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

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
Heart Trouble		
Bleeding Tendency		
Diabetes		
High Blood Pressure		

	Yes	No
Stroke		
Keloid Formation		
Cancer		
Other		

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

	Yes	No
Penicillin		
Other Antibiotics		
Xylocaine		
Codeine		

	Yes	No
Aspirin		
Tetanus Toxoid		
Adhesive Tape		
Other		

MEDICATIONS: List all medications you currently take:

Medication	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	______________	_____________
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: _______________________

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).

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than twenty-four (24) hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than twenty-four (24) hours notice, we are unable to offer that slot to other patients and it causes significant expense to the practice.

Office appointments that are cancelled with less than twenty-four (24) hours notification shall be subject to a **$50.00** cancellation fee. Procedure cancellations require two (2) business days advance notice, and without notification they shall be subject to a **$150.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as an appointment "No Show". No Show patients shall be charged the greater of (a) $50.00 cancellation fee or $150.00 cancellation fee, whichever is applicable; or (b) the amount of deposit paid in advance to reserve office treatment time, if applicable; or (c) if the patient has a prepaid package of MedSpa treatments, one treatment shall be forfeited, as applicable; or (d) if the patient was planning to use a complimentary treatment certificate or discount, such certificate or discount, as applicable.

The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's ability to schedule his/her next appointment. Such cancellation fee shall be charged to the patient's credit card that is required to hold the patient's appointment time.

We understand that special unavoidable circumstances may cause you to cancel within twenty-four (24) hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

____ ________________
PATIENT SIGNATURE DATE