De Silva Medical, Inc
INT. MEDICINE • BARIATRIC • AESTHETICS
PAMELA DESILVA, M.D.

623 West Ave Q, Suite A
Palmdale, CA 93551
Ph: (661) 726-6255 Fax: (855) 451-0552

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ _____ _____
Last First Middle Initial

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell ( ) _____

Birth Date _____ Age _____ Sex: ☐ Male ☐ Female

*Email: _____

*Emergency Contact: _____ Phone #: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS # _____-_____-_____ Occupation _____

Employer _____ Employer Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____ Subscriber _____ Date of birth _____

ID Number _____ Group Number _____

Secondary Insurance Company _____ Subscriber _____ Date of birth _____

ID Number _____ Group Number _____

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Please be aware that Desilva Medical Inc. will charge a $25.00 fee for failed appointments and appointments NOT cancelled 24 hours prior to the scheduled appointment date. $50.00 fee for specialty appointments and 3% finance charge for past due balances over 30 days.

_____ Initial

Assignment and Release:

I the undersigned, _____ assign directly to Desliva Medical Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Desilva Medical Inc. to release all information necessary to secure the payment of benefit. I authorize the use of my signature on all my insurance submissions (including electronically submitted claims).

Signature of insured: _____ **Date:** _____

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Today's Date: _____

Name: _____
Last First Middle

Address: _____
Street Apt # City Zip Code

Home Phone: (___) _____ Work Phone: (___) _____

Date of Birth: _____ Male/Female Weight____ Height____ Age ____

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed _____

Occupation: _____ **Employer:** _____

Referred By: _____

Present Illness: _____

_____ **Date of onset:** _____

Duration: _____

Any other Complaints _____

_____

_____

Past Illnesses:

_____

_____

Past Surgeries: _____

_____

Do you: Smoke_____ Drink Alcohol_____ Abuse Drugs_____
If you, how much?_____ If yes, how much?_____ If you, how much?_____

Allergies (to medication of food):

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Medications You are taking NOW:

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Have any relatives had any of the following:

Cancer	Y	N	Convulsions	Y	N
Tuberculosis	Y	N	Bleeding Disorder	Y	N
Diabetes	Y	N	Kidney Disease	Y	N
Heart Trouble	Y	N	Psychiatric Problems	Y	N
High Blood Pressure	Y	N	Pulmonary Problems	Y	N
Stroke	Y	N	Arthritis	Y	N

GENERAL			Hemorrhoids or piles?	Y	N
Recent Weight change?	Y	N	Frequent diarrhea?	Y	N
Fever of Chills?	Y	N	Heartburn?	Y	N
Hives, Eczema, or rash?	Y	N	Pain in abdomen?	Y	N
Frequent infection or boils?	Y	N	Food sticking in throat?	Y	N
Abnormal pigmentation?	Y	N	Constipation?	Y	N
HANDS, EYES, EARS, NOSE & THROAT			**NECK**		
Eye Disease or injury?	Y	N	Stiffness?	Y	N
Do you wear glasses?	Y	N	Thyroid Trouble?	Y	N
Double Vision?	Y	N	Enlarged Glands?	Y	N
Glaucoma?	Y	N	**RESPIRATORY**		
Allergies?	Y	N	Spitting up blood?	Y	N
Chronic Sinus Trouble?	Y	N	Chronic or frequent cough?	Y	N
Ear Disease?	Y	N	Asthma or wheezing?	Y	N
Impaired hearing?	Y	N	Difficulty breathing?	Y	N
NEUROPSYCHRIATRIC			**RHEUMATOLOGICAL**		
Blurring or vision?	Y	N	Joint pain?	Y	N
Headache?	Y	N	Change in color of hands on exposure to cold?	Y	N
Psychiatric problems?	Y	N	Back pain?	Y	N
Head Injury/loss of consciousness?	Y	N	Pain in calves on walking reviewed by rest?	Y	N
Convulsions?	Y	N	Pain in buttocks on walking reviewed by rest?	Y	N
Numbness, tingling, and or weakness of muscle?	Y	N	**GENITOURONARY**	Y	N
Speech Trouble?	Y	N	Loss of urine?	Y	N
Memory loss?	Y	N	Frequent or night time urination?	Y	N
HEMATOLOGICAL			Burning or painful urination?	Y	N
Blood Disease?	Y	N	Blood in urine?	Y	N
Anemia?	Y	N	Kidney Trouble?	Y	N
Phlebitis or Blood clots?	Y	N	Kidney Stones?	Y	N
Abnormal bruising or bleeding?	Y	N	**GYN HISTORY (WOMEN ONLY)**		
ENDOCRINE			Date of last menstrual cycle?		
Thyroid Disease?	Y	N	Regular___ Irregular___ Spotting___		
Hormone Therapy?	Y	N	Age period started?		
Change in hair growth?	Y	N	Any Pain?	Y	N
CARDIOVASCULAR			Number of Pregnancies?		
Dizzy Spells?	Y	N	Number of Miscarriages?		
Chest Pains or Angina Pectoris?	Y	N	**PREVENTATIVE MEDICINE**		
Shortness of breath?	Y	N	Last Physical Exam?		
Hearth trouble or Heart Attack?	Y	N	Sigmoidoscopy / Colonoscopy?		
High Blood Pressure?	Y	N	Date: Results:		
Swelling of Hands, feet, or ankles?	Y	N	Rectal Exam? Date:		
Heart Murmur?	Y	N	Last Eye Exam?		
Palpitations?	Y	N	**WOMEN ONLY!**		
Pain in calf / thigh?	Y	N	Last Pap/Pelvic Exam?		
Is it relieved by rest?	Y	N	Last Mammogram?		
GASTROINTESTINAL			**MEN ONLY!**		
Ulcers, stomach or duodenal?	Y	N	Last Prostate Exam?		
Vomiting food or blood?	Y	N	PSA?		
Gallbladder Disease?	Y	N			
Liver Trouble?	Y	N			
Bleeding with bowel movement?	Y	N	**REVIEWED BY M.D.:**		

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Patient Name: _____ DOB _____

List Allergies: _____

_____

Medication List

Medication	Dose	Frequency (How Often You Take The Medications)	Frequency (How Often You Take The Medications)

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Family History Information Sheet

Please fill out the following information to the best of your ability for each family member.

Patient Name:_____ Date of Birth:_____

Mother: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Father: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Brother: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Sister: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Children: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Maternal Grandmother: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Maternal Grandfather: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Paternal Grandmother: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

Paternal Grandfather: Alive or Deceased Age: _____
Present/Past Illness: _____
Cause of Death: _____

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Acknowledgment of Receipt of Notice of Privacy Practice Notice

I have ready the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide De Silva Medical Corporation with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)_____

Patient's Signature_____

Date:

De Silva Medical, Inc

INT. MEDICINE • BARIATRIC • AESTHETICS

AUTHORIZATION TO DISCLOSE OF PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Date of Request: _____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without patient authorization.

I hereby authorize DE SILVA MEDICAL, INC., and its employees to obtain my medical records from.

_____

I hereby authorize DE SILVA MEDICAL, INC., and its employees to release my Protected Health information to the following person, health care provider, or business associate:

_____

Effective dates for this authorization: ___/___/___ through ___/___/___
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses of disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health information being used or disclosed under federal law.
4. Refuse to sign this authorization
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature or Patient's Authorized Representative *Date*