DILIP N. DESAI, MD PA

REGISTRATION FORM

PATIENT INFORMATION **PLEASE PRINT**

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt _____ City _____ State _____ Zip _____

Sex: ☐ Male ☐ Female Date of Birth: _____ SS#: _____

Phone: Home _____ Cell _____ Email Address: _____

Language: _____ Race: _____ Ethnicity: _____

Preferred Pharmacy: _____ Address/Phone Number: _____

In case of emergency, who should be notified?

Name: _____ Relationship: _____
Home Phone: _____ Cell/Work Phone: _____

INSURANCE INFORMATION

Payment Information:

☐ Self-Pay/No Insurance (Payment is due at the time of service)

Payment by (check one): ☐ Cash ☐ Check ☐ Credit Card

☐ Medical Insurance (Please provide your insurance card to the receptionist)

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Date of Birth: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other

ASSIGNMENT AND RELEASE

I certify that all information provided above is true to the best of my knowledge. I, the undersigned (patient or legal guardian), authorize medical and/or surgical treatment to be rendered by the doctor and his staff. I hereby authorize payment of insurance benefits to be paid directly to Dilip N. Desai, MD. I understand that I am responsible for payment of non-covered services (co-pay, co-insurance, and deductible).

Patient/Guardian Signature: _____ Date: _____

(If the patient is under 18 years of age, a parent or legal guardian must sign this form.)

PERSONAL HEALTH DISCLOSURE AND PRIVACY NOTICE

The Notice of Privacy Practices states how we may use and/or disclose your health information. It is our policy not to release confidential medical information unless authorized in writing.

I authorize the office to leave my medical information by the following method and will assume responsibility to notify the office whenever it changes:

Preferred Phone #: _____ Can we leave a message? ☐ Yes ☐ No

I authorize the office to discuss my care with: ☐ No one ☐ Spouse _____
☐ Other: _____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices and hereby authorize the use and disclosure of my personal health information as described above.

Consent: I authorize the release of my immunization record to the NJ Immunization Information System.

Patient/Guardian Signature: _____ Date: _____

HEALTH HISTORY SHEET **Date:_____**

Welcome to our practice. To provide you with the best and most comprehensive care possible, we kindly request that you provide the following information. All information is kept strictly confidential and will be released only with your written permission.

Last Name: _____ **First Name:** _____ **Age:** _____ **Sex:** _____

Presenting Problem or Proposed Surgery: _____

Have you or any blood relative had:

	Yes	No	Who	Yr/Age	Doctor Notes Please do not write in this area
Allergies, asthma, hay fever					
Anemia					
Alcoholism					
Arthritis					
Bleeding problems					
Birth defects					
Cancer					
Emphysema					
Epilepsy or seizures					
Heart trouble/arrhythmias					
Mental illness/suicide					
Migraine headaches					
Rheumatic fever					
Diabetes					
Stroke					
Thyroid disease/goiter					
Tuberculosis					
Ulcers					
Venereal disease					
Osteoporosis					
Glaucoma					
Gallstones					
Gout					
Renal failure/dialysis					
Hepatitis					

Have you ever been turned down for military, job, or insurance? ☐ Yes ☐ No

Names of Other present MDs Last visit	**Immunizations**	**Year**
	Tetanus	
	Pneumovax	
	Flu Shot	
	Hepatitis B Series	
	Last TB Test	
	TB: ☐ Positive ☐ Negative	

ALLERGIES: Please list the type and reaction ☐ None

Name of Drug/Item	Reaction	Name of Drug/Item	Reaction

MEDICATIONS:

Name	**Dose**	**Frequency**	**Reason for Prescription**	**Prescribed by**	**Doctor Notes** Please do not write in this area

OB/GYN HISTORY:

Date or no. if requested	Yes	No	Doctor Notes Please do not write in this area
Date of last menstrual period:			
Are your menses irregular?			
No. of days between periods:			
No. of days periods last:			
Spotting between periods?			
Do you forget to do self-breast exams monthly?			
No. of pregnancies:			
Date of last pregnancy:			
No. of live births:			
No. of abortions or miscarriages:			
Date of last Pap smear & by whom:			
Was it abnormal?			
Have you ever had any other abnormal Pap?			
Are you currently using contraception?			
Over 1 year since last mammogram? If yes, date:			

SURGICAL HISTORY:

Name of Operation	Date	Complications	Doctor Notes Please do not write in this area

Have you ever had bleeding problems? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No Date: _____

MAJOR ILLNESS OR INJURY: List any illness or injury requiring hospitalization, prolonged care, or use of medication. Include approximate date.

_____

_____

_____

_____

_____

_____

_____

_____

Dilip N. Desai, MD **Date: _____**

HEALTH HISTORY SHEET

Patient Name: _____

PERSONAL HABITS / RISK FACTORS

	Yes	**No**	**Answers**	**Doctor notes** Please do not write in this area
Do you smoke or chew tobacco?			No. Packs/day:	
Have you ever smoked in the past?			Date started:	
			Date stopped:	
Do you often miss meals?				
Do you have an eating problem?				
Any diet preferences or restrictions?				
Number of caffeine drinks per day:				
Average alcoholic drinks per day:				
Ever had a drinking problem?				
Ever had a drug problem?				
Ever used intravenous drugs?			Date last used:	
Do you ever not use seat belts?				
Hours of sleep per day:				
Highest grade level achieved:				
Do you avoid exercising regularly?				
What exercise do you do?				
How often/week?			Duration:	
What do you do to relieve stress?				
Any pets?				
Any hobbies?				
Occupation:				
Is your job a risk to your health?				
If yes, please explain:				

SOCIAL HISTORY

Are you: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Living with "significant other."	Do you have children? ☐ Yes ☐ No If yes, please list No. and age(s):	**Doctor notes** Please do not write in this area

SEXUAL HISTORY

Are you sexually active?	Yes	No	**Sexual partners in the past year:**	**Doctor notes** Please do not write in this area
Is sex unsatisfactory in any way?			No. men: _____ No. women: _____ No. unprotected: _____	
History of Chlamydia?				
Gonorrhea?				
Venereal warts?				
Are you concerned about AIDS?				
AIDS (continued): Would you like to have a test?				**If there are any special concerns you would like to discuss with the doctor, please write them in the space provided below. Thank you for providing us with this important information.**

Other information not mentioned above: _____

_____

_____

_____

_____

DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVE? ☐ YES ☐ NO