General & Minimally Invasive Surgery
Harvinderpal Singh, M.D., F.A.C.S.

REGISTRATION FORM

Date:		Physician (PCP):	

PATIENT INFORMATION

Last Name:	First Name:		MI:
Social Security #:__ __ __ __ __ __ __ __ __	DOB:		Sex: ☐ M ☐ F
Billing Address:	City:	ST	Zip Code:
Home Phone#:( )	Cell Phone#:( )	Work Phone#:( )	

Contact Preference: ☐ Cell Phone ☐ Home Phone ☐ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

GOVERNMENT MANDATED INFORMATION

Language: ☐ English ☐ Spanish ☐ Indian ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to report

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other _____

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship to patient:	Phone#: ( )

PHARMACY INFORMATION

Pharmacy Name:	Phone#: ( )

INSURANCE INFORMATION

Primary Insurance: ☐ BCBS ☐ Aetna ☐ Cigna ☐ Humana ☐ United Healthcare ☐ Medicaid ☐ Medicare ☐ TriCare ☐ Other	Policy/ID#:	Group#:
Subscriber's Name: ☐ Self ☐ Other: _____	Policy Holder SSN#: *(if other than self)* __ __ __ __ __ __ __ __ __	Policy Holder DOB : *(if other than self)*
Secondary Insurance: ☐ BCBS ☐ Aetna ☐ Cigna ☐ Humana ☐ UnitedHealthcare ☐ Medicaid ☐ Medicare ☐ TriCare ☐ Other:	Policy/ID#:	Group#:
Subscriber's Name: ☐ Self ☐ Other: _____	Policy Holder SSN#: *(if other than self)*	Policy Holder DOB : *(if other than self)*

The above information is true to the best of my knowledge. I hereby authorize payment to Dr. Harvinderpal Singh for medical and/or surgical benefits. I understand that I am financially responsible for any balance. I also authorize Harvinderpal Singh, M.D. to examine and/or treat me or my minor child.

_____ _____

Signature of Patient or Parent/Guardian of Minor Child Date

General & Minimally Invasive Surgery
Harvinderpal Singh, M.D., F.A.C.S.

FINANCIAL POLICY

Thank you for choosing General & Minimally Invasive Surgery as your healthcare provider. We are committed to your experience with our office being a pleasant and positive one, and to your treatment being successful. The following is a statement of our Financial Policy, which we require you to sign and read prior to any visit and/or treatment. Please understand that payment of your bill is considered part of your treatment and we accept cash, checks and debit and credit cards.

Our dedicated staff will work diligently to insure that your insurance claims are filed accurately and promptly. You will be required to show your insurance card at the time of service. If you cannot provide this information, you will be required to pay for the services rendered to you that day. **We require payment of all co-pays at the time of your visit, as well as payment of deductible and coinsurance portions prior to scheduled surgeries.** The amount requested will be a result of verification of benefits provided by your insurance plan. Uninsured patients should consult with our Office Manager to discuss discounts and to make payment plan arrangements.

Medical Records & Forms

1. Medical records requests are responded to as quickly as possible. Please be aware that, by law, we are allowed 14 days to respond to medical records & forms completion requests.
2. Medical records of 10 pages or less are provided **once** at no charge.
3. Medical records totaling over 10 pages, or additional requests for medical records less than 10 pages, will incur a charge of $25 for the first 10 pages, then .25 per page for each page thereafter. Payment is expected in advance.
4. While we provide a standard work note upon your release by the doctor, there is a **$25 charge for the completion of all forms** including FMLA, AFLAC, Disability, Credit Card/Mortgage protection, etc., **each** time they are prepared. These forms are completed as a courtesy, typically within 10 business days, and payment is expected in advance.

Insurance & Insurance Collection

Your insurance policy is a contract between you and your insurance carrier, and we are not a part of that contract. Though we are not contracted with all insurance carriers, we file insurance as a courtesy and a service to you, and will absorb all costs incurred. Our staff will work diligently to ensure that your insurance claims are filed accurately and promptly. However, should your insurance carrier not reimburse us within 60 days, the balance due then becomes your responsibility.

While we file all primary insurance claims, please understand that insurance reimbursement can be a long and difficult process, often resulting in prolonged delays and significantly reduced reimbursement. To assist us in expediting the claim payment process and reduce delays, please authorize and consent to the following:

I have read & agree to the above financial policy.
I hereby assign my insurance benefits and authorize payment to
Harvinderpal Singh, M.D. / General & Minimally Invasive Surgery
I also authorize this Dr. Singh and/or General & Minimally Invasive Surgery to file appeals on my behalf, and, if warranted, file complaint regarding my insurance carrier with the Texas Medical Association and the Texas Department of Insurance.

_____ _____

Signature Date

General & Minimally Invasive Surgery
Harvinderpal Singh, M.D., F.A.C.S.

Acknowledgement of Notice of Privacy Practices

I have received and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. A copy will be available for me to take upon request.

Authorization of Disclosure of Protected Health Information

I authorize General & Minimally Invasive Surgery to disclose my protected health information (PHI) to my family member(s) and/or friend(s) for the purpose of information, treatment and health care.

I understand that this authorization is valid until the time if and when it is revoked in writing.

☐ Yes

Name	Relationship to patient

☐ No

I HEREBY AUTHORIZE MEDICAL INFORMATION TO BE RELAYED TO ME VIA: (Check all that apply)

- ☐ HOME PHONE
- ☐ CELL PHONE
- ☐ WORK PHONE
- ☐ EMAIL ADDRESS
- ☐ LEAVE ON VOICE MAIL/ANSWERING SERICE

_____ _____

Patient Signature Date

General & Minimally Invasive Surgery

Harvinderpal Singh, M.D., F.A.C.S.

11609 Spring Cypress Rd, Unit C

Tomball, Texas 77377

281-290-6300
Telephone

281-290-6302
Facsimile

RELEASE OF MEDICAL INFORMATION

Date: _____

To: _____

Address: _____

Phone: _____ Fax: _____

Patient: _____

Address: _____

Phone: _____ DOB: _____

I authorize you to release the following, by fax or mail to address listed above:

_____all medical records

_____ medical records date from _____ to _____

_____ these specific documents_____

_____

_____

_____

Patient Signature or Parent/Guardian Signature for Minor Child

_____

Witness Signature

HEALTH HISTORY FORM

Name: _____ Date: _____

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past:

□ High blood pressure/Hypertension □ Depression/Anxiety □ Liver Disease □ Thyroid problems □ Asthma □ Glaucoma
□ Seizure's/Epilepsy □ Heart Disease □ Heart Attack/Stroke □ High Cholesterol □ Anemia □ Allergies □ Kidney Disease
□Osteoarthritis □ COPD □ Diabetes □ Migraines □ Gout □GERD □ Psychiatric Illness □ Renal Failure

□Cancer: Type & Location: _____

□Other: _____

Do you have any drug allergies? □Yes □No (if "yes" list all): _____
_____

Medication	Strength	Directions

Social History: ***Government Mandated*** **(Tobacco Control)**

□ **Current Smoker**:

1. How often do you smoke? □ Every Day □Some Days, but not every day
2. How many cigarettes a day do you smoke? □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more
3. How soon after you wake up, do you smoke your first cigarette? □ Within 5 minutes □ 6-30 minutes □ 31-60 minutes
4. Are you interested in quitting? □ Ready to quit □ Thinking about quitting □ Not ready to quit

□ **Former Smoker**:

1. How long has it been since you last smoked? □ 1-3 months □ <1month □ 3-6 months □ 6-12 months □1-5 years □ 5-10 years □>10 years

□ **Never Smoked**

Family History: Please identify any significant medical history for the following family members.

	Alive	Deceased	Present Health or cause of death
FATHER	□	□	
MOTHER	□	□	
SIBLINGS	□	□	

Name:_____ Date:_____

Marital status: ☐ Single ☐Married ☐Divorced ☐Widowed

	Yes	No		Yes	No
alcohol			murmurs		
smoking			palpitations		
sexually active			dizziness		
weight change			chest pain		
loss of appetite			edema		
fever			blood in stool		
weakness			diarrhea		
bleeding problems			vomiting		
fatigue			constipation		
rash			nausea		
moles			difficulty swallowing		
lumps			abdominal pain		
dry or sensitive skin			heartburn		
hives			joint stiffness		
keloid scar formation			leg cramps		
acne			joint pain		
skin cancer			joint swelling		
headache			sciatica		
seizures			fracture		
insomnia			carpal tunnel		
gait abnormality			chronic back pain		
memory loss			depression		
cold			tension/stress		
cough			sleep disturbances		
epistaxis (nose bleeds)			suicidal ideation		
hearing loss			mental or physical abuse		
change in voice			anxiety		
sore throat			easy bleeding		
ringing in ears			bruising		
sinus pain			swollen glands		
shortness of breath			varicose veins		

Patient Name: _____

Patient has used the following unsupervised diet plans:					
	Yes	No		Yes	No
None			Mayo Clinic		
Atkins			Pritkin		
Body For Life/ Bill Phillips			Richard Simmons		
Calorie Counting			Scarsdale		
Gloria Marshall			Still Diet		
High Protein			Sugar Busters		
Hypnosis			Slimfast		
Low Carbohydrate					
Weight Loss attempts using supervised diet plans:					
Jenny Craig			Overeaters Anonymous		
Weight Watcher's			OptiFast		
Atkin's			T.O.P.S		
South Beach			New Direction		
Nutri-System			National Weight Loss		
Diet Center			Health Management Resources		
Co-Morbidities:					
Asthma			Sleep Apnea		
Diabetes			Joint Arthritis		
Headaches			Personal hygiene issues		
Hypertension			Varicose Veins/Stasis		
GERD			Hyperlipidemia		
Infertility			Spine Arthritis		
Intracranial Hypertension			Urinary Incontinence		
Liver Dysfunction			Coronary Heart Disease		
Migraines			Anxiety		
Shortness of breath			Depression		
Patient has used the following medications for weight loss:					
Acutrim			Obtain		
Amphetamines			Phentrol		
Benzphetamine			Plegine		
Dexatrim			Pondimin		
Didrex			Prozac		
Fastin			Redux		
Fen-Phen			Sanorex		
Ionamin/Adipex			Tepanol		
Mazanor			Tenuate		
Meridia			Wehless		
			Xenical		
Patient has used the following behavioral treatment:					
None			Psychologist		
Hypnosis			Residential Programs		