _____
Influenza _____
Pneumonia _____
Rubella _____
Hepatitis _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐
Heart attach/Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐

MISCELLANEOUS NOTES:

_____
_____
_____
_____
_____

Universal Health Care **Patient Registration** **Please Print Legibly**

Name: _____ Date of birth: _____ Marital Status: S M W Sep D

Street Address: _____ SS#: _____

City: _____ State: _____ Zip: _____ Race: _____

Phone: Home: _____ Cell: _____ Work: _____ Ethnicity: Hispanic / Non-Hispanic

Email: _____ Sex: Male / Female Referred by: _____

Spouse's name: _____ Employer: _____

Spouse's employer address: _____ City: _____ State: _____ Zip: _____

Emergency contact: _____ Phone#: _____ Relationship: _____

PATIENT EMPLOYER INFORMATION

Employer name: _____ Phone#: _____ Patient's occupation: _____

Employer address: _____ City: _____ State: _____ Zip: _____

INSURANCE POLICY HOLDER (If not the patient)

Name: _____ DOB: _____ Phone#: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE

Primary Ins Co: _____ Phone#: _____

Primary Ins ID#: _____ Group#: _____

Secondary Ins Co: _____ Phone#: _____

Secondary Ins ID#: _____ Group#: _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

I hereby authorize Amit K Rajvanshi MD PC to apply for benefits on my behalf for covered services rendered by Dr Amit Rajvanshi, or by his order. I request that the payment from my insurance company be made directly to Amit K Rajvanshi MD PC.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in the place of the original. This authorization may be revoked either by me or my insurance company at any time in writing.

Signature: _____ Date: _____
Patient

Signature: _____ Print name: _____ Relationship: _____