

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE



PAGE #
CHART #

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ()	WORK # ()	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ()
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ()	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE # ()

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#
		BENEFIT CODE
		I.D.#
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#
		BENEFIT CODE
		I.D.#

MEDICARE I.D.#	MEDICAID I.D.#
OTHER COVERAGE	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME (please print)	DATE
PARENT / GUARDIAN (please print)	SIGNATURE

HIPAA COMPLIANT

Dr. Deborah Ramanathan's Office
241 Juniper St.
Quakertown, PA 18951
Phone: 215-536-6000
Fax: 215-536-6002

HEALTH QUESTIONNAIRE



REASON FOR VISIT

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

- | | | | |
|-------------------|-------------------|-------------------------|----------------------|
| 1) Epilepsy | 6) Thyroid | 11) Osteoporosis | 16) High cholesterol |
| 2) Migraine | 7) Hayfever | 12) Arthritis | 17) Alcoholism |
| 3) Mental illness | 8) Asthma | 13) Heart disease | 18) Hepatitis |
| 4) Glaucoma | 9) Anemia | 14) Stroke | 19) Cancer |
| 5) Diabetes | 10) Bleeds easily | 15) High blood pressure | 20) |

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
	<i>not including pregnancies</i>			

LIST ALL MEDICATIONS YOU ARE NOW TAKING - INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION	ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
		Tetanus / Td		Rectal/stool	
		Influenza (flu)		Cholesterol	
	SUPPLEMENTS	Pneumonia		Eye exam	
		Hepatitis		TB test	
				Hepatitis	

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Decreased hearing
<input type="checkbox"/> Ringing in ear
<input type="checkbox"/> Ear infections - frequent
<input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain
<input type="checkbox"/> Double or blurred vision
<input type="checkbox"/> Nose bleeds - recurrent
<input type="checkbox"/> Sinus trouble
<input type="checkbox"/> Sore throats - frequent
<input type="checkbox"/> Hoarseness - prolonged
<input type="checkbox"/> Hayfever / Allergies
<input type="checkbox"/> Pneumonia / Pleurisy
<input type="checkbox"/> Bronchitis / Chronic cough
<input type="checkbox"/> Asthma / Wheezing
<input type="checkbox"/> Shortness of breath:
<input type="checkbox"/> on exertion <input type="checkbox"/> lying flat
<input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations
<input type="checkbox"/> Leg pain - when walking
<input type="checkbox"/> Varicose veins / Phlebitis
<input type="checkbox"/> Cold numb feet
<input type="checkbox"/> Loss of appetite - recent | <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> Jaundice / Hepatitis
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis
<input type="checkbox"/> Inflammatory Bowel Syndrome
<input type="checkbox"/> Bloody or tarry stools
<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia
Urination - Overactive Bladder
<input type="checkbox"/> Overnight more than twice
<input type="checkbox"/> More than 8 times / 24 hrs.
<input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage
<input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Painful
<input type="checkbox"/> Stress incontinence — urine leakage with exercise / movement
<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones
<input type="checkbox"/> Urine infections - frequent
<input type="checkbox"/> Weight loss / gain <input type="checkbox"/> Height loss
<input type="checkbox"/> Appetite
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily
<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Cancer <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Decreased energy / endurance
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
<input type="checkbox"/> Tremor / hands shaking
<input type="checkbox"/> Numbness / tingling sensations
<input type="checkbox"/> Headaches — frequent
<input type="checkbox"/> Arthritis / Rheumatism
<input type="checkbox"/> Back pain - recurrent
<input type="checkbox"/> Bone fracture / joint injury
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout
<input type="checkbox"/> Rashes <input type="checkbox"/> Hives
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema
<input type="checkbox"/> Concentration prob <input type="checkbox"/> Sleep problems
<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness
<input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss
<input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness
<input type="checkbox"/> Feelings of worthlessness
<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Chickenpox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Measles <input type="checkbox"/> German measles
<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes
<input type="checkbox"/> AIDS / HIV <input type="checkbox"/> STD | <input type="checkbox"/> Sexual problems / enjoyment
<input type="checkbox"/> Decreased life enjoyment
<input type="checkbox"/> Decreased work performance
<input type="checkbox"/> Alcohol _____ oz. per week
<input type="checkbox"/> Coffee / Tea _____ cups per day
<input type="checkbox"/> Smoking - cig/day _____ # years year quit _____
<input type="checkbox"/> Exercise _____
<input type="checkbox"/> Street drugs _____
<input type="checkbox"/> Unwanted facial hair
Hair loss: <input type="checkbox"/> progressive <input type="checkbox"/> recent
MALES - <input type="checkbox"/> Prostate problems
FEMALES - Please complete
Menstrual flow:
<input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps
Days of flow _____ Length of cycle _____
Date — 1st day of last period _____
<input type="checkbox"/> Pain / Bleeding during or after sex
Number of:
Pregnancies _____ Abortions _____
Miscarriages _____ Live births _____
Birth control method _____
B.C. pill (name) _____
<input type="checkbox"/> Flushing / Menopause

Date of last Pap test _____
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date of last mammogram _____
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
|--|--|--|--|

NOTES

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Dr. Deborah Ramanathan's Office
Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

The _____ appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to _____, for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to _____, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize _____, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize _____, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The _____ will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____ Date _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at _____. I agree to pay _____, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Motor Vehicle Insurance (PIP)

I do not have health insurance. I request my claims be submitted to my motor vehicle carrier. I understand I will be responsible for bills incurred by me in the event my PIP benefit exhausts or denies.

Patient/Guarantor Signature _____ Date _____

Dr. Deborah Ramanathan's Office

Authorization For The Use And/Or Disclosure Of Protected Health Information

I authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

2. I authorize the following persons to make the authorized use and/or disclosure of my protected health information:

3. I authorize the following persons to receive my protected health information:

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon _____

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr Ramanathan, nor will it affect my eligibility for benefits.

8. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

9. I understand that Dr. Ramanathan will receive compensation for its use and/or disclosure of my protected health information.

10. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Dr. Ramanathan, nor will it affect my eligibility for benefits.

I certified that I have received a copy of the authorization.

Signature

Date

Name

Name of Personal Representative

Relationship to Patient