PATIENT REGISTRATION FORM

**Today's Date: _____ Clinic Name: RUPI MANN M.D

PATIENT INFORMATION: (Please use full legal name, no nicknames)

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

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: _____ Marital Status: _____ Drivers Lic#: _____

*Employer Name and Address: _____

_____ Work Phone #: (_____) _____-_____

E-mail Address: _____ Cell Phone #: (_____) _____-_____

Emergency Contact Name: _____ Emerg Phone #: (_____) _____-_____

Please tell us how you heard about us: _____ *Referred by* _____

GUARANTOR INFORMATION: (List person or insured name responsible for bill - use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

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

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (_____) _____-_____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address: _____

_____ Work Phone #: (_____) _____-_____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ Eff Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

Plan Name : _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy / ID #: _____ *Group #: _____ * Eff Date: _____

Claims Address & Phone: _____

*REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.

Please read and sign back of form.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: _____ **Date of Birth:** _____
First Name M.I. Last Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to RUPINDER K MANN p or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MedicalEdge is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to RUPINDER K MANN p or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of the RUPINDER K MANN M.D : Information Privacy Policy. I hereby authorize RUPINDER K MANN or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authoriz RUPINDER K MANN M.D representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying RUPINDER K MANN p to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my MedicalEdge physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME (Please Print): _____

Print Form

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____Date of Birth_____

Address:_____

Phone Number:_____Treatment dates from:_____to_____

I authorize: (enter your current physician's information)

_____

_____

_____

To release copies of my medical records to: (enter your new physician)

RUPINDER K MANN M.D. 72047 DINAH SHORE DR. STE C4 RANCHO

MIRAGE, CA. 92270 PHONE # 760 770- 7600 FAX # 760 770-0500

I authorize release of information of the following portions of my medical record:

_____Mental Health _____HIV/AIDS

_____Substance Abuse _____Communicable Disease

_____All _____Only the following:_____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release **Rupinder Mann, MD** D from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative)_____Date:_____

Relationship to Patient:_____Witness:_____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of thezzerson to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Rupinder K Mann M.D (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date

RUPINDER K. MANN, M.D.

Board Certified in Internal Medicine and Geriatrics

Attention:

I, _____ acknowledge that the following information was shared with me. I understand that if I have an Advance Directive and/or a Power of Attorney in place, I will provide a copy of these documents to Dr. Mann's Offices.

Patients are advised to do an Advance Health care planning including: Advance directive, and a Power of Attorney assignment.

Patients are advised to do an annual Eye exam and Glaucoma screening.

If you have any questions feel free to discuss them with Dr. Mann.

Thank you kindly.

Signature: _____ Date: _____

RUPINDER K. MANN, M.D.

Board Certified in Internal Medicine and Geriatrics

To our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit/debit card, which is imprinted and is an alternative used to pay your bill.

This is an advantage for both you and the hotel or car rental company, since it makes checkout faster, easier, and more efficient.

We have implemented a similar policy, effective August 1, 2015. You will be asked for a credit/debit card number at the time you check in and the information will be held securely until your insurance company has paid its portion and notify us of the amount of your share. At that time, our office will make an attempt to contact you to inform you of your insurance company's determination of payment. If we do not hear from you within 90 business days, we will proceed to charge your credit/debit card for any remaining balance owed by you.

This will be an advantage for you, since you will no longer have to write out and mail us checks. It will be an advantage for us as well, since it will greatly decrease the numbers of statements that we have to generate and send out. The combination will benefit everyone in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask for the Office Administrator.

Thank you,

Rupinder K. Mann, M.D.

Signature: _____

SS#: _____

Address: _____ Zip: _____

Type of Credit/Debit card (please circle one): Visa Master Card Discover

Credit/ Debit Card Number: _____

Exp: (month/year): _____/_____ Security code: _____

Card holder name (please print): _____ Date: _____

Card holder Signature (if different from patient): _____

Please be prepared to show credit/ debit card to out registration clerk

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A2663B 10-04-2005

RUPINDER K. MANN, M.D.
72-047 Dinah Shore, Ste. C4
Rancho Mirage, CA 92270
Phone 760-770-7600 Fax 760-770-0500

Name _____ Date _____

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? ☐ No ☐ Yes
Feeling down, depressed or hopeless? ☐ No ☐ Yes

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ **No problems**

Skin
___ New or change in mole
___ Rash / itching
___ **No problems**

Breast
___ Breast lump / pain / nipple discharge
___ **No problems**

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears
___ **No problems**

Eyes
___ Change in vision / eye pain / redness
___ **No problems**

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)
___ **No problems**

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion
___ **No problems**

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ **No problems**

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___ Concern with sexual function
___ **No problems**

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain _____
___ **No problems**

Endocrine
___ Heat or cold sensitivity
___ **No problems**

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ **No problems**

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ **No problems**

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
___ **No problems**

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ **No problems**

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ **No problems**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

☐ TAKE NO MEDICATIONS

Medication | Dose (e.g. mg/pill) | How many times per day?

_____

_____

_____

Allergies or intolerance to medications (include type of reaction): _____

_____ ☐ NONE

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date _____	Abnormal?	☐ No	☐ Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	☐ No	☐ Yes
Women only:				
Mammogram	Date _____	Abnormal?	☐ No	☐ Yes
Pap Smear	Date _____	Abnormal?	☐ No	☐ Yes
Bone Density Test	Date _____	Abnormal?	☐ No	☐ Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? ☐ NONE

Condition	*Current*	*Past*	*Comments*
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema			
Fractures (broken bones)			Where?
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			

PERSONAL MEDICAL HISTORY Continued: *Condition*		*Current*	*Past*	*Comments*
Gout				
Gynecological Conditions (Endometriosis)				
Gynecological Conditions (Fibroids)				
Gynecological Conditions (Other)				
Heart Attack				
Hepatitis – Type A				
Hepatitis – Type B				
Hepatitis – Type C				
Hepatitis – Other				
High Blood Pressure				
High Cholesterol				
Hip Fracture				
Irritable Bowel Syndrome				
Kidney Disease / Failure				
Kidney Stones				
Liver Disease				
Migraine Headaches				
Osteoporosis				
Pneumonia				
Prostate (enlargement)				
Prostate (nodules)				
Seizure / Epilepsy				
Skin Condition (Eczema)				
Skin Condition (Psoriasis)				
Skin Condition (Abnormal Moles)				
Sleep Apnea				
Stomach Ulcer				
Stroke				
Thyroid (Nodule)				
Thyroid High (Overactive) / Hyperthyroidism				
Thyroid Low (Underactive) / Hypothyroidism				
Other (list)				
Other (list)				

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications. ☐ NONE

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued: *Surgical Procedure*	*Code*	*Yes*	*Year*	*Comments*
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use
Smoke cigarettes: ◻ Never ◻ No ◻ Yes
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: ◻ Pipe ◻ Cigar ◻ Snuff ◻ Chew

Alcohol Use
Do you drink alcohol? ◻ No ◻ Yes
# of drinks/week: _____ ◻ Beer ◻ Wine ◻ Liquor

Drug Use
Do you use marijuana or recreational drugs? ◻ No ◻ Yes
Have you ever used needles to inject drugs? ◻ No ◻ Yes

Sexual Activity
Sexually involved currently: ◻ No ◻ Yes
Sexual partner(s) is/are/have been: ◻ male ◻ female
Birth control method (circle below all that apply): ◻ None needed
Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? ◻ Yes ◻ No
What kind of exercise? _____

_____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? ◻ Good ◻ Fair ◻ Poor
Would you like advice on your diet? ◻ No ◻ Yes

Safety: Do you use a bike helmet? ◻ No bike ◻ Yes ◻ No
Do you use seatbelts consistently? ◻ Yes ◻ No
Does your home have a working smoke detector? ◻ Yes ◻ No

If you have guns in your home, are they locked up?
◻ Not applicable ◻ Yes ◻ No
Is violence at home a concern for you? ◻ No ◻ Yes

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) ◻ Yes ◻ No

SOCIAL HISTORY:

Occupation (or prior occupation): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: _____ Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

_____

_____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Thank-you for taking the time to fill this out.