



# REGISTRATION FORM

(Please Print)

Srinivas R Panja MD

Safrin Ali PA-C

Crystal Cooper, NP

Today's Date:

## PATIENT INFORMATION

Patient's last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Mr.  Miss  Marital status:  
 Mrs.  Ms. Single  Mar  Div  Wid

Patient Email: \_\_\_\_\_ Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_ Pharmacy Ph.no: \_\_\_\_\_

Is this your legal name?  Yes  No If not, what is your legal name? \_\_\_\_\_ (Former name): \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Stress address: \_\_\_\_\_ Social Security no. : \_\_\_\_\_ Cell phone no. : \_\_\_\_\_  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

P.O.box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone no. : \_\_\_\_\_  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Choose clinic because/referred to clinic by (please check one box):  Dr.  Insurance plan  Hospital  
 Family  Friend  Close to home/work  Other

Others family members seen here:

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_\_ Address (if different): \_\_\_\_\_ Cell phone no. : \_\_\_\_\_  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Is this person a patient here?  Yes  No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer address: \_\_\_\_\_ Employer phone no. : \_\_\_\_\_  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Is this person covered by insurance?  Yes  No

Please indicate primary insurance?  MEDICARE  BCBS  AETNA  CIGNA  HUMANA  
 MUTUAL OF OMAHA  UNITED HEALTHCARE  UMR  FIRST HEALTH NETWORK  OTHER

Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no. : \_\_\_\_\_ Birth date: \_\_\_\_\_ Group no. : \_\_\_\_\_ Policy no. : \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

Name of secondary insurance (if application): \_\_\_\_\_ Subscriber's name: \_\_\_\_\_ Group no. : \_\_\_\_\_ Policy no. : \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

## IN CASE OF EMERGENCY

Name of local friend or relative \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Cell phone no. : \_\_\_\_\_  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize (Name of Practice) or insurance company to release any information required to process my claims.

Patient/ Guardian signature

Date

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## Office Policies

- 1. Cancellation and No Show of Appointments:** We require a **48-hour** cancellation notice for your appointment. Failure to do so will result in a **\$25 NO SHOW** fee. Please note that **NO SHOW** fees are the patient's responsibility and will not be billed to your insurance.
- 2. Denial of Service:** If there are a total of 3 or more cancellations and no show, you will no longer be seen in the office.
- 3. Insurance:** Please update the office with your current insurance prior to your visit. This helps us to verify your insurance to confirm if we accept your insurance plan. **Deductible and copay are patients responsibility.** Failure to pay will result in delay or cancelation of an appointment with the doctor.
- 4. Front Desk:** Please update the front desk of any changes in your home address, phone number or pharmacy at the time of your check in.
- 5. Credit Card Charges:** All credit/debit card transactions will be charged 2.5% in addition to the office visit cost. To avoid the fee: we do accept cash (exact change) or check.
- 6. HMO Plan:** This plan **requires a referral form your Primary Care Physician.** Referrals are a patient's responsibility and failure to get one and update the office with a valid referral will result in a cancellation of an appointment.
- 7. Forms and Letters:** We understand that at times various forms and letters may be required to assist with your healthcare needs. Please give us 7-10 business days for completion of requested forms or letters. An administrative fee of **\$25** will be required for **ALL** the forms.

Signature .....

Date .....

DOB ...../...../.....



**NEW PATIENT HISTORY FORM- PAGE 1**

DO YOU HAVE (OR HAVE YOU HAD) ANY OF THE FOLLOWING CONDITIONS?

	YES NO			YES NO	
DIABETES			ASTHMA		
HIGH BLOOD PRESSURE EMPHY			EMPHYSEMA OR COPD		
CHOLESTEROL PROBLEM			ANEMIA		
HEART PROBLEMS			STOMACH ULCER		
STROKE			HEARTBURN		
SEIZURES			ARTHRITIS		
THYROID PROBLEMS			HIV INFECTION		
LIVER PROBLEMS			CANCER		
KIDNEY PROBLEMS			ANXIETY		
OSTEOPOROSIS			PANIC ATTACK		
BROKEN BONES			DEPRESSION		

PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU HAVE OR ANY OTHER REASON YOU SEE A DOCTOR:

PLEASE LIST ANY OPERALONSOR HOSPO ALJZATIONS YOU HAVE HAD, WHERE THESE OCCURRED, AND THE YEAR PERFORMED:

PLEASE LIST ANY MEDICATION ALLERGIES OR BAD REACTIONS 10 MEDICATIONS THAT YOU HAVE RAD

Name .....

DOB ..... / ..... / .....

PCP/Referring Physician .....

WHAT IS YOUR MARITAL STATUS? .....

HOW MANY CHILDREN DO YOU HAVE? .....

WHAT IS YOUR OCCUPATION? .....

DO YOU SMOKE?  YES  FORMER  NEVER

DRINK ALCOHOL?  YES  NO

**FAMILY HISTORY:**

	AGE IF LIVING	AGE AT DEATH	CAUSE?
MOTHER			
FATHER			
BROTHERS			
NO. LIVING			
NO. DEAD			
SISTERS			
NO. LIVING			
NO. DEAD			

HAVE ANY FAMILY MEMBERS BEEN DIAGNOSED WITH THE FOLLOWING? WHO HAS THIS?

DIABETES  YES  NO

HIGH BLOOD PRESSURE  YES  NO

HIGH CHOLESTEROL  YES  NO

HEART ATTACKS AND/OR  YES  NO

BYPASS SURGERY

STROKE  YES  NO

CANCER  YES  NO

THYROID PROBLEMS  YES  NO

KIDNEY STONES  YES  NO

OSTEOPOROSIS  YES  NO

**FOR WOMEN ONLY:**

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL CYCLE? .....

ARE YOUR MENSTRUAL CYCLE REGULAR?  YES  NO

WHAT WAS THE DATE YOUR LAST MENSTRUAL CYCLE STARTED? .....

HAVE YOU GONE THROUGH MENOPAUSE?  YES  NO AT AGE .....

HOW MANY TIMES HAVE YOU BEEN PREGNANT? .....

HOW MANY CHILDREN HAVE YOU HAD ? .....

HOW MANY MISCARRIAGES HAVE YOU HAD ? .....

PHYSICIAN NOTES :

REVIEWED BY: .....

DATE: .....



Srinivas R Panja MD  
Safrin Ali PA-C  
Crystal Cooper, NP

Tel: 713-936-2966  
www.GHEndocrinology.com

**Due to the new laws enacted by congress, we are required to have signed this consent from prior to receiving treatment.**

Do you consent to a medical examination and any procedures or tests deemed necessary by Dr. Srinivas Panja while you are in our office?  YES  NO

Do you consent to the staff releasing information about appointments and or test results to someone on your list?  YES  NO

Do you consent to the staff leaving messages on an answering machine or voice mail system regarding appointments and or test results?  YES  NO

Do you consent to our office mailing you bills to your home?  YES  NO

Please list the names of the person or persons to whom we can discuss medical information with:

NAME	RELATIONSHIP
.....	.....
.....	.....
.....	.....

Signature ..... Date ..... Print Name .....

If you wish this consent to be effective indefinitely or until you have revoked it please Initial here .....

If not initialed you will have to do a new form every time you visit.  
You may revoke this consent at any time. By revoking consent you will receive no further treatment from this office.





**This notice describes how medical/protected health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**Summary:** By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how can obtain access to this information.

As a patient, you have following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

EFFECTIVE DATE OF THIS NOTICE	
CONTACT PERSON	OFFICE OF Dr. PANJA
PHONE NUMBER	713-936-2966

### Acknowledgement of Notice of Privacy Practices

" I here acknowledge that I have received a copy of this practice's NOTICE OF **PRIVACY PRACTICES**.

I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified or changed in any way."

.....  
Patient or Representative Name (please print)

.....  
Patient or Representative Signature

.....  
Date

