RanjanMahajan, MD, PLC

"We Care To Listen To Our Patients"

PATIENT REGISTRATION (Please Print and Complete All Sections Below)

Is your condition a result of an auto accident? **YES** **NO** Work injury? **YES** **NO** Date of injury _____

PATIENT PERSONAL INFORMATION	**EMPLOYMENT STATUS: (Please Circle One)**
Name: _____	EMPLOYED SELF EMPLOYED RETIRED DISABLED
Social Security Number: _____-_____-_____	UNEMPLOYED STUDENT
Date Of Birth: ____/_____/____ **Age**: _____ **SEX:** M F	
Marital Status (circle): S M D W O	**Employer Name:**_____
Address: _____	**Address:** _____
City, State, Zip: _____	**City, State, Zip:** _____
Home Phone: (_____)_____-_____	**Occupation:** _____
Cell: (_____)_____-_____	**Work Phone:** (_____)_____-_____
E-Mail: _____@_____	**Home Phone:** (_____)_____-_____
Spouse's Name: _____	**Spouse's Employer:** _____

RESPONSIBLE PARTY INFORMATION (For Payment Of Bills)

Responsible Party: _____ **Social Security Number:** _____-_____-_____
Address: _____ **Date Of Birth:** _____/_____/_____ Age: _____
Relationship To Patient: _____ Self _____ Spouse _____Child _____ Other

PATIENT INSURANCE INFORMATION (Please Give Insurance Cards and Driver's License To Receptionist)	
Primary Insurance Co. Name: _____	**Secondary Insurance Co. Name:** _____
Insured ID #: _____	**Insured ID #:** _____
Name Of Insured: _____	**Name Of Insured:** _____
Social Security Number: _____-_____-_____	**Social Security Number:** _____-_____-_____
Relationship To Patient: ___Self ___Spouse ___Child __ Other	**Relationship To Patient:** ___Self ___Spouse ___Child __ Other
Insured Date of Birth: _____/_____/_____	**Insured Date of Birth:** _____/_____/_____

EMERGENCY CONTACT

Name Of Person Not Living With You: _____**Relationship:** _____
Address: _____ **Date Of Birth:** _____/_____/_____ Age: _____
City, State, Zip: _____ **Marital Status (circle):** S M D W O

Lifetime Authorization To Release Information & Assignment Of Benefits (Financial Agreement)

I hereby authorize the release of any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to RANJAN MAHAJAN, MD, PLC for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossed-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above named entity. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

Date_____/_____/_____ **Patient Signature:** _____

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Patient Name:_____ Sex: Male Female

Reason for Visit: (Please list your major medical concerns): _____

Medication Allergy	YES NO	
List All Medication Allergies:		
	Are you allergic to iodine	YES NO
	Are you allergic to shellfish	YES NO
	Are you allergic to contrast dye	YES NO

Patient Medication List

Name of Medication	Dosage	Time of Day Taken	Purpose of Medication	Length of time on	Name of Prescribing Dr

Preferred Pharmacy Name: _____ Address: _____ Phone: (____) ___-____
Mail Order Pharmacy: _____ Phone: (___) _____-_____
Patient Name_____ Patient Signature_____
Date_____ Reviewed by_____
Name:_____

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Patient Name:_____

PAST MEDICAL HISTORY

Medical History – Please check any of the following that you have been diagnosed with.

□ Anorexia/Bulimia
□ Anemia
□ Anxiety/Depression
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blocked Arteries
□ Blood Clots
□ Bronchitis
□ Cancer Type:_____
□ Cataracts
□ Chronic Constipation
□ Colon Polyps
□ COPD
□ Macular Degeneration
□ Degenerative Disc Disease
□ Diabetes/Pre-Diabetes
□ Diverticulitis
□ Emphysema
□ Substance Abuse Quit Date:_____
□ Frequent Urinary Infections
□ Gallstones
□ GERD
□ Glaucoma
□ Gout
□ Headaches
□ Heart Attack
□ Heart Failure
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis
□ Herniated Disc
□ High Blood Pressure
□ High Cholesterol/Triglycerides
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory Bowel Disease
□ Insomnia
□ History of Blood Transfusion
□ Irritable Bowel Syndrome
□ Kidney Disease
□ Kidney Stones
□ Meningitis
□ Obesity
□ Osteopenia
□ Osteoporosis
□ Peripheral Vascular Disease/Poor Circulation
□ Pneumonia
□ Prostate Problems
□ Rheumatic Fever
□ Seasonal Allergies
□ Seizures
□ Sleep Apnea
□ Stroke
□ Tuberculosis
□ Varicose Veins
□ Ulcers
□ Alcohol Abuse Quit Date: _____

Any Others:_____

Surgical / Procedure History – Please check any of the following you have had, and list the month/year performed.

□ Appendectomy _____
□ Bunionectomy _____
□ Carotid Surgery _____
□ D&C _____
□ Lumpectomy _____
□ Lasik Surgery _____
□ Tonsillectomy _____
□ Tubal Ligation _____
□ Uterus Removal _____
□ C-Section
□ Cataract Removal _____
□ Hemorrhoidectomy _____
□ Hip Surgery _____
□ Kidney Stones _____
□ Hip Replacement _____
□ Prostate Removed _____
□ Ovaries Removed _____
□ Back Surgery _____
□ Joint Surgery _____
□ Cardiac Bypass _____
□ Gallbladder Removal _____
□ Hernia Repair _____
□ Cardiac Stents _____
□ Thyroidectomy _____
□ Knee Replacement _____
□ Vasectomy _____

Any Others:_____

Hospitalizations – Please list any other hospitalizations you may have had.

1. Reason: _____
Date: _____
Hospital: _____
2. Reason: _____
Date: _____
Hospital: _____
3. Reason: _____
Date: _____
Hospital: _____
4. Reason: _____
Date: _____
Hospital: _____

Women's Health

Number of Vaginal Deliveries:_____
Number of Miscarriages:_____
Number of Abortions:_____
Age of First Period:_____
Number of Pregnancies:_____
Number of C-Sections:_____
Abnormal PAP's?_____

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Patient Name:_____

PHYSICIANS YOU HAVE RECENTLY SEEN

Prior Primary Care Physician: Name: _____ Location: _____

Specialists: Please list most recent physician and specialists you see or have seen;

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor: _____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

Name:_____
Type of Doctor:_____
Phone #:_____
Reason for Visit:_____Mo/Yr_____

HEALTH MAINTENANCE

If you have had any of the following performed, please check the box and list the month/year

□ Last Physical Exam _____
□ Last EKG _____
□ Last Eye Exam _____
□ Labs including a Cholesterol Screen _____
□ Colonoscopy _____
□ Fecal Occult Blood Test (Blood in stool) _____
□ Tetanus Diphtheria (Td) _____
□ Human Papilloma Virus Vaccine (HPV-Gardasil) ____
□ Vaccines Against Hepatitis _____
□ Influenza Vaccine _____
□ Mammogram (Females Only) _____
□ Clinical Breast Exam (Females Only) _____
□ Pap Smear (Females Only) _____
□ Bone Density _____
□ PSA (Males Only) _____
□ Shingles Vaccine (Zostavax) _____
□ Tetanus Diphtheria Pertusis (Tdap) _____
□ Pneumonia Vaccine (Pneumovax) _____
□ TB Screening

SOCIAL HISTORY

What is your current marital status? □ Single □ Married □ Divorced □ Widowed □ Other: _____
Number of Children: _____Ages of Children: _____
With whom do you currently live? □ Self □ Sibling □ Spouse □ Spouse/Children □ Parents □ Significant Other □ Friend/Roommate
Your Occupation: _____ If retired, from what: _____

Do you currently use tobacco products? □ No □ Yes Type: _____Amount per day? _____ How long have you used? _____

Do you have a history of using tobacco products? □ No □ Yes Type & Amount: _____
How long did you use: _____ When did you quit? _____

How much alcohol do you typically drink in **one week?** □ I do not drink alcohol □ Less than one □ Drinks per week:_____

Do you use drugs? □ No □ Yes What type? _____ Do you have a history of drug addiction? □ No □ Yes

Are you sexually active? □ Yes □ No □ Never Do you use condoms? □ Yes □ No
Sexual Partners: Male____ Female_____ Both_____
Do you have any history of STD's? □ No □ Yes If yes, what type? _____
The CDC recommends that everyone be screened for HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? □ Yes □ No

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Patient Name: _____

	Deceased? Y/N	Aneurysms	Arthritis	High BP	Heart Problems	High Cholesterol	Lung Problems	Gout	Stroke	Seizures/Epilepsy	Breast Cancer	Skin Cancer	Ovarian Cancer	Colon Cancer	Prostate Cancer	Diabetes	Kidney Disease	Thyroid Problems	Osteoporosis	Bleeding Problem	Allergies/Asthma	Mental Illness	Tuberculosis	Others (list)
Father																								
Mother																								
Paternal Grandfather																								
Paternal Grandmother																								
Maternal Grandfather																								
Maternal Grandmother																								
Brother																								
Brother																								
Sister																								
Sister																								
Son/ Daughter																								
Son/ Daughter																								
Other																								
Other																								

Check the appropriate item listed across the top row for each relative. Please list only blood relatives.

Patient Signature: _____ **Date:** _____/_____/_____

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PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Sex:** M F **Date Of Birth:** _____/_____/_____ **Date:** _____/_____/_____

REVIEW OF SYSTEMS:

Please Circle YES or NO if you have any of the following problems **at the present time.**

Constitutional			**Ears, Nose, Throat, Mouth**			**Eyes**		
Good general health	YES	NO	Hearing loss or ringing	YES	NO	Wear glasses/contacts	YES	NO
Recent weight change	YES	NO	Sinus problems	YES	NO	Blurred/double vision	YES	NO
Night sweats, fevers	YES	NO	Nose bleeds	YES	NO	Eye disease or injury	YES	NO
Fatigue	YES	NO	Sore throat/voice change	YES	NO	Glaucoma	YES	NO

Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest pain	YES	NO	Shortness of Breath	YES	NO	Nausea/vomiting	YES	NO
Palpitations	YES	NO	Cough	YES	NO	Abdominal pain	YES	NO
Heart trouble	YES	NO	Wheezing/asthma	YES	NO	Rectal bleeding	YES	NO
Swelling hands/feet	YES	NO	Coughing up blood	YES	NO	Bowel problems	YES	NO

Musculoskeletal			**Neurological**			**Integumentary (Skin/Breast)**		
Muscle pain or crams	YES	NO	Frequent headaches	YES	NO	Change in hair or nails	YES	NO
Stiffness/swelling joints	YES	NO	Paralysis or tremors	YES	NO	Rashes or itching	YES	NO
Joint pain	YES	No	Convulsions/seizures	Yes	NO	Breast lumps	YES	NO
Trouble walking	YES	NO	Numbness/tingling	YES	No	Breast pain or discharge	YES	NO

Endocrine			**Hematologic/Lymphatic**			**Allergic/immunological**		
Excessive thirst/urination	Yes	No	Bruise easily	YES	NO	Food allergies	YES	NO
Thyroid disease	YES	NO	Slow to heal	YES	NO	Aspirin allergies	YES	NO
Hormone problem	YES	NO	Enlarged glands	YES	NO	Antibiotic allergies	YES	NO

Genitourinary-Male			**Genitourinary-Female**			**Psychiatric**		
Blood in urine	YES	NO	Blood in urine	YES	NO	Insomnia	YES	NO
Kidney stones	YES	NO	Kidney stones	YES	NO	Confusion/memory loss	YES	NO
Sexual problems	YES	NO	Sexual problems	YES	NO	Depression	YES	NO
Testicular pain	YES	NO	Menstrual problems	YES	NO			

ADVANCED DIRECTIVES

Do you have a living will/advanced directive? **NO YES**

Do you have a Do Not Resituate document? **NO YES**

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Signed:_____ **Date:** _____

PHYSICIAN STATEMENT: I have reviewed old records. I have reviewed the questionnaire with this patient.

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Signed:_____	**Date: _____**

Patient Name (printed) _____ Date of Birth ____/____/____

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize Dr. Ranjan Mahajan, MD, PLC, in regards to my protected health information:

____To call me at work
____To call me at home
____To call my cell phone
____To speak with anyone listed on the Right To Share Information list
____To only speak with me
____To fax information to me at this secured number_____
____Other _____
(Alternative address)
_____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Dr. Ranjan Mahajan, MD, PLC, reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends please list those individuals that we are authorized to release information.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we offer this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization reviews. An example of this would be submitting a claim to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be medical review, legal services, and auditing functions.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Office Manager (Privacy Officer):

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written, complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our offices. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201
(202)619-0257 or toll free: 1-877-696-6775

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health insurance information. I understand that the office of Dr. Ranjan Mahajan has the right to change its **Notice of Privacy Practices** from time to time. I may contact this office at anything at the above address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), that I have certain rights to privacy regarding the protection of my health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand this office is not required to agree to my requested restrictions, but once agreed upon, this office is bound to abide by such restrictions. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Patient Name (Printed): _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so documented below:

Date: _____ Initials: _____ Reason: _____

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FINANCIAL POLICY

MEDICARE PATIENTS:

-We will be billing, as a courtesy, to the secondary insurance. If payment is not received within 60 days of the date of service, the payment will become the patients' responsibility

-If your secondary insurance is Blue Cross Blue Shield out of state, 20% of the total charges are to be paid prior to leaving the office on the day of service.

-If you do not have a secondary insurance, 20% of the total charges are to be paid prior to leaving the office on the day of service.

NON-MEDICARE PATIENTS:

-All co-payments are required to be paid prior to being seen by the Doctor or Nurse Practitioner.

ALL PATIENTS:

-All previous open balances are required to be paid to your next appointment. Including, but not limited to , any deductibles or non-covered services.

-In the event of a returned check, the practice will charge an additional $25 handling fee that is to be paid by cash or credit card. The practice will no longer accept personal checks for a period of one (1) year.

ACKNOWLEDGMENT:

I acknowledge that I have read and understood all aspects of Dr. Ranjan Mahajan, MD, PLC Financial Policy as stated above. I hereby accept that this Financial Policy binds me. I hereby also acknowledge that I have received a copy of above policy.

Patient Name (Printed): _____

Signature: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: _____ **Date Of Birth:** _____/_____/_____
(Please Print your Name) Last First MI

I hereby authorize:
Name: _____
(Please Print Doctor Name) Last First MI
Address: _____
City, State, Zip: _____
Phone No: (_____)_____ **Fax No: (_____)_____**

To release my medical records in your possession to:
Name: Ranjan Mahajan, MD, FACP
150 Clearwater Largo Rd, N, #2, Largo, FL, 33770
Phone No: 727 518 0822

Please fax documents to: 727 518 6511

Please send the following specific information: (Specify dates of service)
_____
_____
_____
_____
Reason for release:
_____
_____
_____

I understand records maintained on my behalf may contain information regarding the diagnosis of treatment of HIV (AIDS virus), other sexually transmitted diseases, drugs and/or alcohol abuse, mental illness or psychiatric treatment. Further, I acknowledge the information to be released may contain documentation of treatment for psychiatric, psychological, and chemical abuse including, but not limited to, drugs and/or alcohol, as well as sickle cell anemia. I give my specific authorization for these records to be released.
This release is effective for six (6) months from the date of execution, however, it may be revoked by me at any time by providing notice in writing to the above named part.

_____ _____/_____/_____
Signature of patient/parent/legal guardian Date
_____ _____/_____/_____
Signature of Witness Date

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