GAURANG S. PANDYA, M.D.

555 W. Putnam, Porterville, CA 93257
(559) 782-8533 Fax (559) 782-8544

Patient No._____
Guarantor No._____

Last Name: _____ First Name:_____ Middle:_____

Street Address: _____ City_____ Zip_____
Mail if different address:_____ City_____ Zip_____

Birth Date: _____-_____-_____ Age:_____ Sex: M / F Social Security # _____ -_____-_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner
If married spouses name: _____

BEST # TO CALL FIRST
( )Home Phone: (_____) _____-_____ ( )Alternate or Mess Phone: (_____) _____- _____
( )Work Phone: (_____) _____-_____ ( ) Cell Phone: (_____) _____- _____

Emergency Contact: _____Relation:_____ Phone #_____

E-MAILADDRESS:_____
Would you like to receive medical updates from Dr. Pandya by e-mail: ☐ by Mail:☐

IF MINOR FULL NAME OF PARENTS: _____
Who is responsible for this account:_____

☐ **Medicare #**_____ ☐ **Medical # _____**
☐ **Other Fill out below:**

Insurance CO:_____ Phone # (_____) _____-_____
Name of Insured: _____
Insurance ID # _____ Group/Plan # _____
Insurers DOB: _____ SSN: _____
Address of the Insured: _____
Name and Address of Employer _____
_____ City: _____ Zip:_____
Occupation:_____ Number of Employer: (_____)_____-_____

Is patient covered by additional insurance?
Name of Insured: _____
Insurance ID # _____Group/Plan # _____
Insurers DOB: _____ SSN: _____
Address of the Insured: _____
Name and Address of Employer: _____
_____City: _____ Zip:_____
Occupation:_____ Number of Employer: (_____)_____-_____

PHARMACY PREFERRED AND LOCATION:
_____CITY:_____

WHOM SHALL WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
PRIMARY CARE DOCTOR: _____REFERRING DOCTOR: _____
Primary Language: _____Interpreter required: ☐ YES ☐ NO

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Date: _____Name: _____DOB: _____Age_____ Sex Male/Female

Chief complaint HISTORY OF PRESENT ILLNESS:

Referring physician_____

Did you have any x-rays? CAT scans Ultrasound Mammography Chest X-ray MRI other _____

PERSONAL PAST MEDICAL HISTORY:

MEDICATIONS DOSE TIMES/DAY DOCTOR

ALLERGIES: Circle

Penicillin	Sulfa	Codeine	Morphine	Aspirin	Seasonal allergies	Other

PAST MEDICAL PROBLEMS AND ILLNESSES: LIST or circle (Or place N/A if none, and date if possible)

CARDIOVASCULAR SYSTEM:

Hypertension	Heart Attack	Bypass surgery	Heart Failure	Artrial Fibrillation
PVC's	Chest Pain	Leg pain after walking	Other	

RESPIRATIORY SYSTEM:

Bronchial Asthma	Bronchitis	COPD	Emphysema	Valley Fever
Pneumonia	Smoking	Coughing blood	Other	

GASTROINTESTINAL SYSTEM:

Hepatitis A, B, or C	Vomiting	Distention	Constipation	Rectal Bleeding
Abdominal Bleeding	Liver Condition	Diarrhea	Diverticulitis	Abdominal Surgery
Acid Reflux	Hiatal Hernia	Difficulty Swallowing	Peptic Ulcer	Other

ENDOCRINE SYSTEM:

Diabetes Mellitus	Thyroid	Other

URINARY SYSTEM:

Kidney Stones	Urinary Tract Infection	Prostate	Leaking urine	Other

OB & GYN:

FMP	LMP	Cycle days	Flow	Pain
Last Pap smear	Cancer	Endometriosis	Pain During sex	Vaginal Discharge
Pregnancies	Children	Abortion	Breast Lump	Breast Surgery
Nipple discharge	Last Mammogram		Other	

NEUROLOGICAL SYSTEM:

Stroke	Head injury	Other

SKELETAL SYSTEM:

Fractures	Joint swelling	Joint pain	Joint Locking	Arthritis
Gout	Rheumatoid arthritis	Back Problems	Other	

CANCER:

Breast	Colon	Other

PAST OPERATIONS:

Appendix	Gallbladder	Hernia	Prostate	Joint Surg
Neck Surgery	Colon	Stomach	Intestinal	Liver
Thyroid	Hysterectomy	Ovary	Cesarean section	Breast
Heart Surgery	Ear Nose and Throat Surgery ☐	Colonoscopy Date:	Upper Endoscopy Date:	Neurological
Back Surgery	Other			

HOSPITALIZATIONS

Reason:_____

INJURIES

_____

_____

CHILDHOOD ILLNESSES:

_____

_____

_____

SOCIAL HISTORY:

Alcohol	How much	Exercise
Smoking	How much	Diet
Coffee	How much	Married / Divorced
Drugs	How much	Children
Caffeinated beverages	How much	Working

FAMILY HISTORY:

Cancer. Yes/no Diabetes. Yes/no Other. Yes/no

_____

_____

_____

Gaurang S. Pandya, MD
555 w. Putnam Avenue, Porterville, CA 93257
Privacy Officer Phone # (559) 782-8533

Accounting of Disclosures of Protected Health Information

Patient Name: _____ Date:_____

Date	Recipient's Name & Address	Info Disclosed	Purpose of Disclosure	Comments

The following disclosures are not included in this accounting because the HIPAA Privacy Rule excuses them from the Accounting requirement: 1) Disclosures for purposes of treatment, payment or health care operations; 2) Disclosures to you, or pursuant to an authorization you have signed; 3) Disclosures to people involved in your case; 4) Disclosures for national security or intelligence purposes; 5) Disclosures to correctional institutions or law enforcement officials to the extent this medical practice has received notice from that agency or official that providing you with an accounting of those disclosures would be reasonably likely to impede the agency's or official's activities; 7) Disclosures of information which excludes direct identifiers for purposes of research, public health or health care operations; 8) Disclosures which are incident to a use or disclosure otherwise permitted or authorized by law and 9) Disclosures which occurred before April 14, 2003.

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Authorization for Treatment, Insurance Billing and Release of Medical Information

- I authorize medical and surgical treatment provided to my dependent or I.
- I understand that I am responsible to pay for the services received by the person named below.
- As a courtesy, Dr. Pandya and his staff will bill my insurance company for the services provided to my dependent or I. If necessary for this purpose, I authorize the release of medical information to my health plan.
- I authorize Dr. Pandya and his staff to bill my health plans for the services provided to my dependent or I.
- I am responsible for my deductible and also co-payments at every office visit.
- If my deductible is satisfied, Dr. Pandya will bill my health plan. If my deductible has not been satisfied, I will make payment for the services at the time of receiving the services.
- I agree to pay $10.00 missed appointment fee if I forgot to notify Dr. Pandya's office of my inability to keep my appointment.
- I agree to pay $100.00 cancellation fee for surgery/procedure after it has been scheduled.

Our Credit Policy

- I will be responsible for the payment of all the services received by my dependent or I, if my health plan does not pay Dr. Pandya after attempts by his staff.
- Dr. Pandya's office will send only three statements, one each month, for the balance I owe for the services.
- If I am not able to pay off my balance within the three months, I will contact Dr. Pandya's office to enter in to a payment agreement for my balance. In that event, I will be charged a 10% interest per year on my unpaid balance and will continue to receive statements.
- If the balance is not paid up in full by the end of the three months, my account will be sent to a collection agency and I will be responsible for the collection agency costs and any attorney fees.
- If I request and receive services not covered by my health-plan I agree to pay for those services in full before receiving the services.

I have read, understand and agree to all the above-mentioned policies.

Insured: _____ Patient Name:_____

Address:_____ City: _____

_____ _____
Signed Date

_____ _____
Guarantor's name if patient is a minor Relationship to patient

REVISED 08-22-11

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Privacy Policies Acknowledgement form.

Date: _____ Name: _____

The HIPPA Law of 1996 has set guidelines for disclosure of protected health information to you and other parties for various reasons. We will provide an Accounting of Disclosures of Protected Health Information to you when you ask for the information. This will cost you request processing fee as set from time to time.

With respect to each reportable disclosure, we have provided the following:

1. The date of the disclosure;
2. The name of the entity or person who received the information and if known, the address of that entity or person;
3. A brief description of the protected health information disclosed; and
4. A brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure, or a copy of the written request for disclosure we received from the Secretary of DHHS to determine our compliance with the HIPPA Privacy Rule or from a public health authority, the FDA, your employer, law enforcement, a court or administrative tribunal or grand jury, an attorney, a coroner, an organ or tissue procurement organization, or researcher for purposes authorized in our Notice of Privacy Practices. Where we have made multiple disclosures to the same person or entity for the same purpose, we have indicated the frequency, periodicity, or number of disclosures made during the accounting period and the date of the first and last disclosures.

The following disclosures are not included in this accounting because the HIPPA Privacy Rule excuses them from the Accounting requirement: 1) Disclosures for purposes of treatment, payment or health care operations; 2) Disclosures to you, or pursuant to an authorization you have signed; 3) Disclosures to people involved in your care; 4) Disclosures for national security or intelligence purposes; 5) Disclosures to correctional institutions or law enforcement officials if you were in their lawful custody; 6) Disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing you with an accounting of those disclosures would be reasonably likely to impede the agency's or official's activities; 7) Disclosures of information which excludes direct identifiers for purposes of research, public health, or health care operations; 8) Disclosure which are incident to a use or disclosure otherwise permitted or authorized by law and 9) Disclosures which occurred before April 14, 2003.

I have read the above information and understand the disclosure policy. All my questions were answered and hereby I acknowledge receiving a copy of this notice.

Date: _____ Signature_____if the patient is minor then

Acknowledging responsible person's relationship to the patient._____

Witness Signature_____Date: _____