Saraswati Dayal, MD, FACS, LLC
5 Summit Avenue, Suite 105 ♦ Hackensack, NJ 07601

Patient Registration Form

Date: _____

Patient Information

Patient Name: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____
City State Zip

Phone #: Home: _____ Cell: _____ Work: _____

Email Address: _____
(e.g., mickeymouse@disneyworld.com)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner/Significant Other

Race: ☐ Asian ☐ Black/African American ☐ Caucasian ☐ Hispanic ☐ Other ☐ Declined to Specify

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused to Report

Language Spoken: ☐ English ☐ Spanish ☐ Other: _____

Employment Information

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed

Employer Name: _____ Phone: _____

Street Address: _____
City State Zip

Insurance Information

PRIMARY INSURANCE:

Insurance Company Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscribers Name: _____ Subscribers Date of Birth: _____

Subscribers SSN: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE: ☐ No Secondary Insurance

Insurance Company Name: _____ Effective Date: _____

Policy Number: _____ Group Number: _____

Subscribers Name: _____ Subscribers Date of Birth: _____

Subscribers SSN: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

INJURY RELATED TO: ☐ N/A ☐ Motor Vehicle Accident ☐ Workman's Compensation

Insurance Carrier: _____

Address: _____ Phone Number: _____

Claim Number: _____ Adjustor's Name: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone #: Home: _____ Work: _____ Work: _____

Primary Care Physician	
Physician Name:	
Address:	
Phone Number:	

Pharmacy – Is it Mail Order? ☐ Yes ☐ No	
Pharmacy Name:	
Address	
Phone Number	

_____ _____

Signature of Patient **Date:**

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Patient Registration Form

Patient Name:	Date of Birth:	Date:

In order to protect your privacy, we ask that you complete this form so we know the ways in which we may communicate with you regarding your health information. Please mark as many of the communication options below you feel comfortable with so we have multiple ways to reach you regarding important matters concerning your health care.

Disclosures to Authorized Individuals

I agree that **Saraswati Dayal, MD** may disclose certain portions of my health information to a relative, friend and/or other caregiver because such person is involved with my health care or payment relating to my health care. In that instance, that **Saraswati Dayal, MD** will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

☐ **I wish to make no designation at this time**

☐ **I wish to designate the following person(s)**

I designate the following person(s) listed below as person(s) involved with my health care or payment (please indicate as applicable) relating to my health care for the purpose of **Saraswati Dayal, MD** making the limited disclosures as indicated.

- I understand that I am not required to list anyone.
- I also understand that I may change this list at any time in writing.

Name: _____ Relationship: _____
Phone: _____ ☐ Health Information ☐ Billing/Insurance Information

Name: _____ Relationship: _____
Phone: _____ ☐ Health Information ☐ Billing/Insurance Information

Name: _____ Relationship: _____
Phone: _____ ☐ Health Information ☐ Billing/Insurance Information

Message Contact Information

I understand that if I check the box "detailed message," I agree that the staff of and/or **Saraswati Dayal, MD** may leave a detailed messaged at the indicated telephone number. Detailed messages include: appointment reminders, insurance/financial issues, test results and any other information regarding my care or treatment.

I wish to be contacted in the following manner (Please check all that apply)

☐ Home Phone: _____ ☐ Detailed Message ☐ Call Back Message Only
☐ Cell Phone: _____ ☐ Detailed Message ☐ Call Back Message Only
☐ Other Telephone: _____ ☐ Detailed Message ☐ Call Back Message Only

Consent and Authorization

A copy of this consent and authorization may be used in place of the original. I have read and understand the terms of this document. I have had an opportunity to ask question about the use or disclosure of my health information and the contents of this form. I acknowledge consent and agree to the terms and conditions of this document.

Signature of Patient or Legal Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

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Patient Registration Form

Patient Name:	Date of Birth:	Date:

Consent to Treat and Financial Responsibility

General Consent for Examination and Treatment
I hereby consent and authorize **Saraswati Dayal, MD** and ancillary medical personnel of **Saraswati Dayal, MD** to perform medical examinations and provide routine medical care for all my visits to **Saraswati Dayal, MD.** This may include routine diagnostic and laboratory procedures and tests, medication administration and other routine care for which a specific informed consent will not be signed by me. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at **Saraswati Dayal, MD.**

Financial Responsibility
Subject to applicable law and the terms and conditions of any applicable contract between **Saraswati Dayal, MD** and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I agree to be financially responsible and obligated to pay **Saraswati Dayal, MD** for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to me (or the above- named patient), I agree to be financially responsible and obligated to pay **Saraswati Dayal, MD** for the patient balances due.

Assignment of Benefit
In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to **Saraswati Dayal, MD** all rights, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding **Saraswati Dayal, MD** regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by **Saraswati Dayal, MD** to challenge a determination of benefits made by a third-party payer. This specifically includes filing appeals/arbitration/litigation in my name or on my behalf, against my health care carrier. I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer.

- **I understand that my current insurance must be on file with Saraswati Dayal, MD for my insurance to be billed and as such, I will be expected to present my insurance card and identification at each visit to verify my insurance coverage.**

Medicare Acknowledgement
I request that payment of authorized Medicare benefits be made to **Saraswati Dayal, MD** for any services furnished to me. I authorize any holder of medical information about me to release to The Centers for Medicare & Medicaid Services, and its agents any information needed to determine these or the benefits payable for related services. for related services. I understand that I will be responsible for any deductible, coinsurance, and non-covered expense.

Motor Vehicle Insurance Acknowledgement
I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me. This specifically includes filing arbitration/litigation in your name/on my behalf against the **PIP carrier/health care carrier.** I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc. I specifically authorize such healthcare providers to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient Acknowledgement of Personal Information
I attest that all information provided to **Saraswati Dayal, MD** is accurate. **If any of my personal information changes, including my address, phone number or insurance information, I will inform Saraswati Dayal, MD as soon as I can.**

Signature of Patient or Legal Representative:_____ Date: _____

Print Name: _____

Relationship to Patient: _____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices (NPP)

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of the *Notice of Privacy Practices*, which describes the health information privacy practices of the practice, the medical staff, and affiliated health care providers that jointly perform payment activities and business operations with the practice.

- "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

Your Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our *Notice of Privacy Practices*. This Acknowledgement Form will become part of your permanent medical record.

Signature of Patient or Legal Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):

_____

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Health History Questionnaire

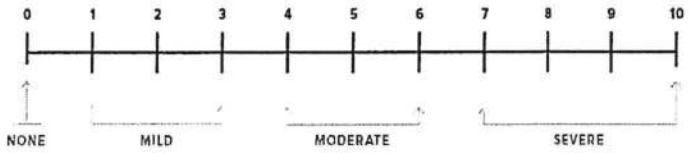
Please Answer All of the Following Health Question

Reason for today's visit: _____

Are you having pain? ☐ Yes ☐ No

If yes, circle the level of pain on the chart to the right.

Where? _____



What other symptoms are you experiencing? _____

Social History: Tobacco and Alcohol Use		
Do you use any tobacco products (cigarettes, cigars, pipes, chewing tobacco, electronic cigarettes)?	☐ Yes ☐ No	
If you use a tobacco product, are you interesting in quitting?	☐ Yes ☐ No	
During the past four weeks, how many alcoholic beverages (beer, wine, liquor) have you had?	☐ 10+ per week ☐ 2-5 per week ☐ No alcohol at all	☐ 6-9 per week ☐ 1 or less per week

Medical History

Please list all current medications (including vitamins, herbal supplements, over-the-counter, eye drops), dose, and frequency.
(e.g., Lipitor 20 mg 2/ day; Aspirin low dose 1/day; Coumadin 5 mg Mon, Wed, Fri)
☐ Check the box if you do not take any medications/vitamins/supplements

Medication name	Dose/amount	How often is it taken?

Do you have any drug or other allergies? ☐ Yes ☐ No If yes, please list allergies below and your reaction.

Allergies (Drug, Food, Environment)	
1.	**4.**
2.	**5.**
3.	**6.**

Please list any surgeries you have had and the year the surgery was done (e.g., Hernia repair 2017; Appendectomy2000,etc.)

Past Surgical History	
1.	**4.**
2.	**5.**
3.	**6.**

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Health History Questionnaire

Family History
Please limit to immediate family health problems (parents, siblings and children). Include current age, or age at death and any health/mental health problems such as cancers, high blood pressure, stroke, diabetes, cholesterol, osteoporosis, depression, Alzheimer's/Dementia etc.

Relative	Alive	Deceased	Age or Age at Death	Health/Mental Health Problems or Cause of Death
Mother				
Father				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Child				
Child				
Child				

Past Medical History : Please indicate whether you have ever had any of the following.

	Yes	No		Yes	No		Yes	No
Amputations	☐	☐	Heart Disease	☐	☐	Seizures	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Stroke/Aneurysm	☐	☐
Clotting disorder	☐	☐	High cholesterol	☐	☐	Substance abuse	☐	☐
Diabetes	☐	☐	Kidney disease	☐	☐	Thyroid disease	☐	☐
Dementia/Alzheimer's	☐	☐	Nerve/muscle disease	☐	☐	Ulcer (GI)	☐	☐
Depression	☐	☐	Osteoporosis	☐	☐	Varicose Veins	☐	☐
Eye Disease	☐	☐	Other Cancer	☐	☐	Other	☐	☐

Review of Systems: Are you currently having or have you had any of the following problems

Constitutional Symptoms	Yes	No
Weight change	☐	☐
Chills	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Headache	☐	☐
	☐	☐

Eyes	Yes	No
Blurred vision	☐	☐
Double vision	☐	☐
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Light sensitivity	☐	☐

Ear/Nose/Throat/Mouth	Yes	No
Congestion	☐	☐
Ear discharge	☐	☐
Ear infection	☐	☐
Ear pain	☐	☐
Hearing loss	☐	☐
Mouth sores	☐	☐
Nosebleeds	☐	☐
Sinus infection		
Sore throat		
Tinnitus		
Trouble swallowing		

Respiratory	Yes	No
Apnea	☐	☐
Chest tightness	☐	☐
Choking	☐	☐
Frequent Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Cardiovascular	Yes	No
Chest Pain	☐	☐
Circulation problem	☐	☐
Heart rhythm problems	☐	☐
High blood pressure	☐	☐
Varicose veins	☐	☐

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Health History Questionnaire

Review of Systems (Continued): Are you currently having or have you had any of the following problems

Gastrointestinal	Yes	No
Abdominal Pain	☐	☐
Anal bleeding	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Indigestion/heartburn	☐	☐
Nausea/Vomiting	☐	☐

Endocrine	Yes	No
Cold or heat intolerance	☐	☐
Excessive thirst	☐	☐
Increased urine	☐	☐
Increased hunger	☐	☐
Tired/sluggish	☐	☐
	☐	☐
	☐	☐

Genitourinary	Yes	No
Bladder control issues	☐	☐
Difficulty urinating	☐	☐
Painful urination	☐	☐
Urine retention	☐	☐

Musculoskeletal	Yes	No
Joint pain	☐	☐
Neck pain	☐	☐
Back pain	☐	☐

Skin	Yes	No
Skin rash	☐	☐
Persistent itching	☐	☐
Boils	☐	☐

Neurology	Yes	No
Tremors	☐	☐
Dizzy spells	☐	☐
Numbness/tingling	☐	☐
Seizures	☐	☐

Hematologic/ Lymphatic	Yes	No
Blood clotting	☐	☐
Bleeding tendencies	☐	☐
History of anemia	☐	☐
Swollen glands	☐	☐
	☐	☐

Allergic/ Immunologic	Yes	No
Environmental	☐	☐
Food	☐	☐
Drug	☐	☐

Emotional Health

In the last two weeks how often have you been bothered by any of the following problems

Please select one answer	Not at all	More than half the days	Several days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

Living Will/Advance Directives

Do you have a living will/advance directive or health care power of attorney? ☐ Yes ☐ No ☐ I do not know
If yes, Name:_____ Relationship: _____

If, no or you do not know, would you like more information on this? ☐ Yes ☐ No

Signature of Patient or Legal Representative:_____ Date: _____

Print Name: _____

Relationship to Patient: _____