PERMIAN GASTROENTEROLOGY, P.A.
MRUNAL C. PATEL, M.D. GOVIND B. PATEL, M.D.
DIPLOMATE AMERICAN BOARD OF
INTERNAL MEDICINE AND GASTROENTEROLOGY
PRACTICE LIMITED TO GASTROENTEROLOGY

REGISTRATION FORM

Referred by : _____ Todays Date _____

PATIENTS'S INFORMATION

Patient Legal Name:
First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

Telephone # _____ Cell # _____

Date of Birth _____ Sex _____ Martial Status _____

Social Security Number _____

Full or Part Time Student _____

EMPLOYERS INFORMATION

Employer Of (Circle one) Patient, Guarantor, Student
Employer's Name _____

Employer's Address _____ Telephone _____

City _____ State _____ Zip _____

EMERGENCY CONTACT (NEED TWO)

In case of emergency, please contact #1 _____
Relationship to Patient _____
Phone number of Contact _____

2 contact _____
Relationship to Patient _____
Phone number of Contact _____

INFORMATION ON BACK

4214 ANDREWS HWY. STE. 203 MIDLAND, TEXAS 79703 TELEPHONE: (432) 697-1000 FAX: (432) 697-6000

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PRIMARY INSURANCE INFORMATION

Name of Insurance Company_____

Group Number _____ Policy #_____

SUBSCRIBER INFORMATION

Name _____

Address _____ Telephone_____

Policyholder Date of Birth _____

Policyholder Social Security # _____

Policyholder Employer _____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company_____

Group Number _____ Policy #_____

Policyholder Name _____

Policyholder Date of Birth _____

Policyholder Social Security # _____

Employer Name _____

ASSIGNMENT OF BENEFITS – RELEASE OF MEDICAL INFORMATION

I request that payment of my Insurance Benefits to be made on my behalf to PERMIAN GASTROENTEROLOGY, P.A., for any services furnished me by PERMIAN GASTROENTEROLOGY, P.A.

Signed _____ Date _____

I authorize the release of medical information for the purpose of processing my medical claim. I understand that I am financially responsible for any balance not covered by my Insurance Carrier.

Signed _____ Date_____

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Name: _____ Date of Birth _____

Occupation : _____

Drug Allergies _____

List of all medications you take including prescription & over-the-counter medicines.

Medication Name & Strength	How Many?	How Often ?	How long have you taken it?

Check any of these illnesses you have ever had:

_____High Blood Pressure	_____ Anemia	_____Thyroid Problems
_____Heart Attack	_____Bleeding Tendency	_____Breast Problems
_____Heart Disease	_____Blood Transfusion	_____Mental Problems
_____High Cholesterol	_____Pneumonia	_____Seizures
_____Rheumatic Fever	_____ Tuberculosis	_____Arthritis/Gout
_____Diabetes	_____ Emphysema	_____Psoriasis
_____Strokes	_____ Diverticulosis	_____Venereal Disease
_____Cancer	_____ Hepatitis	_____ HIV/AIDS

List below and **OPERATIONS** You have had YEAR

_____ _____

_____ _____

Your last ***COLONOSCOPY*** _____

Your last FLEXIBLESIGMOIDOSCOPY _____

HAVE YOU SEEN ANY OTHER GASTROENTEROLOGIST IN THE AREA ? _____

4214 ANDREWS HWY. STE. 203 MIDLAND, TEXAS 79703 TELEPHONE: (432) 697-1000 FAX: (432) 697-6000

Do you drink coffee or tea? _____ How much? _____

Do you drink alcoholic beverages? _____ How much? _____

If you quit drinking alcohol, when did you quit? _____

How much did you drink prior to quitting? _____

Do you use any tobacco products? YES NO (If yes, fill in the next line)

_____cigarettes/cigars/pipe/chew per day for _____years

If you quit, when did you quit? _____ (Fill in above for usage prior to quit

Have you ever use illegal drugs? YES NO

Have you ever had a blood transfusion? YES NO

Do you have any tattoos? YES NO

Are any parts of your body pierced? YES NO

Are you sexually active? YES NO

FAMILY HISTORY - Check any of these that a blood relative has had.

_____ Diabetes _____ High Blood Pressure _____ Heart Trouble _____ St

_____ Cancer - If yes, what kind of cancer? _____

_____ Any other serious illness – please specify_____

	If Living		If Deceased	
	Age	Any Illness?	Age of Death	Cause of Death
Father				
Mother				
Brother				
Sister				
Spouse				
Children				
Children				
Children				
Children				

Note: This is a confidential record of your medical history and it will be kept in this office. Information contain herein will not be released to any person except when you have authorized it.

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HIPAA NOTICE OF PRIVACY PRACTICES

PERMIAN GASTROENTEROLOGY, P.A.
4214 ANDREWS HWY, STE 203
MIDLAND, TX 79703
432-697-1000

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

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others 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 any 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is 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 your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, 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 the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature_____ Date_____

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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