PATIENT INFORMATION FORM

Name: _____ E-Mail: _____

New Patient? _____ Previous Patient? _____ Previous name if different: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Sex: Female _____ Male _____ Marital Status: S _____ M _____ W _____ D _____

Home Address: _____

City: _____ State: _____Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Business Phone: (_____) _____

Employer: _____ Occupation: _____

Bus. Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Occupation: _____

Spouse's Cell Phone: (_____)_____ Business Phone: (_____)_____

Spouse's Employer & Address: _____

Nearest Relative: _____ Phone: (_____)_____

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

Are you currently under the care of a physician? Yes: _____ No: _____

If Yes, Name: _____ Phone: (_____)_____

Medical Insurance Co.:_____

Insured: _____ Group#: _____ Policy#: _____

Reason For This Consultation: _____

How Were You Referred To Our Office: _____

Medication Allergies: Yes _____ No _____ List: _____

Do You Have Any Unusual Bleeding Tendencies: Yes _____ No _____

List Any Illnesses: _____

List Any Medications You Are Presently Taking: _____

List Any Previous Surgeries: _____

Height: _____ Weight: _____ Recent Change In Weight: _____

Are you currently pregnant or trying to get pregnant? Yes: _____ No: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Sanjay Grover, M.D. to furnish information to insurance companies concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or authorized third party.

_____ _____

Patient Signature Date

GROVER AESTHETICS

SANJAY GROVER MD, FACS

PATIENT QUESTIONNAIRE

Name: _____ Age: _____

Primary Concern/Interest: _____

FAMILY HISTORY: Give age if living or age and cause of death.

Father _____ Mother _____

Siblings _____ Children_____

Is there an immediate family history (someone related by blood) of any of the following:

Yes	No

Yes	No

Heart Trouble

Bleeding Tendency

Diabetes

High Blood Pressure

Stroke

Keloid Formation

Cancer

Other

ALLERGIES AND SENSITIVITIES: Indicate which, if any are present:

Yes	No

Yes	No

Penicillin

Other Antibiotics

Xylocaine

Codeine

Aspirin

Tetanus Toxoid

Adhesive Tape/Latex

Other

MEDICATIONS: List all medications you currently take:

	Dosage	Frequency
Cortisone, ACTH, other steroids	_____	_____
Sedatives, Sleeping Pills, Tranquilizers	_____	_____
Blood Pressure Regulators	_____	_____
Digitalis, Nitroglycerine, Cardiac Drugs	_____	_____
Thyroid	_____	_____
Aspirin, Coumadin, Heparin	_____	_____
Birth Control Pills/Hormones	_____	_____
Appetite Suppressants- including Phen-Fen	_____	_____
Herbal/Homeopathic	_____	_____
Accutane	_____	_____
Other_____	_____	_____

SOCIAL HISTORY (circle one)

Tobacco:	None	1pack/day or less	2 packs/day	More
Alcohol:	None	Socially	Daily	Other
Drugs:	None	Marijuana	Cocaine	Other

SURGICAL HISTORY: List all prior surgeries, as well as cosmetic (including chemical peels).

Type: _____ Date: _____ Surgeon: _____

Type: _____ Date: _____ Surgeon: _____

Type :_____ Date: _____ Surgeon: _____

Did you experience any problems or complications during or following above procedures?

No_____ Yes_____ Please explain: _____

_____

PAST MEDICAL HISTORY: List any prior hospitalizations below (e.g. accidents, surgeries, etc.).

Purpose: _____ Date: _____ Physician: _____

Purpose: _____ Date: _____ Physician: _____

Purpose: _____ Date: _____ Physician: _____

Have you recently been under the care of a physician for any reason? Yes_____ No_____

If yes, please explain: _____

_____

Name, Address & Telephone Number of Physician: _____

_____

REVIEW OF SYSTEMS: Check if any apply:

	Yes	No		Yes	No
Skin Disease	___	___	High/Low Blood Pressure	___	___
Eye, Ear, Nose Throat	___	___	Rheumatic Fever	___	___
Thyroid	___	___	Anemia, Bleeding Problems	___	___
Palpitations	___	___	Arthritis	___	___
Diabetes	___	___	Liver	___	___
Shortness of Breath	___	___	Psychiatric	___	___
Chronic Cough	___	___	Tuberculosis	___	___
Asthma	___	___	Hepatitis	___	___
Chest Pain/Heart Murmur	___	___	HIV	___	___

Is there any history not noted above of which the doctor should be aware? Yes_____ No_____

If yes, please explain: _____

_____

_____

This information is correct and true to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or healthcare operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ Date: _____

GROVER AESTHETICS

SANJAY GROVER MD, FACS

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Sincerely,
Dr. Grover and Staff

Print Name: _____

Signature: _____ Date: _____

OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS (HIPAA)

Our office is fully committed to complying with HIPAA guidelines by:

1. Providing appropriate *security* for our patient records.
2. Protecting the *privacy* of our patients' medical information.
3. Providing our patients with proper *access* to their medical records.
4. Appropriately *maintaining* our patient information and billing processes in compliance with national HIPAA standards.

Acknowledgement of Notice of Privacy Practices

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Dr. Sanjay Grover. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www.drgrover.com and in our office. You may request a copy of this Notice of Privacy.

_____ _____

Signature of Patient/Patient Representative Date

_____

Name of Patient/ Patient Representative (please print), Relationship to Patient

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Compliance Officer (Office Manager).