PATIENT REGISTRATION—Manjul Patwardhan MD Prof corp

Please print clearly in black ink.
Fields with an asterisk (*) are required for billing purposes.

Patient's Information **Today's Date**: _____

Name*(**As shown on your insurance**) _____
Last First M. I.

Address*_____Apt/Unit_____City_____State____ Zip_____

Date of Birth*_____/_____/_____ ***Email Address**_____
Required for billing purposes

Month Date Year
Home: (____) _____ _____Cell: (____) _____ (we will text you appointment reminders)

Social Security #_____Driver License# _____ State _____

O Male O Female O Single O Married O Other O Employed O Not-Employed O Student

Emergency Contact Information

Contact Name: _____ Phone#_____ Relationship_____

Patient's Employer Information if Applicable

Employer Name_____ Patient's Occupation _____

Address: _____ City _____State _____ Zip _____

Spouse's Information-If Applicable

Spouse's Name* (LAST, FIRST, MIDDLE) _____

Insurance Information-if Applicable
(Please provide both Insurances Carriers information if applicable)

1) Primary Insurance Carrier*: _____ O Medicare O POS O EPO O PPO O HMO O Other

Policyholder's name*: _____

Policy/ID #_____Group#_____Social Security #_____

Relation to Policy Holder*: O Self O Spouse O Child O Other

2) Secondary Insurance Carrier*: _____O Medicare O POS O EPO O PPO O HMO O Other

Policy/ID #_____Group#_____

How did you hear about our Office? _____
(Referring Person's Name Please, we would like to thank them for trusting us)

MEDICAL HISTORY QUESTIONAIRE------Manjul Patwardhan MD Prof Corp

Family Practice/ Obesity Medicine

Today's Date: _____ Date of Birth: _____

Patient Name: _____

Primary Care Physician: _____

ANY ALLERGIES to Medication or Food: _____

Reason for your visit today: _____

Please list current medications taken:

Past Medical History (circle)	***Past Surgical History***	***Date***
Cardiac Disease	Open Heart	
Hypertension	Angioplasty	
Diabetes/ High Cholesterol	Gall Bladder	
Asthma	Appendectomy	
Emphysema/Chronic Bronchitis	Back	
Stroke	Knee	
Seizures	Other	
Cancer		
Tuberculosis	***Any hospitalization in the past***	
Thyroid problems	***Any physical or mental disability***	
Migraines	***Any psychiatric problems in the past***	

Social History:

Do you smoke? _____If yes, how much and for how many years? _____

Do you drink Alcohol? _____If yes, how much per week? _____

Do you take any illicit drugs? _____

Family History: (please circle)

Diabetes
Stroke
Coronary Artery Disease
High Blood Pressure
Cancer
Depression/Other Psychiatric disorders
Other: _____

Personal/Occupational history

Married/Single-
Children -

Occupation: _____
any occupational hazard?

For females Last menstrual period_____
Past Menstrual Cycles_____

Did you have following in the past:

Chicken pox, Mumps, Measles, Hepatitis, Tuberculosis, Leprosy, Gonorrhea, Syphilis, HIV, Chlamydia, Venereal diseases, Herpes, Chemical dependency, Alcoholism.

Date of your last physical exam: _____

\Manjul Patwardhan MD Prof Corporation
10353 Torre Ave., Ste A, Cupertino—CA 95014
Ph (408) 725-1777

By signing below, I acknowledge and accept the following:

1. I understand that my medical insurance plan is a benefit to help pay for my medical care. Manjul Patwardhan M.D. Prof Corp. will bill my insurance as a courtesy. I am clear that I am 100% responsible for the fee if not coved by my insurance for some reason.

2. I am responsible to pay co-payment at each office visit with the doctor.

3. **If Manjul Patwardhan M.D. is *not a participating* provider with my insurance carrier, I understand that I am fully responsible for payment at the time services are rendered.** It's my responsibility to make sure the treating doctor/lab/x-ray/ other services are covered by my insurance plan. My insurance determines payment based on medical necessity, eligibility and benefit of my plan. I understand I am responsible for payment for denied charges due to lack of medical necessity, non-eligibility or non-covered services.

4. We respectfully request your payment within 30 business days of receiving a statement. Please pay in time to avoid any collection activity. Manjul Patwardhan MD prof. Corp. will charge my credit card on file for balances (deductibles, co-insurances, not covered procedures and visits) and notify by mail or phone.

5. If bill is in dispute, I agree to call the business office manager to resolve the problem. Business office hours are from Monday- Friday, 10:00 AM-3:00 PM.

6. I have been presented with a copy of notice of privacy practice in accordance with Health Portability and Accountability Act of 1996 (HIPPA).

7. I authorize the release of any information necessary to process my claims. A copy of this authorization can be used in place of original.

    a. Do you wish to restrict information given to your spouse or family member? _____

    b. Please list name and phone number of family members with whom you agree to share your medical information.

    _____

    _____

    _____

Patient/Parent/Guardian Signature_____**Date**_____

Print Name_____