North Highland Medical
611 North Highland Avenue
Murfreesboro, TN 37130

PATIENT REGISTRATION

(PLEASE PRINT)

Requesting to be the patient of: Satyen S. Saraswat DATE:_____

NAME:_____ GENDER:_____

SOC. SEC. NUMBER:_____ BIRTHDATE:_____

ADDRESS:_____ EMAIL:_____

CITY:_____ ZIP CODE:_____

TELEPHONE:_____ OCCUPATION:_____

EMPLOYED BY:_____ PHONE:_____

EMPLOYERS ADDRESS:_____

IN CASE OF EMERGENCY: Name and Phone Number_____

ARE YOU: MARRIED_____SINGLE_____WIDOWED_____DIVORCED_____

NAME OF SPOUSE:_____ BIRTHDATE:_____

EMPLOYED BY:_____ PHONE:_____

EMPLOYERS ADDRESS:_____

INSURANCE: DO YOU HAVE A MEDICARE ADVANTAGE OR HMO INSURANCE?

Primary Insurance:_____

Subscriber Name:_____ Date of Birth:_____

Subscriber ID:_____ Group Number:_____

Relationship to Subscriber:_____ Subscriber SSN#:_____

Secondary Insurance:_____

Subscriber Name:_____ Date of Birth:_____

Subscriber ID: _____ Group Number:_____

Relationship to Subscriber:_____ Subscriber SSN#:_____

You may contact me by telephone regarding appointments, billing questions, test results, or other health related information.

YES_____NO_____

You may leave a message for me on an answering machine or voicemail.

YES_____NO_____

I authorize you to discuss appointment matters and health status with the following individuals:

1. Name:_____ Phone:_____
2. Name:_____ Phone:_____
3. Name:_____ Phone:_____

I authorize you to discuss my billing matters with the following individuals:

1. Name:_____ Phone:_____
2. Name:_____ Phone:_____
3. Name:_____ Phone:_____

Preferred pharmacy w/ address or phone number

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)*, I have certain rights to privacy regarding my protected 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 have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* at any time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is uses or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Response to the following section is optional but requested by insurance companies

RACE: American Indian or Alaskan Native_____ Caucasian_____ Hispanic_____
African American_____ Pacific Islander_____ Other_____
ETHNICITY: Hispanic or Latino_____ Non-Hispanic or Latino_____
LANGUAGE: English_____ Spanish_____ Korean_____ Hindi_____ Other_____

Patient Name:_____
Patient Signature:_____
Date:_____

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Please read and initial each section.

Suresh C. Saraswat, M.D., P.C. appreciates the confidence you have shown in choosing us to provide for your healthcare needs. We aim to offer the best quality medical care to all our patients. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Thank you for your understanding and cooperation in this matter.

Co-Pay & Deductible Policy

1. You are responsible for payment of any co-pays/coinsurance/deductible as determined by your insurance carrier. **We expect these payments at the time of service**. Payment of all co-pays/coinsurance/deductibles is expected at the time the service is rendered for the patient.
2. Many insurance companies have additional stipulations that may affect your coverage. **It is ultimately the patient's responsibility to know their coverage and benefits**. You are responsible for any amounts not covered by your insurance carrier. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your remaining balance.
3. I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all collection fees, court costs, attorney fees, and any other charges incurred in the collection of any balance due.

I have read the above policy regarding my financial responsibility to Suresh C. Saraswat, M.D., P.C. for providing medical services to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Suresh C. Saraswat, M.D., P.C. the full amount of the bill incurred by the above named patient with the agreement that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

Patient Name Date

Signature

If you cannot make full payment at the time of service you will need to meet with the insurance manager to see about other arrangements.

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Patient Name: _____ DOB: _____

MEDICAL HISTORY

Please check if you have or have had any of the following:

GENERAL
___Weight Gain/Loss
___Fatigue
___Fever/Chills
___Weakness
___Trouble Sleeping

SKIN
___Rashes
___Lumps
___Itching
___Dryness
___Color Changes
___Hair/Nail Changes

HEAD
___Headache
___Head Injury
___Neck Pain

EARS
___Decreased Hearing
___Ringing in Ears
___Earache
___Drainage

CARDIOVASCULAR
___Chest Pain/Discomfort
___Tightness
___Short of Breath w/Activity
___Difficulty Breathing While Laying Down
___Swelling

GASTROINTESTINAL
___Difficulty Swallowing
___Heartburn
___Changes in Appetite
___Nausea
___Change in Bowel Habits
___Rectal Bleeding
___Constipation
___Diarrhea
___Yellow Eyes or Skin

EYES
___Vision Loss/Changes
___Glasses/Contacts
___Pain
___Redness
___Blurry/Double Vision
___Flashing Lights
___Specks
___Glaucoma
___Cataracts

NOSE
___Stuffiness
___Discharge
___Itching
___Hay Fever
___Nose Bleeds
___Sinus Pain/Pressure

NECK
___Lumps
___Swollen Glands
___Pain
___Stiffness

URINARY
___Frequency
___Urgency
___Burning/Pain
___Blood in Urine
___Incontinence
___Change in Urinary Strength

NEUROLOGIC]
___Dizziness
___Fainting
___Seizures
___Weakness
___Numbness
___Tingling
___Tremor

THROAT
___Bleeding
___Dentures
___Sore Tongue
___Dry Mouth
___Sore Throat
___Hoarseness
___Thrush
___Non-healing Sores

RESPIRATORY
___Cough
___Sputum
___Coughing up Blood
___Short of Breath
___Wheezing
___Painful Breathing

VASCULAR
___Calf Pain W/ Walking
___Leg Cramping

ENDOCRINE
__Heat/Cold Intolerance
___Sweating
___Frequent Urination
___Thirst

PSYCHIATRIC
___Nervousness
___Stress
___Depression
___Memory Loss

HEMATOLOGIC
___Ease of bruising/bleeding

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Patient Name:_____ Date of Birth:_____

Are you allergic to any medications? Y N

If yes please list medication and the reaction you had

_____

_____

Is this visit workers comp related? Y N

Is this visit related to an auto accident? Y N

Is this visit related to disability? Y N

Do you smoke? YES NO If yes, how much?_____How long?_____

Do you drink alcohol? YES NO If yes, how often?_____

Do you have a living will? YES NO

Please list the reason for your visit today and ALL symptoms_____

_____

_____

When did your symptoms start? (Please give exact date if possible)_____

Last Menstrual Period_____Last Pap smear_____

When was your last annual physical? (Please give exact date if known)_____

When was your last tetanus shot? (Please give exact date if known)_____

Are you currently on any medication? YES NO If yes, please list ALL your medications and dosages. Please include over the counter/natural/herbal medications as well_____

_____

_____

Have you had any past surgeries/hospitalizations? YES NO If yes, please list with dates_____

_____

_____

FAMILY HISTORY

Father (circle one) Living/Deceased Siblings (circle one) Living/Deceased

Mother (circle one) Living/Deceased Children (circle one) Living/Deceased

Please indicate your family medical history :(parents, grandparents, siblings, children)

Alcohol Abuse Anemia Arthritis Asthma Bladder Problems

Bleeding Disease Breast Cancer Colon Cancer Depression Diabetes Heart Disease

High Blood Pressure High Cholesterol Kidney Disease Lung/Respiratory Disease

Migraines Osteoporosis Rectal Cancer Seizures Severe Allergy Stroke/CVA

Thyroid Problems Other Cancer (please specify) _____

**Mother, Grandmother or Sister developed heart disease before age 65

**Father, Grandfather or Brother developed heart disease before age 55