SAHAI SURGICAL
GENERAL COLORECTAL ONCOLOGY

TODAY'S DATE: ______________________

PATIENT NAME: ______________________
DATE OF BIRTH: ____/____/_____ AGE: ______
PRIMARY DR: ______________________
REFERRRING DR: ______________________

CHIEF COMPLAINT

____
____
____
____

PAST MEDICAL HISTORY:

	Yes	No
Heart Disease		
Hypertension		
High Cholesterol		
Diabetes Type: ______		
Stroke/TIA		
COPD		
Cancer: ______________		
Bleeding disorder		

SURGICAL HISTORY:

	DATE

DATE OF LAST COLONOSCOPY: ____________

CURRENT MEDICATION:

	DOSE

MEDICATION ALLERGIES:

	REACTION

SOCIAL/PERSONAL HISTORY:

OCCUPATION	
MARITAL STATUS	
TOBACCO?	Never ___ Former ___ Current ___ Packs/day ___
ALCOHOL?	How often: __ 0, __ 1x/mo, __ 2-4x/mo, __2-3x/wk, __4 or more/wk #/occasion: __1-2, __3-4, __5-6, __7-9, __10 or more How often >6/day: __never, __<monthly, __monthly, __weekly, __daily
PREGNANT?	Yes _______ No_______

FAMILY MEDICAL HISTORY:

	ILLNESS
FATHER Living _____ Deceased _____	
MOTHER Living _____ Deceased _____	
SIBLINGS How many _____________	

Do you have an advanced directive (living will, power of attorney, etc.)?
Yes: ______ No: ______

ROS- PLEASE CHECK ANY OF THE FOLLOWING YOU MAY HAVE HAD IN THE PAST YEAR

	Yes	No		Yes	No
Headaches			Incontinence		
Vision changes			Depression		
Hearing loss			Chest pain		
Shortness of breath			Anxiety		
Cough			Bleeding problems		
Stomach ulcer			Chills		
Blood in stool			Fever		
Diarrhea			Loss of appetite		
Constipation			Night sweats		
Bladder/kidney inf.			Skin rash		
Joint pain			Weakness		
Stiffness			Weight gain		
Swelling			Weight loss		
Dizziness					
Thyroid disease					
Anemia					

SAHAI SURGICAL
GENERAL COLORECTAL ONCOLOGY

Aalok K. Sahai, M.D. Rohit K. Sahai, M.D.

PATIENT INFORMATION FORM

DATE ______________________________ { } MARRIED { } SINGLE { } SEPARATED { } DIVORCED { } PARTNERED

PATIENT LAST NAME ____________________ **FIRST NAME** ________________ **MI** ____ SEX (PLEASE CIRCLE) M / F

AGE ______ DATE OF BIRTH ____________________ EMAIL ______________________________

ADDRESS ______________________________ CITY __________ STATE ______ ZIP ______

PHONE ____________________ CELL ________________ SOCIAL SECURITY NUMBER ____________________

EMPLOYER ______________________________ PHONE ______________ OCCUPATION ______________

SPOUSE LAST NAME ____________________ **FIRST NAME** ____________________________ **MI** ______

DATE OF BIRTH ________________ PHONE ________________ SOCIAL SECURITY NUMBER ______________

EMPLOYER ______________________________ WORK PHONE ______________________________

PRIMARY INSURANCE ____________________________________ PHONE ________________________

INSURED ____________________________ ID# ____________________ GROUP# ________________

SECONDARY INSURANCE __________________________________ PHONE ________________________

INSURED ____________________________ ID# ____________________ GROUP# ________________

PRIMARY CARE PHYSICIAN ____________________________________ **PHONE** ____________________

REFFERING PHYSICIAN ______________________________________ **PHONE** ____________________

IN CASE OF EMERGENCY

NAME ____ PHONE ________________________

PHARMACY NAME ________________ CROSSROADS ________________ DO YOU HAVE A LIVING WILL? ☐YES ☐ NO

AUTHORIZATIONS AND RELEASE (PLEASE INITIAL BELOW)

_____ I am aware that I am responsible to pay co-pays and deductibles set forth by Medicare or Commercial Insurance Plans at the time of service.

_____ I hereby authorize by signing below to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under Medicare or Commercial Insurance Plans be made payable directly to Sahai Surgical Specialists, PLC and/or Aalok Sahai and MD, Rohit Sahai, MD. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any services deemed non-covered by my insurance company.

_____ I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I understand that there will be additional costs accessed in addition to my account balance. This additional amount could be as high as 33%.

_____ I am aware that if I request my medical records, I understand to allow 7-10 days for the process of the release of medical records.

_____ I am aware of a $25.00 fee for FMLA or Disability Paperwork. I understand this is to be paid at the time of retrieving my FMLA or Disability Paperwork.

By signing below, I acknowledge that I have read and understand the above statements.

PATIENT SIGNATURE ____ **DATE** ________________

PARENT OR GUARDIAN (IF MINOR) ____________________________________ **DATE** ________________

INDUSTRIAL INFORMATION

INDUSTRIAL INJURY __ YES __ NO TYPE OF INJURY ________________________ DATE OF INJURY ______________

INDUSTRIAL INSURANCE NAME ____________________ CLAIM# ____________ PHONE# ______________

NAME OF CASE MANAGER ____

Phoenician Pain

SAHAI SURGICAL

Sahai Surgical specialist

963 N McQueen
Chandler AZ 852258149
Ph: 480-646-8440 Fax:480-646-8441

ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: **Gender:** **Date:**

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never (0 points)

☐ Monthly or less (1 point)

☐ Two to four times a month (2 points)

☐ Two to three times a month (3 points)

☐ Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 (0 points)

☐ 3 or 4 (1 point)

☐ 5 or 6 (2 points)

☐ 7 to 9 (3 points)

☐ 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

☐ Never (0 points)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Points 0

Interpretation

☐ Positive

☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

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PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Sahai Surgical Specialists of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Sahai Surgical Specialists has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this Sahai Surgical Specialists at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand the information will be used/disclosed for the following purposes:

1. To inform me of my medical condition(s) by phone, mail, email or in person
2. To give information/referrals/medical records/samples/prescription/test results to you or the person(s) named on this form by phone, mail, email or in person
3. For treatment, payment and health care operations

I understand that I may request in writing how Sahai Surgical Specialists restricts my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Sahai Surgical Specialists are not required to agree to my requested restrictions, but if Sahai Surgical Specialists does agree, then the practice is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Sahai Surgical Specialists have taken action relying on this consent.

I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO PERSON(S) BELOW:

Name: ______________________________ Relationship: ____________________

Name: ______________________________ Relationship: ____________________

Patient Signature: ____

Patient Name: ______________________________________ Date: __________
Please print

Relationship to Patient: ______________________________________

SAHAI SURGICAL SPECIALISTS, PLC
Aalok K. Sahai, M.D.
Rohit K. Sahai, M.D.
963 N McQueen Road
Chandler, Arizona 85225

EMAIL CONSENT FORM

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website
  – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

☐ *OPTION 1 – **ALLOW** UNENCRYPTED EMAIL*

I understand the risks of unencrypted email and do hereby give permission to Sahai Surgical Specialists to send me personal health information via unencrypted email

Signature **Date** **Printed Name**

Please print email address (parent or guardian if patient is minor)

☐ *OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL*

I do not wish to receive personal health information via email

Signature **Date** **Printed Name**

Please print email address (parent or guardian if patient is minor)

PATIENT'S BILL OF RIGHTS

- You have a right to seek consultation with the physician(s) of your choice
- You have a right to contract with your physician(s) on mutually agreeable terms
- You have a right to talk privately with your physician(s) and to have your health care information protected
- You have a right to use your own resources to choose the care of your choice
- You have a right to refuse medical treatment even if it is recommended by your physician(s)
- You have a right to be informed about your medical condition/treatment and take part in decisions about your care. To be informed about the risks and benefits of treatment and appropriate alternatives
- You have a right to refuse third-party interference in your medical care, and to be confident that your actions in seeking or declining medical care will not result in third-party-imposed penalties for patients or physicians
- You have a right to receive full disclosure of your insurance plan explaining the coverage and benefits

Patient Name: ______________________________ DOB: __________ DATE: ______________

SAHAI SURGICAL SPECIALISTS, PLC
Aalok K. Sahai, M.D.
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963 N McQueen Road
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Rohit Sahai, M.D.

963 N McQueen Road
Chandler AZ, 85225
Office: 480-646-8440 / Fax: 480-646-8441

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that Sahai Surgical Specialists release my medical records to:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ **Fax:** ____________________

I hereby authorize and request my medical records to be released to Sahai Surgical Specialists from:

Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ **Fax:** ____________________

I authorize to release the following information:

☐ **Consult Notes** ☐ **Lab Reports, Pathology Reports** ☐ **Imaging Reports** ☐ **All Patient Records**

____

____

Patient Name: ______________________________ **DOB:** ____________________
Please Print Name

Patient Signature: ______________________________ **DATE:** ____________________

When requesting the release of records, please allow 7-10 business days to process – Thank you.