# REGISTRATION SHEET

**1. P**atient **N**ame ( Last, Fst )_____ Age_____DOB_____

S.S.#_____ Marital Status: Single Married Divorced Widow

Address_____City_____Zip_____

Phone_____Cell_____WK_____--Etn-_____

Email_____

Employer Name_____Occupation_____

Address_____City_____Zip_____

Race and Ethnicity follow current Federal Standards published by the Office of Management and Budget.

Ethnicity : _____Non-Hispanic _____Hispanic Preferred Language_____

RACE: _____African or African American _____Asian or Asian American _____Caucasian or European American

_____Native American or Other Pacific Islander _____ Other Race_____ Smoking_____

Pharmacy Name_____Location / # _____

**2. S**pouse / Responsible **N**ame (L/F)_____ Age_____DOB_____

S.S.#_____ Driver Lic #_____Exp Dt_____

Address_____City_____Zip_____

Phone_____Cell_____WK_____

(Sp/Resp Party)Employer Name_____ Occupation_____

Phone # _____ Extn _____

**3. E**mergency Contact_____Relation_____Phone_____

**4. Pt. Insurance Name**_____

Name of Insured_____Relation_____

ID Number_____Grp # _____

**5. D**o you have any other insurance coverage. YES_____ NO_____

**6. I AGREE TO PAY ANY BALANCE OF PROFESSIONAL SERVICE CHARGES WHICH EXCEEDS INSURANCE PAYMENT.**

Patient Sign_____Date_____

**URVASHI SURA MD** **OB - GYN** **PATIENT QUESTIONNAIRE**

**NAME**

**REASON FOR VISIT**

**PAST MEDICAL & FAMILY HISTORY** ***PLEASE CHECK (✓) IF YOU (SELF) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS***

| | | SELF | FAM |
|---|---|---|---|
| 1 | WT LOSS-GAIN | ☐ | |
| 2 | HEADACHES / MIGRAINE | ☐ | ☐ |
| 3 | HEART DISEASE ☐ VALVULAR DIS ☐ RHEUMATIC DIS ☐ | ☐ | ☐ |
| 4 | HIGH BLOOD PRESSURE | ☐ | ☐ |
| 5 | HIGH CHOLESTEROL | ☐ | ☐ |
| 6 | RESPIRATORY DISEASE PULMONARY (LUNG) | ☐ | ☐ |
| 7 | BREAST DISEASE | ☐ | ☐ |
| 8 | JAUNDICE / HEPATITIS | ☐ | ☐ |
| 9 | HIATAL HERNIA (REFLUX) | ☐ | ☐ |
| 10 | PEPTIC ULCER (STOMACH) | ☐ | ☐ |
| 11 | BOWEL DISEASE | ☐ | ☐ |
| 12 | KIDNEY DISEASE | ☐ | ☐ |
| 13 | URINARY INCONTINENCE **(TYPE)** | ☐ | ☐ |
| | INFECTIONS | ☐ | ☐ |
| | FREQUENCY | ☐ | ☐ |
| 14 | PELVIC PAIN | ☐ | ☐ |

| | | SELF | FAM |
|---|---|---|---|
| 15 | BLOOD TRANSFUSIONS | ☐ | |
| 16 | ANEMIA / BLOOD DISORDER | ☐ | ☐ |
| 17 | VARICOSE VEINS / PHLEBITIS | ☐ | ☐ |
| 18 | DIABETES | ☐ | ☐ |
| 19 | THYROID DISEASE | ☐ | ☐ |
| 20 | CANCER (TYPE) | ☐ | ☐ |
| 21 | EPILEPSY / NEUROLOGICAL DIS | ☐ | ☐ |
| 22 | ALZHEIMER'S DISEASE | ☐ | ☐ |
| 23 | ARTHRITIS - JOINT PAIN | ☐ | ☐ |
| 24 | OSTEOPOROSIS | ☐ | ☐ |
| 25 | SKIN DISEASE | ☐ | ☐ |
| 26 | UNWANTED FACIAL HAIR | ☐ | |
| 27 | ANXIETY / DEPRESSION | ☐ | ☐ |
| 28 | SLEEP PROBLEMS | ☐ | ☐ |

**HOSPITAL ADMISSIONS** ***LIST THOSE OPERATIONS & SERIOUS ILLNESS' WHICH REQUIRED HOSPITALIZATION*** ***(EXCLUDING PREGNANCY)***

| YEAR | REASON FOR ADMISSION / HOSPITAL | YEAR | REASON FOR ADMISSION / HOSPITAL |
|---|---|---|---|
| | | | |
| | | | |

**MEDICATIONS** ***LIST ALL MEDICATIONS - YOU ARE CURRENTLY TAKING (DOSAGE - FREQUENCY) - INCLUDE OVER THE COUNTER DRUGS***

VITAMINS
NUTRITIONAL SUPPLEMENTS

**DRUG ALLERGIES**

**MENSTRUAL HISTORY** AGE AT FIRST PERIOD — IF MENSTRUATING - DATE OF LAST PERIOD (1st day)

PERIOD INTERVAL ***Number*** (1st day to 1st day) - ***of days*** — DURATION OF BLEEDING — CRAMPS Y N — ☐ MILD ☐ SEVERE ☐ MOD. ☐ ALWAYS PRESENT — MEDICATIONS FOR CRAMPS Y N

HOW MANY PERIODS IN THE LAST YEAR — BLEEDING (SPOTTING) BETWEEN PERIODS Y N

**VAGINAL INFECTIONS** ***- History of*** ☐ YEAST ☐ TRICHOMONAS ☐ CHLAMYDIA ☐ HERPES ☐ GONORRHEA ☐ BACTERIAL VAGINOSIS

**PAP TEST** DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL — **MAMMOGRAM** DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

**CONTRACEPTIVE HISTORY** CURRENT METHOD — IF PILL - BRAND — PAST METHODS

**OBSTETRICAL HISTORY** ***- Number of*** PREGNANCIES — PREMATURE BABIES — MISCARRIAGES — ABORTIONS — LIVING CHILDREN

| BORN YEAR / MOS. | WEEKS PREG. | WT | SEX | TYPE OF DELIVERY | REMARKS | BORN YEAR / MOS. | WEEKS PREG. | WT | SEX | TYPE OF DELIVERY | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | 4 | | | | | |
| 2 | | | | | | 5 | | | | | |
| 3 | | | | | | 6 | | | | | |

**MENOPAUSAL HISTORY** ***If Applicable -*** HOT FLASHES Y N TREATMENT -

**TESTS** ☐ CHOLESTEROL ☐ BONE DENSITY ☐ COLON / RECTAL

**SEXUAL HISTORY** ☐ SATISFACTORY ☐ UNCOMFORTABLE ☐ WISH TO DISCUSS

**SOCIAL HISTORY** **SMOKING** CIG / DAY — # YEARS — **ALCOHOL** OZ / WK — **COFFEE** CUPS / DAYS — **STREET DRUGS**

**Urvashi Sura M.D. Inc.**
7365 Carnelian St. #125 Rancho Cucamonga, Ca. 91730 (909) 980-7743

**NOTICE OF PRIVACY PRACTICES - EFFECTIVE APRIL 15,2003**
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. **If you have any questions about this, please contact staff at above given address.**.

**YOUR HEALTH INFORMATION** This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by the law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**FOR TREATMENT:** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or people who do not work in our office and family members and other healthcare providers in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering sonograms and other personnel who are involved in taking care of you and your health.

**FOR PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you.

**FOR HEALTHCARE OPERATIONS:** We may use and disclose health information about you in order to run the office, to evaluate the performance of our staff and to help us decide what additional services we should offer, and how we can become more efficient, or whether certain new treatments are effective and make sure that you and our other patients receive quality care.

**APPOINTMENT:** We may contact you to schedule/reschedule or for missed appointments.

**HEALTH-RELATED PRODUCTS AND SERVICES:** If you revoke you consent, we will not be permitted to use or disclose information for purposes of treatment or health care operations, and we may therefore choose to discontinue providing you with healthcare treatment and services. You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time/date.

**REQUIRED BY LAW:** We will disclose health information about you when require to do so by federal, state or local law. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**SPECIAL SITUATIONS:**

**PUBLIC HEALTH RISKS:** We may disclose health information about you if threat to your health, or safety in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products. We may disclose health information to a health oversight agency for audits, investigations, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

**LAWSUITS AND DISPUTES:** If you are involved in a lawsuit or dispute or in response to a lawsuit or subpoena we may disclose health information about you.

**INFORMATION NOT PERSONALLY IDENTIFIABLE:** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**WORKERS' COMPENSATION:** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**FAMILY AND FRIENDS:** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friend if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, use our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide dates on your progress and prognosis. We may also use our professional judgment and experience to make a reasonable inferences that is in your best interest to allow another person to act on your behalf to pickup, for example, filled prescriptions, medical supplies, or lab reports.

**YOUR RIGHTS:** You have the following rights regarding health information we maintain about you:

**RIGHT TO INSPECT AND COPY:** You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to **[Designated privacy official contact]** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee $ 30.00. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and your denial. The person conducting the review will not be the person who denied your request, and will comply with the outcome of the review.

**RIGHT TO AMEND:** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to **[Designated privacy official contact]**. We may deny your request for an amendment under certain circumstances.

**RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have the right to request an "accounting of disclosure". This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We may charge you for providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**RESTRICTION:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**CHANGES TO THIS NOTICE:** We reserve the right to change this notice, and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

**COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact designated privacy official contact. You will not be penalized for filing a complaint.

**I HAVE BEEN EXPLAINED/READ, UNDERSTOOD, RECEIVED AND AGREE.**

**PRINT NAME** _____

**SIGN** _____ **DATE:**_____