

Mukesh C. Saraiya M.D., P.A.
3200 Colorado Blvd, Suite 200
Denton, Texas 76210
(940) 381-0971

Patients Responsibilities

- 1. At the end of each visit you will be instructed to follow up for your condition in so many day depending on your health status, therefore it is your responsibility to keep the follow up appointment or reschedule if not able to make the appointment, also notify us of any unresolved issues for earlier appointment.**
- 2. Please make sure you update us with your current demographic information such as address, phone and insurance in order for us to communicate with you in a more efficient way.**
- 3. Notify us with any medication side effects immediately.**
- 4. For medication refills call your pharmacy ahead of time during office hours so they can fax us the request.**
- 5. Prior to your visit let my office know if you had any hospital stay, or any test performed since your last visit, so we can obtain the test results to discuss it with you.**
- 6. Office hours are Monday thru Friday from 9:00 am to 5:30 pm. We will be closed from 11:30 am to 1:00 pm.**

I _____, read and accept the above responsibilities.

Signature

Date

Mukesh C. Saraiya, M.D.

Patient Registration

Name _____ Height _____ Weight _____ SS# _____

Street Address _____ Date of Birth _____ Marital Status: S M W Sep D

City _____ State _____ Zip _____

Telephone Home _____ Telephone office _____

PrimaryCarePhysician _____ ReferringPhysician _____

Spouse's Name _____

Spouse's Employer/Address _____

Emergency Contact _____ Telephone _____ Relationship _____

Patient Employer Information

Employer Name _____ Telephone _____

Employer Address _____ City/State _____ Zip _____

Patients Occupation _____

Insured Person (If not patient)

Employer Name _____ Telephone _____

Employer Address _____ City/State _____ Zip _____

Relationship to Patient _____

Insurance

Medicaid# (if applicable) _____ Medicare# (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Telephone _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Telephone _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. Mukesh Saraiya to apply for benefits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company/companies be made directly to Dr. Mukesh Saraiya (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

This is to inform you that I may be referring you to Atrium Medical Center for care. I have an investment in Atrium Medical Center. As a physician investor, I can help assure that you receive quality care.

Date _____ Signature _____

(Patient, parent, or guardian)

Allergies –List Your Allergies including any medications that caused an allergic reaction.

List ALL Allergies	Allergic reaction

Past Medical History- Please provide a complete history including all illnesses, injuries, hospitalizations and operations.

List All Illnesses, Injuries & Operations	Date	Hospital	Treatment	Physician
Immunizations/Vaccinations <input type="checkbox"/> DPT ___/___/___ <input type="checkbox"/> Measles ___/___/___ <input type="checkbox"/> Mumps ___/___/___ <input type="checkbox"/> Pneumococcal ___/___/___ <input type="checkbox"/> Smallpox ___/___/___ <input type="checkbox"/> Influenza ___/___/___ <input type="checkbox"/> Thphoid ___/___/___ <input type="checkbox"/> Polio ___/___/___ <input type="checkbox"/> Tetanus ___/___/___ <input type="checkbox"/> MMR ___/___/___ Lot#: _____	Blood Type <input type="checkbox"/> A+ <input type="checkbox"/> A- <input type="checkbox"/> B+ <input type="checkbox"/> B- <input type="checkbox"/> AB <input type="checkbox"/> AB- <input type="checkbox"/> O+ <input type="checkbox"/> O- <input type="checkbox"/> Other: _____	Blood Transfusions No. of Transfusions: _____ Date(s) Reason(s) _____ _____ _____	Last Chest X-Ray : _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Last TB Skin Test: _____ <input type="checkbox"/> Positive <input type="checkbox"/> Abnormal Last EKG: _____ Last Eye Exam: _____	

Family History- Please list all Blood Relatives with their current health status and any illnesses they have had or have.

List Blood Relatives	Health Status	Age If Living	Age At Death	Cause Of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

Social History- Please check the appropriate boxes and fill in the accurate amounts of standard portions

Mental Work:	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	Hours Per Day: _____	Number of Children: _____
Physical Work:	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	Hours Per Day: _____	
Exercise:	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	Hours Per Day: _____	Types Of Exercise: _____
Alcohol:	<input type="checkbox"/> Never	<input type="checkbox"/> Beer(s)___ Per Week	<input type="checkbox"/> Liquor __Per Week	<input type="checkbox"/> Wine ___ Per Week	How Many years: ____
Smoking:	<input type="checkbox"/> Never	<input type="checkbox"/> Current	<input type="checkbox"/> Discontinued	Type: _____	Quantity: _____ How Many Years: _____
Caffeine:	<input type="checkbox"/> None	Cups Per Day: _____	How Many Years: _____	Other: _____	
Aspirin:	<input type="checkbox"/> None	Quantity Per Day: _____	How Many Years: _____	Other: _____	
Nutritional Information:	<input type="checkbox"/> Low Sodium Diet	<input type="checkbox"/> Diabetic Diet	<input type="checkbox"/> Low Fat Diet	<input type="checkbox"/> Vegetarian Diet	<input type="checkbox"/> Low Cholesterol Diet <input type="checkbox"/> Other: _____
Miscellaneous Drugs:	<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Antacids	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Diet Pills	<input type="checkbox"/> Laxatives <input type="checkbox"/> Marijuana <input type="checkbox"/> NutraSweet
	<input type="checkbox"/> Pain Pills	<input type="checkbox"/> Saccharin	<input type="checkbox"/> Sleeping Pills	<input type="checkbox"/> Vitamins	<input type="checkbox"/> Other: _____

Mukesh C. Saraiya, M.D.

PATIENT'S FULL NAME: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

INSTRUCTIONS FOR LEAVING MESSAGES AND/ OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

- | | | | |
|--|-----|----|---------|
| OK TO GIVE INFORMATION TO SPOUSE | YES | NO | |
| OK TO LEAVE INFORMATION ON ANSWERING MACHINE | YES | NO | |
| OK TO GIVE INFORMATION TO PARENT/CHILDREN | YES | NO | |
| OK TO GIVE INFORMATION TO CAREGIVER
SPECIFY): _____ | YES | NO | (PLEASE |
| OK TO COMMUNICATE WITH ANY OTHER PERSON
(PLEASE SPECIFY): _____ | YES | NO | |
| COMMUNICATE ONLY WITH ME | YES | NO | |

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED ON WRITING.

(SIGNATURE)

(DATE)

OTHER
COMMENTS: _____

Mukesh Saraiya M.D., P.A.
And
Denton Sleep Disorders Laboratory
3200 Colorado Blvd Suite 200
Denton, Texas 76210
(940) 381-0971

Acknowledgement of Receipt of Notice of Privacy Policy

I _____ have received a copy of the Privacy Policy, and I have read them. I understand that if I have any further questions I may contact the office for further information.

Signature

Date