SHREE SUBHASH, M.D., P.C.
Adult & Pediatric Urology
Diplomate American Board of Urology

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OFFICE POLICY

HMO policy holders are required by their insurance plans to obtain proper referrals prior to an office visit to a specialist. Without a proper referral payment is due in full at the time of the visit.

HMO and PPO co-payments are due at the time of a visit.

This office accepts payments made by cash or check. We do not take credit cards.

Patients are responsible for registering with this office a phone number (s) where they can be reached during normal office hours.

Patients are responsible for notifying this office of changes in address, phone numbers and insurance.

It is the patient's responsibility to keep track of his/her appointments. Unless notification is given twenty-four hours in advance during normal office hours a charge will be made for broken appointments as follows: Office visit - $35.00, Office or Hospital procedures - $75.00. This amount will be billed to the patient, not the insurance company.

A charge of $25.00 will be made for checks returned for insufficient funds.

Patient medical records are retained for six years following the last patient encounter except records of a minor child, which are maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years regardless of the age of the child. Destruction of medical records is in a manner protecting patient confidentiality.

I have read the above office policy.

_____ _____

Name Date

_____

Signature

A copy of this signed policy will be provided upon request.

Shree Subhash, M.D., P.C.

Date_____

I wish to be contacted in the following manner (check all that apply).

____ Home telephone_____

_____ OK to leave detailed message with_____
_____ OK to leave message on answering machine
_____ Leave message with call back number only

____ Work telephone_____
Message will be left with call back number only.

____ Cell phone_____

_____ Written Communications (all correspondence by mail will be marked "Confidential")
_____ OK to mail to my home address.
_____ OK to mail to my work address.

My medical information may be discussed with or provided to:
_____
Relationship to me_____ (husband, wife, friend, etc.)

Other:_____

_____ _____
Name Signature

This form can be amended at any time. Please contact our office if you wish to make changes.

DATE_____ **REGISTRATION** **SHREE SUBHASH. M.D..P.C.**

NAME: (Last)_____(First)_____ MI___AGE____ SEX____

STREET ADDRESS:_____APT #_____

CITY:_____ STATE_____ ZIP_____

DATE OF BIRTH_____MARITAL STATUS_____

SOCIAL SECURITY #_____OCCUPATION_____

HOME PHONE #_____ WORK PHONE #_____

OTHER PHONE #_____

EMPLOYED BY_____

EMPLOYERS ADDRESS_____

NAME OF SPOUSE/ PARENT_____

SPOUSE/PARENT'S EMPLOYER_____

ADDRESS_____

PRIMARY INSURANCE_____

ID #_____ GROUP #_____

SECONDARY INSURANCE_____

ID#_____GROUP #_____

REFERRED BY_____PRIMARY CARE PHYSICIAN_____

I understand that I will be responsible for any amount of my bill not covered by my health insurance.

_____ _____
SIGNATURE OF INSURED DATE

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT_____ SOCIAL SECURITY #_____

ADDRESS_____ DATE OF BIRTH_____

HOME PHONE_____ WORK OR OTHER PHONE_____

EMPLOYER_____ADDRESS_____

I agree to be financially responsible for this account _____DATE_____
(signature)

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

(Signature) _____ Date_____

Shree Subhash, M.D.,P.C.

MEDICAL INFORMATION

Name:_____
Date:_____

What problem are you here for today?

Do you have any of the following conditions? Please answer "yes" or " no".

YES	NO	
____	____	Heart murmur or mitral valve prolapse
____	____	(If yes, do you need antibiotics prior to dental work or surgery?)
____	____	Diabetes
____	____	High blood pressure
____	____	Coronary artery disease
____	____	History of chest pain
____	____	History of heart attack
____	____	Pacemaker
____	____	History of stroke
____	____	Asthma
____	____	Pulmonary disease
____	____	Cancer

____Other_____

List any surgery you have had: or check none ( )

_____ _____
_____ _____
_____ _____

List allergies to you have to medications,latex or iodine or check none ( )

_____ _____
_____ _____

List medications you are currently taking: or check none ( )

_____ _____ _____
_____ _____ _____
_____ _____ _____

Has anyone in your family had any of these conditions ?

Prostate cancer: Yes ( ) No ( )
Kidney or bladder cancer: Yes ( ) No ( )
Kidney stone: Yes ( ) No ( )

Do you smoke? Yes ( ) No ( )
Do you alcoholic beverages? Yes ( ) No ( )
Do you jog or run? Yes ( ) No ( )