PATIENT REGISTRATION FORM

Advanced Digestive Disease Consultants

Deb K Mukhopadhyay M.D

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial: _____

Date of Birth:_____ Sex: M - F Phone #: _____

Home Address:_____

City:_____ State:_____ Zip:_____

Social Security #: _____

EMAIL ADDRESS:_____

Emergency Contact #(____) _____-_____

Emergency Contact Name: _____

INSURANCE INFORMATION

INSURANCE NAME:_____

SUBSCRIBER NAME:_____ SUBSCRIBER S.S #: _____

BIRTH DATE:_____/_____/_____ GROUP #:_____ POLICY #:_____

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:_____

SECONDARY INSURANCE:_____

SUBSCRIBER NAME:_____ SUBSCRIBER S.S #:_____

BIRTH DATE: _____/_____/_____ GROUP #: _____ POLICY #:_____

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:_____

REASON FOR VISIT

☐ DIARRHEA

☐ CONSTIPATION

☐ ABDOMINAL PAIN

☐ BLOATING

☐ GAS

☐ BELCHING

☐ VOMITING

☐ NAUSEA

☐ TROUBLE SWALLOWING

☐ CHOKING

☐ BLOOD IN THE STOOL

☐ ACID REFLUX

☐ ANY OTHER SIGNS OR SYMPTOMS OR REASON FOR YOUR VISIT PLEASE LIST BELOW:

_____

ALLERGIES	REACTIONS

MEDICATIONS	DOSE/MG	FREQUENCY

PATIENT HEALTH PROBLEMS

CANCER	**LIVER**	**HEART**
☐ COLON CANCER	☐ HEPATITIS A	☐ HIGH BLOOD PRESSURE
☐ STOMACH CANCER	☐ HEPATITIS B	☐ HEART ATTACK
☐ BREAST CANCER	☐ HEPATITIS C	☐ CONGESTIVE HEART FAILURE
☐ LIVER CANCER	☐ CIRRHOSIS	☐ OTHER: _____
☐ OTHER: _____	☐ OTHER: _____	
RESPIRATORY	**GASTROINTESTINAL**	**ENDOCRINOLOGY**
☐ COPD	☐ LACTOSE INTOLERANT	☐ DIABETES TYPE 1
☐ ASTHMA	☐ COLON POLYPS	☐ DIABETES TYPE 2
☐ SLEEP APNEA	☐ GALLBLADDER REMOVED	☐ THYROID DISEASE
☐ OTHER: _____	☐ GERD	☐ HYPOTHYROID
	☐ APPENDIX REMOVED	☐ OTHER: _____
	☐ OTHER: _____	
BLOOD	**RENAL**	**SURGERY HISTORY**
☐ VON WILLEBRANDS	☐ KIDNEY STONE	☐ LIST BELOW: _____
☐ HEMOPHILIA	☐ KIDNEY FAILURE	_____
☐ CLOTTING	☐ DIALYSIS	_____
☐ ABNORMALITIES	☐ OTHER: _____	_____
☐ OTHER: _____		_____
		_____

HEIGHT:	WEIGHT:

SEXUAL ORIENTATION: STRAIGHT HOMOSEXUAL BISEXUAL PATIENT DECLINES TO SPECIFY

SMOKE HISTORY		ALCOHOL USE
☐ NONE	☐ VAPING	☐ YES
☐ EX SMOKER	☐ MARIJUANA	☐ NO
☐ CIGARETTES		☐ OCCASSIONALLY
☐ CHEW TOBACCO		

FAMILY HISTORY

☐ CIRRHOSIS OF LIVER	MOTHER	FATHER	OTHER:
☐ CROHN DISEASE	MOTHER	FATHER	OTHER:
☐ LIVER DISEASE	MOTHER	FATHER	OTHER:
☐ DISEASE	MOTHER	FATHER	OTHER:
☐ HEART DISEASE	MOTHER	FATHER	OTHER:
☐ COLON CANCER	MOTHER	FATHER	OTHER:
☐ CHRONIC PANCREATITIS	MOTHER	FATHER	OTHER:

☐ OTHER PLEASEE LIST HERE: _____

PHARMACY INFORMATION

NAME: _____

ADDRESS:_____ CITY:_____ STATE: _____ ZIP:_____

PHONE NUMBER:_____

NOTICE OF CANCELLATION OF CLINIC APPOINTMENTS

It is the goal of Dr Deb K. Mukhopadhyay to Provide the highest quality healthcare to our patients with the greatest efficiency possible. To obtain this goal, we require all patients to arrive for their scheduled appointment on time. We understand that occasionally appointments cannot be met or may need to change. To ensure the best care of patients, we require a 24-hour cancellation notice.

I understand the policy and agree that if an appointment is missed or canceled less than 24 hours before the scheduled Appointment time. I will personally be responsible for the coverage. The fee for missed appointments is $50.00.

SIGNATURE:_____ **DATE:**_____

PRINT NAME:_____ **DATE:**_____

THANK YOU

NOTICE OF CANCELLATION OF ENDOSCOPY APPOINTMENTS

It is the goal of Dr Deb K. Mukhopadhyay to Provide the highest quality healthcare to our patients with the greatest efficiency possible. To obtain this goal, we require all patients to arrive for their scheduled appointment on time. We understand that occasionally appointments cannot be met or may need to change.

To ensure the best care of patients, we require a 72-hour cancellation notice before scheduled EGD/colonoscopy.

I understand the policy and agree that if an appointment is missed or canceled less than 72 hours before the scheduled appointment time, I will be responsible for $ 150.00.

SIGNATURE:_____ **DATE:**_____

PRINT NAME:_____ **DATE:**_____

Release of Informations form

I hereby authorize the release of all my medical information relating to the treatment I have received. Do not release any further information to any other person(s) without my consent

REFERRING Primary Care Physician or Specialist INFORMATION

NAME:_____

ADDRESS:_____ CITY_____ STATE_____ ZIP:_____

TELEPHONE:_____ FAX#_____

Release Information To:

Deb K Mukhopadhyay, MD

Advanced Digestive Disease Consultants

653 N. Town Center DR Suite #314

Las Vegas, NV 89144

Telephone : (702) 233-0666

Fax: (702) 233-8176

Email: advanceddigest@gmail.com

Patient Information:

Patient Name**:** _____

Social Security: _____

Date of Birth:_____

I understand that if my records are released to me that pursuant to nrs code # 629.061, I will be changed a nominal dee of .60 cent per page

Signature: _____

Date:_____

HIPAA NOTICE OF PRIVACY PRACTICE

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 THIS IS IN REFERENCE TO **ADVANCED DIGESTIVE DISEASE CONSULTANTS.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information about, including demographic information, that identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may use and disclosed by your physician, our office staff and other outside of our office that are Involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and related services, This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the businesses activities to your physician's practice. These activities Include, OK but are not limited to, quality assessment activities, employee. Training of medical professionals, licensing, and conducting or arranging for other business activities. For example, we may disclose your health information to medical professionals that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your and indicate your physician. We may also call you by name in the waiting room when your physician ls ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of your appointment. we may use or disclose your protected health information in the following situations without yow authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceeding: Law Enforcement: Coroners, Funeral Director and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirement of Section 164500.

Signature:_____