Terracina Surgical Arts

295 Terracina Blvd Redlands, CA 92373
Phone: (909) 798-9950 Fax: (909) 798-9958

Anil Punjabi MD DDS

Name:_____Address:_____Today'sDate_____

City:_____State:_____ZipCode:_____

Hm #_____ Wk #_____Cell #_____Email:_____

Which phone number would be best for us to reach you? Hm Wk Cell

Age: _____Birthdate:_____Social Security #:_____Sex: F M Marital Status: S M W Sep D

DriversLicense_____Occupation:_____Employer_____

WorkAddress:_____City:_____State:_____Zip Code_____

Spouse's name _____ Wk#_____Cell#_____

Nearest Relative/Friend_____Phone:_____Address:_____

Person Financially Responsible: ____ Patient ___ Parent ___ Other:_____

If Parent or Other, please complete the following:

Name:_____Relationship to patient:_____Phone #:_____

Address:_____Age: _____Birthdate:_____Social Security #:_____

Employer:_____Employer's Phone #_____

Employer's Address:_____
Street City State Zip Code

INSURANCE INFORMATION:
Primary Insurance:_____Policy #_____Group #_____

Secondary Insurance:
_____Policy#_____Group#_____

Name of Subscriber:_____Subscriber's DOB: _____

Subscriber's Social Security #:_____ Relationship to You:_____

REASON FOR CONSULTATION:_____

REFERRED BY:_____

The undersigned hereby consents to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier for rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process my insurance claim.

_____ _____-
_____

Patient's Signature **Parent or Guardian's Signature**

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Summary of Notice of Privacy Practices

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.

What is this Notice and Why is it Important?

By law, physicians and their nurses and other clinical personnel, are required to protect the privacy of your identifiable medical and other health information (protected health information).

Physicians are also required by law to give you this notice to tell you how we may use and give out ("disclose") your protected health information. We must follow the terms of this notice when using or disclosing your protected health information. We are required to obtain your permission before using or disclosing your protected health information, except as described below.

How May We Use Your Protected Health Information?

Physicians generally are required to obtain your written authorization ("permission") before using your protected health information. This section explains those situations where, under federal law, physicians may use or disclose your protected health information without your permission.

- **Treatment:** We use and disclose your protected health information to health care services to you. This includes uses and disclosures to:

    1. treat your illness or injury, or
    2. contact you to provide appointment reminders, or
    3. give you information about treatment alternative or other health related benefits and services that may interest you.

- **Payment:** We may use and disclose your protected health care information for our health care services that we or others provide to you. This includes uses and disclosures to:

    1. submit and obtain payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payor), or
    2. verify that your payor will pay for your health care.

- **Health Care Operations:** We may use and disclose your protected health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care that you we provide you. This also includes uses and disclosures to:

    1. evaluate the quality and competence of our nurses and other health care workers,
    2. train staff and administrative personnel, or

3. identify health related services and products that may be beneficial to your health and then contact you about the services and products

We may also disclose your protected health information to third parties to assist us in these activities, but only if they agree in writing to maintain the confidentiality of your health information. We may also disclose your protected health information to your health care providers to enable them to conduct their own quality reviews, compliance activities and other health care operations.

In addition, we may use and disclose your protected health information under the following circumstances:

- **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your protected health information to relatives, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in and general condition. If you object to such disclosures, please notify Dr. Punjabi or his staff.

- **Branches of Federal and Local Government:** As required by law, we may disclose your protected health information to appropriate government offices including, but not limited to, Department of Public Health, U.S. Food and Drug Administration (FDA), Medicare and Medical, law enforcement officials or judicial/administrative proceedings, such as in response to a subpoena.

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE, WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US WRITTEN AUTHORIZATION.

Your Rights Regarding Your Health Information

Right to Request Access to Your Health Information: You may request access to your medical record file and billing records in order to inspect and request copies of the records. All requests for access must be made in writing.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical records file or billing records. All requests for amendments must be in writing. We will comply with your request unless we believe that the information to be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing and sent to our office.

Right to An Accounting of Disclosures of Your Health Information: Upon written request, you may obtain an accounting of certain disclosures of health information made by us (other than for treatment, payment or health care operations and for any disclosures made pursuant to your authorization). The period of your request cannot exceed six years and does not apply to disclosures that occurred prior to August 13, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable fee.

Right to Request How Information is Provided to you: You may request, and we will try to accommodate, any reasonable written request for you to receive protected health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the Use of Your Health Information: You may request that we restrict the use of disclosure of your protected health information. All requests for such restriction must

be made in writing. While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction and it is our policy not to agree to such restrictions.

Right to Change Terms of This Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all protected health information that we hold, including any information created or received prior to using the new notice. If we change this notice, we will post the revised notice in our practice area. You may also obtain any revised notice by contacting our office.

ANIL PUNJABI MD DDS
Board Certified
American Board of Plastic Surgery
American Board of Oral & Maxillofacial Surgery

PLEASE SIGN AND DATE BELOW TO INDICATE THAT YOU HAVE RECEIVED A COPY OF YOUR HIPPA PRIVACY NOTICE. Your signature simply acknowledges that you received a copy of this notice.

_____
Print Name (Last, First, Middle Initial)

_____
Signature

_____
Date

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I understand that Dr. Punjabi is licensed and regulated by the Medical Board of California.

_____
Signature

_____
Date

Terracina Surgical Arts

Anil P. Punjabi MD DDS

About Financial Arrangements And Insurance

We are committed to providing you with the best possible care. If you have medical/dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

As a courtesy Dr. Punjabi's staff will file a claim form to your insurance, but you are financially responsible for the services rendered for yourself or the above patient regardless of your insurance. Payment for services is **due at the time services are rendered** unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa and a payment plan w/ CareCredit, which allows you to make flexible, low monthly payments, and has interest free options. **Upon credit approval** for the payment plan, you can charge your treatment immediately.

I will be paying my estimated co-pays by: [ ] Cash [ ] Visa/Mastercard
[ ] Check [ ] CareCredit

There will be a charge of $20.00 for return checks. Balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ % per month. We reserve the right to charge $25.00 for cancelled or broken appointments without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable.
3. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical and dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature:_____ Date:_____

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Anil Punjabi MD DDS

Medical History

Name_____Date of Birth_____Age____

Occupation/Job Title_____

Name/Phone Number of Private Physician_____
Name/Phone Number of Dentist_____

Height_____Present Weight_____

The following information is necessary to help your physician make important decisions regarding your medical care. Please answer the questions thoroughly.

CHIEF COMPLAINT (*Explain why you are here to see the doctor)* Are you ☐ Right Handed ☐ Left Handed

_____
_____
_____

HISTORY OF PRESENT ILLNESS/PROBLEM
(Explain how the problem/illness started, has progressed and what your goals are.)

_____
_____
_____
_____

PAST MEDICAL HISTORY Do you have (or have you had): *(Explain in the space available)*

yes	no		yes	no		yes	no	
☐	☐	Diabetes	☐	☐	Sleep Apnea	☐	☐	Blood Clotting Problem
☐	☐	Hyperthyroidism	☐	☐	Asthma	☐	☐	Deep Venous Thrombosis
☐	☐	Hypothyroidism	☐	☐	Pneumonia	☐	☐	PulmonaryThromboembolism
☐	☐	Hypertension	☐	☐	Valley Fever	☐	☐	Mental Illness
☐	☐	Heart Disease	☐	☐	Tuberculosis	☐	☐	HIV or AIDS
☐	☐	Vascular Disease	☐	☐	Emphysema/Bronchitis	☐	☐	Neurologic Disease
☐	☐	Heart Attack	☐	☐	Kidney Stones	☐	☐	Peripheral Neuropathy
☐	☐	Hepatitis/Jaundice	☐	☐	Urinary Tract Infection	☐	☐	Myasthenia Gravis
☐	☐	Liver Disease	☐	☐	Renal Failure	☐	☐	Amyotrophic Lateral Sclerosis
☐	☐	Stomach Ulcers	☐	☐	Cancer (type of cancer)	☐	☐	Multiple Sclerosis
☐	☐	Gastroesophageal Reflux			_____	☐	☐	Stroke
☐	☐	Arthritis				☐	☐	Rheumatic Heart Disease
☐	☐	Mitral Valve Prolapse	☐	☐	Heart Murmur	☐	☐	Artificial Hip/Knee joint Replacement
☐	☐	Damaged/Artificial Heart Valve						
☐	☐	Congenital/Inborn Heart Defect						

☐	☐	Seizures

Other (Not mentioned above)_____

_____

Patient Name_____ **Date**_____

PREVIOUS SURGERIES ☐ NONE
(*check all that apply; indicate the year of the surgery)*

☐ Cosmetic (Please list)_____

_____

☐ Ear
☐ Oral Surgery
☐ Tonsils
☐ Neck
☐ Nasal
☐ Sinus
☐ Eye (Type of surgery)_____
☐ Eyelid
☐ Breast
☐ Back
☐ Joints (*please list which)*

☐ Gallbladder
☐ Appendectomy
☐ Hemorrhoid
☐ Colon
☐ Gastric Bypass
☐ Hernia
☐ Stomach
☐ Hysterectomy
☐ C-Section
☐ Coronary Artery Bypass
☐ Carotid Bypass
☐ Peripheral Vascular

Others *(Please list)*

_____

_____

yes no
☐ ☐ Have you or a family member ever had a problem with anesthesia? Who?_____
What type of problem?_____

_____

PREVIOUS ACCIDENTS/INJURIES *(Indicate if work related)*_____

_____

_____

HOSPITALIZATIONS/EMERGENCY ROOM VISITS *(within the last year)*_____

_____

_____

MEDICATIONS ☐ NONE ☐ BIRTH CONTROL PILLS
List any current or recent medications. **INCLUDE THE DOSAGE.** Use the back of the page if necessary.

Medicine	Dosage

Do you take any of the fallowing homeopathic products or dietary supplements?

yes	no		yes	no		yes	no		yes	no	
☐	☐	St. John's Wart	☐	☐	Garlic	☐	☐	Echinacea	☐	☐	Metabolife
☐	☐	Vitamin E	☐	☐	Melatonin	☐	☐	Valerian	☐	☐	Diet Pills_____
☐	☐	Bilberry	☐	☐	Ephedra	☐	☐	Ginkgo biloba	☐	☐	Other:_____
☐	☐	PC-SPEC	☐	☐	Licorice root	☐	☐	Cayenne			
☐	☐	Yohimbe	☐	☐	Ginger	☐	☐	Aloe			

☐ **Yes** ☐ **No** Do you need to take antibiotics prior to any dental or surgical procedure?

☐ ☐ **Do you understand that any of these products must be discontinued 2 weeks prior to surgery to avoid complications?**

Patient Name_____ **Date**_____

ALLERGIES ☐ NONE
LATEX ALLERGIES ☐ YES ☐ NO

List any medications allergies. INCLUDE WHAT HAPPENS TO YOU when you take this medication.

Medication	Side Effects/Allergic Reaction

SOCIAL HISTORY

Occupation:_____How long?_____

Workers Compensation patients: Detail your job duties on the back of this page.

Are you presently single, married, separated, divorced, or widowed? *(Circle)*

Smoking:_____packs per day. How may years?_____
☐ Previously smoked up to _ packs per day; date quit_____ ☐ Never Smoked

Alcohol consumption: _____ drinks per (day / week / month) of (beer / wine/ liquor) *(Circle)*
Do you use, or have you used, any recreation drugs? ☐ Yes ☐No *(List)*_____

REVIEW OF SYSTEMS *(Explain in the space available any yes answers)*

List changes in weight, appetite, and energy level; recent chills, fever, and night sweats_____
_____

HEENT

yes	no		yes	no	
☐	☐	Dry Eyes	☐	☐	Hearing Changes
☐	☐	Obstructed Vision	☐	☐	Vision Changes (Type)_____
☐	☐	Glaucoma	☐	☐	Glasses
☐	☐	Recent Upper Respiratory Infection	☐	☐	Contacts
☐	☐	Sinusitis	☐	☐	Dental Infection

Cardiorespiratory

yes	no		yes	no	
☐	☐	Chest Pain/Discomfort	☐	☐	Chronic Cough
☐	☐	Shortness of Breath	☐	☐	Palpitations
☐	☐	Heart rhythm problems	☐	☐	Wheezing

Breast

yes	no		yes	no	
☐	☐	Nipple Numbness	☐	☐	Breast Lump
☐	☐	Nipple Inversion	☐	☐	Back Pain
☐	☐	Breast Pain	☐	☐	Neck Pain
☐	☐	Shoulder Pain	☐	☐	Present Bra Size _____
☐	☐	Rashes Under or Between Breast	☐	☐	Anyone in the family with breast cancer?
☐	☐	Date/Result of Last Mammogram_____			Who?_____Age when diagnosed _____
☐	☐	Nipple Discharge	☐	☐	Breast fed children? How long?_____

Gastrointestinal

yes	no		yes	no	
☐	☐	Heartburn	☐	☐	Abdominal Pain
☐	☐	Nausea/Vomiting	☐	☐	Diarrhea
☐	☐	Rectal Bleeding	☐	☐	Changes in Bowel Habits

Genitourinary

yes	no		yes	no	
☐	☐	Painful Urination	☐	☐	Herpes
☐	☐	Frequent Urination	☐	☐	Syphilis
☐	☐	Blood in Urine			

Obstetrics/Gynecology

yes	no		yes	no	
☐	☐	Menopause	☐	☐	Are you now or is it possible that you are pregnant
☐	☐	Menstrual Problems	☐	☐	Are you nursing

Birth History

Number of live children _____
Number of pregnancies _____
Number of Abortions: Spontaneous_____ Therapeutic _____

Nervous System

yes	no		yes	no	
☐	☐	Seizures	☐	☐	Weakness
☐	☐	Paralysis	☐	☐	Numbness or Tingling. Where?
☐	☐	Blackouts			_____

Bleeding/Clotting Tendency *(Describe circumstances)*

yes	no	
☐	☐	Difficulty trying to clot
☐	☐	Have your required a blood transfusion?
☐	☐	Acute pain or swelling in a leg

Psychiatric

Who is your psychiatrist?_____ Who is your psychologist?_____
For what condition?_____

yes	no	
☐	☐	Have you discussed having surgery with him/her?
☐	☐	May I discuss your surgery with your psychiatrist/psychologist?
☐	☐	Does he/she have you on any medications? Which?_____

Family History Is there a family history of any of the following problems?

yes	no		yes	no	
☐	☐	Diabetes Mellitus	☐	☐	Melanoma
☐	☐	Heart Disease	☐	☐	Breast Cancer
☐	☐	Lung Disease	☐	☐	Colon Cancer
☐	☐	Kidney Disease	☐	☐	Lung Cancer
☐	☐	Bleeding Problems	☐	☐	Ovarian Cancer
☐	☐	Anesthesia Problems	☐	☐	Other Cancer:_____
☐	☐	Stroke			
☐	☐	Other Conditions: (Refer to page 1)			

Parents:

Mother	☐ Alive	☐ Deceased	Cause of death:_____
Father	☐ Alive	☐ Deceased	Cause of death:_____

All of the foregoing is true to the best of my knowledge

_____ _____
Patient Signature Date

_____
Physician's Signature Date