Rena Ahuja, M.D.
355 Placentia Ave. Ste. 209 Newport Beach CA 92663
Office 949.209.2789 Fax 888.726.1822

NEW PATIENT REGISTRATION FORM

Name (Last/Middle/First)_____
Martial Status_____Date of Birth_____Age_____Gender_____
Social Security Number_____
Race:_____ Ethnicity_____Preferred Language_____
Driver's License Number_____ State____ Exp___
Address _____
City _____ State_____ Zip_____
Email address _____
Phone – Home _____ Work_____Cell_____
Name/Address/Phone of Pharmacy:_____
Do you prefer to be contacted by phone or email (please circle one)
Preferred Message Phone Number _____
May we leave confidential message at the number listed above? Yes____ No_____
In case of emergency, who should be notified? _____
(name/phone number)
Relationship_____

Spouse's Name_____
Address_____ Mobile _____

Policy Holder (if different from patient)
Last Name_____First Name_____
Middle name_____ Gender_____
DOB_____ Social Security Number_____
Driver's License Number_____ State_____ Exp_____
Address_____
City_____State_____Zip_____

Name of Employer_____
Employer's address/phone_____

Who was your last provider? _____
Physician & Practice Name Address

Insurance Information:

Primary Health Insurance Plan _____
Policy Holder's Name_____ ID#_____
Group #_____
Phone_____
Secondary Health Insurance Plan_____
Policy Holder's Name_____
ID#_____ Group_____ Phone_____

Do you have Advanced Directive? Yes _____ No _____
Who may we thank for your
referral?_____
◊Walk-In ◊Advertisement ◊Online ◊Other:
I certify that the above information is true and correct to the best of my knowledge.

Patient/Guardian Signature _____Date _____

Rena Ahuja M.D.
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PATIENT FINANCIAL RESPONSIBILITY FORM
EFFECTIVE JAN 2018

Thank you for choosing Rena Ahuja M.D. for your medical needs. We are committed to providing you with the highest quality of healthcare. We ask that you read and sign this form to acknowledge your understanding of our financial policies.

Patients Financial Responsibilities (PLEASE INITIAL ON EACH LINE)

_____ • The patient is ultimately responsible for the payment for treatment and care. **It is the patient's responsibility to call their insurance to check if their insurance plan is active or inactive and if Dr. Rena Ahuja is In-Network or Out-of-Network.**

_____ • We will write lab orders for you. However, it's the patient's responsibility to confirm which labs are covered or not covered by their insurance. We take no responsibility for the labs ordered. Any questions should be directed to the insurance.

_____ • Patients are responsible for payments of co-pays, co-insurances, and deductibles as well as all other procedures and treatments not covered by their insurance plan. It is the patient's responsibility to confirm whether or not treatments, procedures and labs are covered by their insurance.

_____ • **Co-pays, Deductibles (estimate), Co-insurance (estimate) are due at the time of service. If payment from your insurance company results in credit balance, that balance will be refunded to you within 60 days.**

_____ • Patients may incur, and are responsible for payments of additional charges, if applicable, these charges may include:
Charge of returned checks: $25

_____ • **We require a 24-hour notice if you are unable to keep your scheduled appointment. If we do not receive a 24-hour notice, you will be charged a fee of $25.**

Due Bills

Upon receiving a balance due bill from our billing office, all charges are payable within 30 days. A 1.5% monthly finance charge is added to all amounts after 30 days. This represents a percentage rate of 18% annual fee. All accounts, on reaching 90 days past due, are subject to submission to an outside collection agency if satisfactory arrangements are not made with the billing office.

Authorization to pay benefits to physician

I hereby assign payment directly to Rena Ahuja M.D. for medical benefits, if any, otherwise payable to me for services provided at the clinic.

Authorization to release information

I hereby authorize Rena Ahuja M.D to release any information required in the course of my examination and treatment to my referring physicians and/or my insurance company.

Acknowledgment

I have read and understand the above Financial Policy and Benefits Authorization and agree to all provisions outlined herein and I give consent to access, treat and test.

_____

Patient Signature or Responsible Party **Date**

Rena Ahuja MD
355 Placentia Ave. Suite 209
Newport Beach, CA 92663
Phone: (949) 209-2789 Fax: (888) 726-1822

PATIENT HIPAA CONSENT FORM

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

CONSENT FOR USE OF E-MAIL

Dear Patients,

Our office uses email for non-urgent communication with our patients. We use it to send information to patients. It is generally a one way communication, however, sometimes patients prefer to communicate with the office via email. Please note that it is for non-urgent communication only.

For any life threatening emergency call 911 or go to the nearest emergency room. For any other important matters, please call our office at 949-209-2789.

I understand the purpose of the use of email and the office will not be held liable for any matters that arise with unreturned emails in a timely matter.

Patient Signature:_____ Date:_____

_____

Print Name

PRESCRIPTION REFILL / RESULTS POLICY

I hereby acknowledge that I have read the prescription refill policy/lab results policy and will comply with it.

Dr Ahuja and her staff will try their best to notify patients of any results. However, it is ultimately the patient's responsibility to follow up on their results. We require patients to visit the doctor to discuss results/labs to address any concerns. No lab results will be sent to the patient via email or fax before their appointment with the doctor.

Patient Signature:_____
Name:_____Date:_____

Rena Ahuja MD
355 Placentia Ave. Suite 209 Newport Beach, CA 92663
Phone: 949.209.2789 Fax: 888.726.1822

Health Summary

Please bring all you medications and supplements at the time of your first visit.
Patient's name (please print): _____D.O.B_____
Today's Date:_____ Age:_____ Marital Status:_____
Date of last Physical:_____ Height_____ Weight_____
Reason for visit:_____ Occupation:_____
Background: ◊ Ashkenazi ◊ Asian ◊ Mediterranean ◊ Middle Eastern ◊ European ◊ Southeast Asian ◊ African ◊ Native American ◊ Other_____
Name/Address/Phone of Pharmacy:_____

Personal Medical History

◊Heart Disease/Murmur/Angina
◊High Cholesterol
◊High Blood Pressure
◊Low Blood Pressure
◊Leg edema/ Swelling
◊Heart Burn/ GERD
◊Skin Problems
◊Anemia
◊Arthritis
◊Back Pain
◊Autoimmune Diseases
◊Stroke
◊Kidney Disease
◊Cancer type:_____
◊Blood Disorders
◊Chemical Dependency/Alcohol
◊Diabetes
◊Urinary Tract Infections
◊Vaginal Discharge
◊Fibroids
◊Liver Problems
◊Hepatitis
◊STD
◊HIV
◊Seizures
◊ Headache/ Migraines
◊Ulcers/Colitis/IBD
◊Diverticular Disease
◊Prostate Problems
◊Asthma
◊Bronchitis
◊Lung Problems/ COPD
◊Sinus
◊Seasonal Allergies
◊Tonsillitis
◊Ear Problems
◊Eye Problems: Glaucoma/Cataracts
◊Neurological Problems
◊Depression ◊Anxiety
◊Psychiatric Care
◊Hypothyroidism ◊Hyper
◊Kidney Disorders

Past Surgeries, Traumas, Accidents or Hospitalizations

1.
2.
3.
4.
5.
6.
7.
8.

Allergies:

Medication Allergies-

Food-

Environmental/Other-

Do you have difficulty tolerating herbs? ◊Yes ◊No ◊Unknown

Current Medications: Please list **ALL** meds that you are currently taking and include dosage and how often you take each medication.

Medication: Dose per day

1.
2.
3.
4.
5.
6.
7.

Current Nutritional Supplements and/or Herbs: Dose per day

1.
2.
3.
4.
5.
6.

Family Medical Conditions:

(Please check and list age of diagnosis)

	Father	Mother	Grandparent(s)	Sibling(s)	Aunt/Uncle	Children
Cancer (type)						
High Cholesterol						
Heart Disease (CAD)						
High Blood Pressure						
Stroke						
Diabetes						
Osteoporosis/Penia						
Arthritis, Gout						
Kidney Disease						
Tuberculosis						
Thyroid Disease						
Asthma						
Chemical Dependency						
Depression						
Neurological Diseases (Parkinsons,Alzheimers)						

Other family conditions:

Health Habits

How often do you exercise?
◊Never ◊Sometimes ◊Daily
Aerobic exercise (hrs per week)_____
Weight training (hours per week)_____
Please describe your exercise routine:_____
(Weight bearing, Aerobic, Yoga, and Pilates)
Have you ever smoked? ◊Yes ◊No Number of years____
If Current Smoker, how many packs daily _____
Use of smokeless tobacco ◊Yes ◊No

Have you ever used street drugs?
If yes, what kind and how much_____
Caffeine? ◊Yes ◊No
If yes, how much and how often?_____
Stress? ◊Yes ◊No
Alcohol? ◊Yes ◊No
If yes, how much and how often?_____
Do you take time for any hobbies? If so, which ones?
Who lives with you?_____
Do you have pets?_____

REVIEW OF SYMPTOMS: *Are you **Currently** experiencing any of the following? Please check ALL boxes that apply.*

Constitutional
◊Good health lately ◊Fevers ◊Chills ◊Recent weight loss ◊Recent weight gain ◊Fatigue ◊Sweats

Allergies ◊Watery eyes ◊Itchy nose, eyes, or roof of mouth ◊Sneezing ◊Hay fever ◊Hives ◊Runny Nose

Eyes ◊Wear glasses/Contacts ◊Glaucoma ◊Blurred Vision ◊Double vision ◊Flashers/Floaters

Sleep ◊Snoring ◊Stop breathing at night ◊Wake up gasping for air at night ◊Dry Mouth ◊Wake up with headaches ◊Often tired during the day/while driving ◊Often fall asleep while reading/ watching TV ◊Difficulty falling asleep or loss of sleep

Skin ◊Rash ◊Itching ◊Change in skin color ◊Change in shape/size of mole ◊Non-healing Sores

Ear, Nose &Throat ◊Hearing loss ◊Ringing in ears ◊Earaches ◊Ear discharge ◊Sinus problems ◊Nose bleeds ◊Sore throat ◊Voice hoarseness ◊Difficulty swallowing ◊Persistent cough

Gastrointestinal ◊Loss of appetite ◊Change in bowel movements ◊Blood in Stool ◊Stomach pain ◊Hemorrhoids ◊Nausea ◊Vomiting ◊Vomiting blood ◊Diarrhea ◊Heartburn/Indigestion ◊Bloating ◊Constipation

Cardiovascular ◊Chest pain ◊Palpitations/Fast heart beat ◊Trouble

lying flat ◊Swelling of ankles/legs ◊Irregular heart beat ◊High blood pressure ◊Low Blood pressure ◊Varicose veins ◊Poor circulation

Respiratory ◊Shortness of breath ◊Coughing up blood ◊Wheezing ◊Frequent Cough

Hematologic ◊Easy bleeding/bruising ◊History of Anemia ◊Bleeding gums ◊Enlarged glands ◊History of blood transfusion ◊Slow healing after a cut

Genitourinary ◊Frequent urination ◊Burning or painful urination ◊Blood in urine ◊Change in force of stream ◊Dribbling or incontinence ◊Urinary urgency or hesitancy ◊History of kidney stones ◊Sexual difficulty

Endocrine ◊Excessive thirst/urination ◊History of diabetes ◊Heat or cold intolerance ◊Thyroid problems

Neurological ◊Frequent or recurrent headaches ◊Lightheadedness ◊Fainting ◊Dizziness ◊Numbness ◊Tingling ◊Weakness in extremities ◊History of Seizures ◊Forgetfulness

Psychiatric ◊Depression ◊Anxiety ◊Nervousness ◊Memory loss

Musculoskeletal ◊Joint pains ◊Joint swelling ◊Joint stiffness ◊Back pain ◊Muscle pain/cramps

Female only ◊History of Abnormal PAP ◊Bleeding in between periods ◊PMS ◊Breast lumps ◊Nipple discharge ◊Menstrual pain ◊Hot flashes ◊Vaginal discharge ◊Painful intercourse ◊Mood swings ◊Vaginal dryness

Menopause age___
Age of start of menstruation___
Date of last menstrual period _____
Cycles are generally ◊Regular ◊irregular
Average # of days between periods____
Average # days of bleeding _____
◊Heavy ◊Moderate ◊Light
Date of last pap-smear_____
result_____

If applicable:

Are you pregnant or planning to be pregnant soon? Y or N
If pregnant, are you currently breastfeeding? Y or N
Number of Pregnancies_____
living children#____
Number of normal vaginal deliveries_____ c-section_____
Number of Miscarriages___Abortions____
Any complications during your pregnancy or childbirth?_____
Did you breastfeed your children?_____ if so, how long?____
Current form of Birth Control if applicable_____
Date of last Mammogram_____
result_____
Have you ever been on HRT (Hormone replacement therapy)?_____

Males Only

Last PSA____ Frequent urination at night ◊Lump in testicle ◊Penile discharge
◊Erection difficulties ◊Sore on Penis

Thank you for your time.

Rena Ahuja MD
355 Placentia Ave. # 209 Newport Beach, CA 92663
Phone: 949.209.2789 Fax: 888.726.1822

AUTHORIZATION FOR USE/RELEASE OF HEALTHCARE INFORMATION:

NAME: _____ DOB:_____

I VOLUNTARILY AUTHORIZE AND direct the healthcare provider named below to disclose my health information during this term of this authorization to the recipient that I have identified below

Name/address of your prior and current doctors and fax number:

_____

_____

TO RELEASE HEALTHCARE INFORMATION REGARDING THE PATIENT LISTED ABOVE TO:

Rena Ahuja MD
355 Placentia Ave. #209
Newport Beach, CA 92663
Fax: 888-726-1822

Purpose:

This request for authorization applies to: [**Please check the appropriate box.**]

◊ All Health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence and records from my other health care providers that the above-named health care provider may hold.

◊ All of my health information described above except for the following:

_____

◊ Only medical records relating to the following condition, treatment and date of treatment: _____

_____

◊ Other:_____

Re disclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or revoke (at anytime) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my healthcare provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my healthcare provider at my healthcare provider's regular office address. The revocation will be

effective immediately upon my healthcare provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my healthcare provider for answers to my question about the privacy of my health information at my healthcare provider's regular office telephone number. I understand that I have right to receive copy of this authorization from my healthcare provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Patient Signature:_____Date: _____

_____ _____

Print Signature of witness

If individual is unable to sign this authorization, please complete the information below.

_____ _____ _____

Signature of Personal Representative Legal relationship Date

_____ _____

Name (please print) Witness signature