

Confidential Patient Information
Rajiv Kwatra, M.D.

Date: _____

Patient Name: _____ SS#: _____ Date of Birth: _____ M F

Address: _____

City: _____ State: _____ Zip: _____ Home Phone No: _____

Referred by: Please enter physician's full name: _____

Primary Care Physician: Please enter physician's full name: _____

Current Marital Status: Married Single Divorced Widow/Widower

Employer: _____ Occupation: _____

Employer Address: _____

In case of Emergency contact: _____ Relation: _____

Address: _____ Phone No: _____

Do you have medical insurance: No Yes—please list the following:

Primary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ M F

Marital Status: _____

Insured SS#: _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy No: _____

Group No: _____

Insured's Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ M F

Marital Status: _____

Insured SS#: _____

Relationship to Insured: _____

Insured's Date of Birth: _____

Policy No: _____

Group No: _____

Insured's Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Please note our office policy states that payment for services that are not to be billed to insurance are due at the time of visit. If we are billing your insurance carrier and you have a co-pay, please pay at the time of service. Thank you.

PLEASE READ THE FOLLOWING, SIGN, AND DATE. THANK YOU.

I hereby authorize Rajiv Kwatra, M.D. to furnish the above insurance company(s) all medical information necessary to process any appropriate claim(s). I also authorize payment of medical benefits to Rajiv Kwatra, M.D. I accept full responsibility for ALL my incurred charges including charges which my insurance company may or may not cover. I am responsible for all charges incurred for the treatment/services I receive, whether I have or may not have insurance.

Patient or Guardian's Signature _____ Date _____

Medical History and Consent

Rajiv Kwatra, M.D.

Name: _____ Age: _____ Date of Birth _____ M F

Occupation _____

Current Marital Status: Married Single Divorced Widow/Widower

Primary Care Physician _____ None

Dermatologist _____ None

Referring Physician _____ None

MEDICATIONS:

What medications are you currently taking including over the counter medicines and vitamins?

None Yes — Please list:

Are you currently taking Aspirin? No Yes if no and you stopped recently, how long since you had your last dose: _____ days

Do you take high dose Vitamin E (200-400 units/day) No Yes if no and you stopped recently, how long since your last dose _____ days

ARE YOU ALLERGIC TO ANY MEDICATIONS?

No Yes --- Please list: _____

CURRENT SKIN PROBLEM:

Location of skin problem(s) today: _____

How long has this problem been present? _____

Has the area been biopsied: No Yes ---by whom and when: _____

Check all that apply to today's problem: Change in: Size Color Texture Shape

Other _____

Symptoms: None Bleeding Pain Tingling Ulceration Infection Itching

Other _____

SOCIAL HISTORY:

Do you smoke? No Yes — I have smoked _____ packs per day for _____ years.

If you are a former smoker, no matter how long ago, please fill in the blanks:

I have smoked _____ packs a day for _____ years.

Do you drink alcohol? None Less than one drink daily 1-2 drinks daily 3 or more drinks daily

Do you wear sunscreen? No Yes If yes --- SPF _____

HISTORY:

Have you had any plastic surgery in the past: No Yes --- please list all procedures and when:

Do you have Diabetes: No Yes --- how long: _____

Are you taking medications that suppress your immune system: No Not sure Yes --- name of medication: _____

Medical History and Consent

Name: _____

HISTORY CONTINUED

Pleas list any **CURRENT** major illnesses: _____

Do you have a history of previous skin cancers? No Yes --- please list _____

History of exposures to area: X-ray or Radiation Ultraviolet light

Have you used tanning beds in the past: No Yes --- how often and for how many years: _____

Do you have a family history of skin cancer: None

Basal Cell Cancer, which relative _____

Squamous Cell Carcinoma, which relative _____

Melanoma, which relative _____

Other _____

HEALTH

SKIN: Normal Slow Healing Hypertrophic Scaring Keloids

Other _____

BLEEDING PROBLEMS: None Low Platelets Anemia

Other _____

CARDIOVASCULAR: Normal Pacemaker Artificial Heart Valve Angina (chest pain)

High Blood Pressure Heart Attack --- When: _____

Other _____

MUSKULOSKELETAL: Normal Arthritis Artificial Joints --- please list: _____

Other _____

EYES/EARS/NOSE/THROAT: Normal Hearing Aid Impaired Vision --- please list problem and which eye: _____

Other: _____

GASTROINTESTINAL: Normal Ulcers Colitis Irritable Bowel

Other _____

Endocrine: Normal Diabetes Thyroid Problems

Other _____

NEUROLOGICAL: Normal Stroke Seizures

Other _____

RESPIRATORY: Normal Asthma Emphysema

Other _____

PSYCHIATRIC: Normal Anxiety Depression

Other _____

INFECTIONS: None Hepatitis B Hepatitis C HIV/AIDS Tuberculosis

Other _____

The answers I have provided are true to the best of my knowledge. I understand that in the course of my visit today tests may be required for evaluation and diagnosis. A skin biopsy is often required and can leave a scar where it is taken from. I hereby give my consent to be evaluated and have tests performed such as a skin biopsy as necessary:

Signature/patient or power of attorney (guardian)

Date

Name _____ Date _____

Pharmacy information:

Pharmacy Name _____
Crossroads or Address _____
Phone number _____

Medications:

Do you have any changes in your medications?

Vaccination Status:

Have you received an influenza immunization? NO YES If yes, When _____

Have you received an pneumonia immunization? NO YES If yes, When _____

Social History:

How often do you drink alcohol? NEVER OCCASIONALLY WEEKLY DAILY

Do you smoke? NO FORMER SMOKER YES if yes, I have smoked _____ packs per day for _____ years.

Falls:

Have you fallen in the past 12 months? YES NO If yes, how many times _____

Do you use a WHEELCHAIR WALKER CANE OTHER

Advanced Care:

Do you have a health care proxy in the event you are unable to make your own medical decisions? NO YES If yes, Name _____ phone # _____

Do you have a living will? NO YES

Which statement best reflects your wishes on advanced care recommendations?

___ DO NOT INTUBATE: I do not wish to have a breathing tube, even if it is necessary to save my life.

___ DO NOT RESUSCITATE: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

___ FULL CARDIOPULMONARY RESUSCITATION: I want full cardiopulmonary resuscitation efforts to be made.

IMPORTANT INFORMATION REGARDING THIS PACKET

Read your brochures and complete your paperwork

1. Please read all the materials enclosed carefully. If you have not read the brochures and other material thoroughly, we will ask you to do so prior to proceeding. This will easily cause a half hour delay. Please also fill in and complete all paperwork in this packet. No one likes to do paperwork including us. However, if you do not have your paperwork completed before coming you will have to do so when you arrive at the office. This will also easily cause another half hour delay. For your own sake, try to complete these things before arriving. It will make your time at our office much less stressful and your appointment will run much more smoothly. Please bring a photo ID and your insurance card.
2. Directions from your home to our office and back to your home.

You will get the best directions possible on how to get to our office on 3rd street and how to get back home from there by going to www.google.com. Once on the google home page click on the "maps" link. On the maps link page click the "get directions" link. Enter your address in the first column and our address in the second column and then click the "get directions" link to the right side. A map will appear showing how to get to the 3rd street office from your home with written instructions to the left. Click "print" and the map and instructions will print out in one page. Afterwards, click the link to flip flop the addresses. To do this, look between the two columns where you originally entered the addresses. You will see two arrows and the addresses will flip flop. Click the "get directions" link again and a map will appear with directions on the best way to get from 3rd street office back to your home. Press "print" and the map and instructions will print out on a single page. Follow the directions on the back of the "What is Mohs surgery" or "Rajiv Kwatra M.D." brochures.

3. **Patience is a Virtue**

This is a surgical practice. All we do all day is surgery to treat skin cancers and see patients in consultation for surgery. We try very hard to stay on time but surgery by its nature is unpredictable. Some days we run ahead and other days we run behind. One patient may require much more time than expected to complete some portion of their care and that is what usually gets us behind schedule. We apologize in advance if you are one of the other patients inconvenienced by this, but rest assured that if you are the one patient that needs extra time, we will not rush away.

4. **HIPAA**

We are required by the government to have you read and sign the following. In the interest of saving paper, please bring this with you to your appointment. Rajiv Kwatra, M.D. has adopted this Sanction Policy as of October 1st 2003, to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations requirement for such a policy, as well as to fulfill our duty to protect the confidentiality and integrity of confidential information as well as electronic medical information as required by law.

Rajiv Kwatra M.D. has adopted a security policy requiring Rajiv Kwatra M.D. and its staff and agents to protect the integrity and confidentiality of electronic medical and other sensitive information pertaining to our patients. In addition, Rajiv Kwatra M.D. has adopted policies and standards to carry out the objectives of the security policy. Each of these policies and standards notes that all providers, staff and agents or Rajiv Kwatra M.D. must adhere to these policies and standards.

Patient Signature _____ Date _____

Witness _____ Date _____

Rajiv Kwatra, M.D.