REGISTRATION FORM

Today's Date: ____/____/____ PCP: ______________________________

PATIENT INFORMATION(Please Print)

Patient's Last Name First Middle	?Mr. ?Miss ?Mrs. ?Ms	Marital Status (Circle One) Sing / Mar / Div / Sep / Wid

Name Other (Legal / Maiden if applicable)	Date of Birth	Age	Sex

Street Address City State Zip Code	Social Security	Home Phone No ( )

P.O. Box	City	State	Zip Code

Occupation	Employer	Employer Phone No. ( )

Driver's License State and No.	E-Mail Address

Primary Doctor	Referral Doctor

INSURANCE INFORMATION(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)(Please Print)

Insured Last Name First Middle	Date of Birth	Social Security

Insured Address City State Zip Code	Insured Phone No. ( )

Insured Occupation	Insured Employer and Address	Insured Employer Phone No ( )

Please Indicate Primary Insurance

?Insurance ?Medicare ?Medicaid ?Private Pay ?Other

____

Subscriber's Name	Subscriber's S.S.#	Birth Date	Group #	Policy #	Co-Pay $

Patient's Relationship to Subscriber: ?Self ?Spouse ?Child ?Other

Name of Secondary Insurance(if applicable)	Group #	Policy #

IN CASE OF AN EMERGENCY (Please Print)

Name of Friend or Relative (not living at the same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize KuldipBanwait MD or the insurance company to release any information required to process my claims.

X____

PATIENT/Guardian Signature DATE

Kuldip Banwait, MD – 800 Quail Creek Drive, Suite 101, Amarillo TX 79124 - (806) 354-9400 Fax: (806) 354-9403

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____, acknowledge that I have received a copy of Notice of Privacy Practices from the office of KuldipBanwait MD.

Patient Signature Date

Patient Legal Representative (if applicable) Date

Print Name of Legal Representative Relationship to Patient

FOR OFFICE USE ONLY

We have made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

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Name of Office Representative: ____

Date Placed in Patient Chart: ____

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CENSENT TO TREATMENT

DATE: _______________

I, ____, hereby voluntarily consent to out-patient care by KuldipBanwait MD PA encompassing routine diagnostic procedures, examinations and medical treatment including (but not limited to routine laboratory work [such as blood, urine, and other studies], taking x-rays, heart tracings, and administration of medications).

PATIENT SIGNATURE: ____

ASSIGNMENT OF BENEFITS AUTHORIZATION, RELEASE, AND LIABILITY

a. I hereby authorize the release of any medical information including the diagnosis and the treatment or examination redered to me during the period of such care to third (3rd) party payer to process this claim and /or other health practitioners. Moreover, I authorize the holder of my medical records to release a CMS/ Centers for Medicare & Medicaid Services and its agents any information to determine these benefits payable for related services.
b. I certify that the information given ny me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize and request Medicare or other insurance company benefits be made on my behalf directly to the doctor or doctors group, otherwise payable to me for any services furnished by him.
c. I further understand that my insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or me dependents. Moreover, I agree to pay for any services that are rendered if my insurance denies them for any reason.

PATIENT SIGNATURE: ____

PLEASE LIST BELOW THE PHARMACY YOU WOULD LIKE TO USE:

____

____

Phone #: ______________________________

Mail In:

____

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PERMISSION TO LEAVING RESULTS

In the event that there is lab, pathology results, or post procedure follow-up calls for the physicians, or his staff, please specify how this office may leave messages, (example: Machine, or designated relative).

I give my permission for this office to leave lab, pathology results, or post procedure follow-up calls as follows:

- ○ Myself only
- ○ My spouse
- ○ Anyone who answers the telephone
- ○ My answering machine
- ○ Other ______________________________

Signature of Patient: _______________________________________Date: _______________________

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Date: _____________________________

Name: ____**DOB**:______________**Age**:_________**Sex**:________

Reasons for Consultation:____

____

____

____

Past Medical History: (check all that apply)___Hypertension ____Heart Disease ___High Cholesterol ___Stroke___Asthma/Emphysema/Bronchitis___Seizures ____Depression ___Diabetes ___Thyroid Disease

___Cancer a)Colon b)Lung c)Prostrate d)Breast e)Others____

Past Surgical History: ____

____

Social History: Tobacco use ____no ____ yes number of packs per week____ Number of years_____

Alcohol use ____no ____yeswhat type________________ How much__________

Family History:

Colon Cancer___Colitis___Peptic Ulcer Disease ___ Liver Disease___ Other__________________________________

Current Medications and dosage: ____

____

Drug Allergies: ____

Office Use Only

ROS: General: no weakness_______ no dizziness________ no fatigue________ CNS: no headache________

Lungs No cough ________ No SOB ________ GI: As above Musculoskeletal: No joint pain_________

CVS: No chest pain __________ No Palpitations__________ Skin: No rash_________

Genitourinary: No dysuria________ No hematuria__________ Psychiatric: No depression_________

HEENT: PERRLA EOMI

Lungs: B/L Clear

CVS: S1S2 RR________

ABD: ______________________________

____

EXT: +PIP ________ No Edema ________

CNS: AAOX 3 __________

B/P Pulse Weight

A/P____

____

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