PANKAJ LAL MD PC

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Gaithersburg, MD 20878-1417

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PATIENT REGISTRATION FORM

* = *REQUIRED INFORMATION IN, PLEASE PRINT*

PATIENT NAME* **LAST**	**FIRST**	**MIDDLE**		**DATE OF BIRTH***
HOME ADDRESS*	**APT. NO.**	**CITY**	**STATE***	**ZIP CODE***
OCCUPATION * ☐ **EMPLOYED** ☐ **RETIRED** ☐ **STUDENT**	**SOCIAL SECURITY # ***	**MARITAL STATUS*** ☐ **S** ☐ **M** ☐ **D** ☐ **W**	**SEX*** ☐ **M** ☐ **F**	**HOME PHONE***
EMPLOYER	**EMPLOYER'S ADDRESS**	**EMAIL**		**CELL #** / **WORK # ***
SPOUSE (OR PARENT) NAME	**SPOUSE (OR PARENT) EMPLOYER**			**SPOUSE / PARENT WORK PHONE:**
REFERRING DOCTOR NAME:		**REFERRING DOCTOR PHONE:**		

PRIMARY INSURANCE INFORMATION *

SUBSCRIBER'S LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**	**SUBSCRIBER'S DATE OF BIRTH**
SOCIAL SECURITY NUMBER	**HOME PHONE**		**RELATIONSHIP TO PATIENT**
PRIMARY INSURANCE COMPANY NAME			
ADDRESS			
CITY	**STATE**	**ZIP**	
ID OR POLICY #	**GROUP / CODE**	**EFFECTIVE DATE**	

SECONDARY INSURANCE INFORMATION *

SUBSCRIBER'S FIRST NAME	**LAST NAME**	**RELATIONSHIP TO PATIENT**	
SECONDARY INSURANCE NAME ☐ **SPOUSE OR** ☐ **INDIVIDUAL POLICY**		**ID OR POLICY #**	**GROUP OR CODE #**
ADDRESS			
CITY	**STATE**	**ZIP**	

PATIENT AUTHORIZATION

I, _____, hereby authorize, **Pankaj Lal MD PC.** to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or _____ Insurance Company,
(Name of other insurance company)
be made directly to the above named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.
(Name of Medigap Carrier)

_____ _____
DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

PATIENT MEDICAL INFORMATION

NAME _____ **DATE** _____

AGE _____ **SEX** _____ **MARITAL STATUS** _____

PRIMARY PHYSCIAN _____

REASON YOU ARE SEEING THE DOCTOR TODAY.

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST

_____

_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING:	**(PLEASE CHECK)**	
	YES	**NO**
1. **CHEST PAIN, PRESSURE, DISCOMFORT, HEAVINESS**	_____	_____
2. **SHORTNESS OF BREATH**	_____	_____
3. **PALPITATIONS (SKIPPED OR RACING HEARTBEAT)**	_____	_____
4. **DIZZINESS, FAINTING**	_____	_____
5. **NUMBNESS, TINGLING IN HANDS OR FEET**	_____	_____
6. **LEG OR CALF PAIN WHEN WALKING**	_____	_____
7. **ANKLE SWELLING (FLUID RETENTION)**	_____	_____
HAS A DOCTOR TOLD YOU THAT YOU HAVE OR HAVE HAD:	**YES**	**NO**
1. **ANGINA**	_____	_____
2. **CORNOARY ARTERY DISEASE (BLOCKED ARTERIES)**	_____	_____
3. **HEART ATTACK**	_____	_____
4. **HEART FAILURE (WEAKNESS OF THE HEART MUSCLE)**	_____	_____
5. **ARRHTHMIA (IRREGULAR HEARTBEAT)**	_____	_____
6. **LEAKING OR NARROWED HEART VALVE**	_____	_____
7. **ANEURYISM (DILATED OR LEAKING BLOOD VESSEL**	_____	_____
8. **HIGH CHOLESTEROL**	_____	_____
9. **HIGH BLOOD PRESSURE (HYPERTENSION)**	_____	_____
10. **DIABETES**	_____	_____
11. **ASTHMA OR EMPHYSEMA**	_____	_____
12. **BLOOD CLOTS IN LEGS OR LUNGS**	_____	_____

HAVE YOU HAD ANY MAJOR SURGERY (OPERATIONS)?

SURGERY	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

IS THERE A HISTORY OF DISEASE OF THE HEART OR BLOOD VESSELS, HYPRETENSION AND HIGH CHOLESTEROL?

FAMILY MEMBER	HISTORY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU SMOKE? _____ IF SO, FOR HOW LONG _____
HOW MANY PACKS A DAY? _____
IF YOU HAVE QUIT, HOW LONG AGO? _____

WHAT MEDICINES ARE YOU PRESENTLY TAKING?

MEDICINES	DOSE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Capital Cardiac Care

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TEL (301) 569-7135 FAX (301) 569-7134

HIPAA NOTICE ACKNOWLEDGEMENT

We are required by law to maintain the privacy of, and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information (**PHI**).

Your signature below is an acknowledgement that you have read our HIPAA Notice of privacy practices.

I hereby understand and accept that as per HIPPA policy. NO medical information or records will be released to any person other than myself without my written consent and authorization.

Name (print) _____ **Date** _____

Signature _____

If you would like an authorized person (family or friends) to have access to your medical information, please fill in below. Otherwise, write 'self.'

Name (print) _____

Relationship _____

Phone Number _____