Patient Registration:

Name: _____ DOB: _____ Sex M/F

Address:_____ City _____ State: _____

Zip Code: _____

Home Phone: _____ Social Security Number: _____

Race: Caucasian Hispanic African American Native American Asian Other_____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Marital Status: Single Married Widow Other

Emergency Contact:

Name: _____

Phone Number: _____

Relationship to Patient: _____

If you have an insurance deductible, half of the deductible amount is required before scheduling surgery.

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General, Breast & Laparoscopic Surgery

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Bloomfield, NJ 07003
(973) 429-9844

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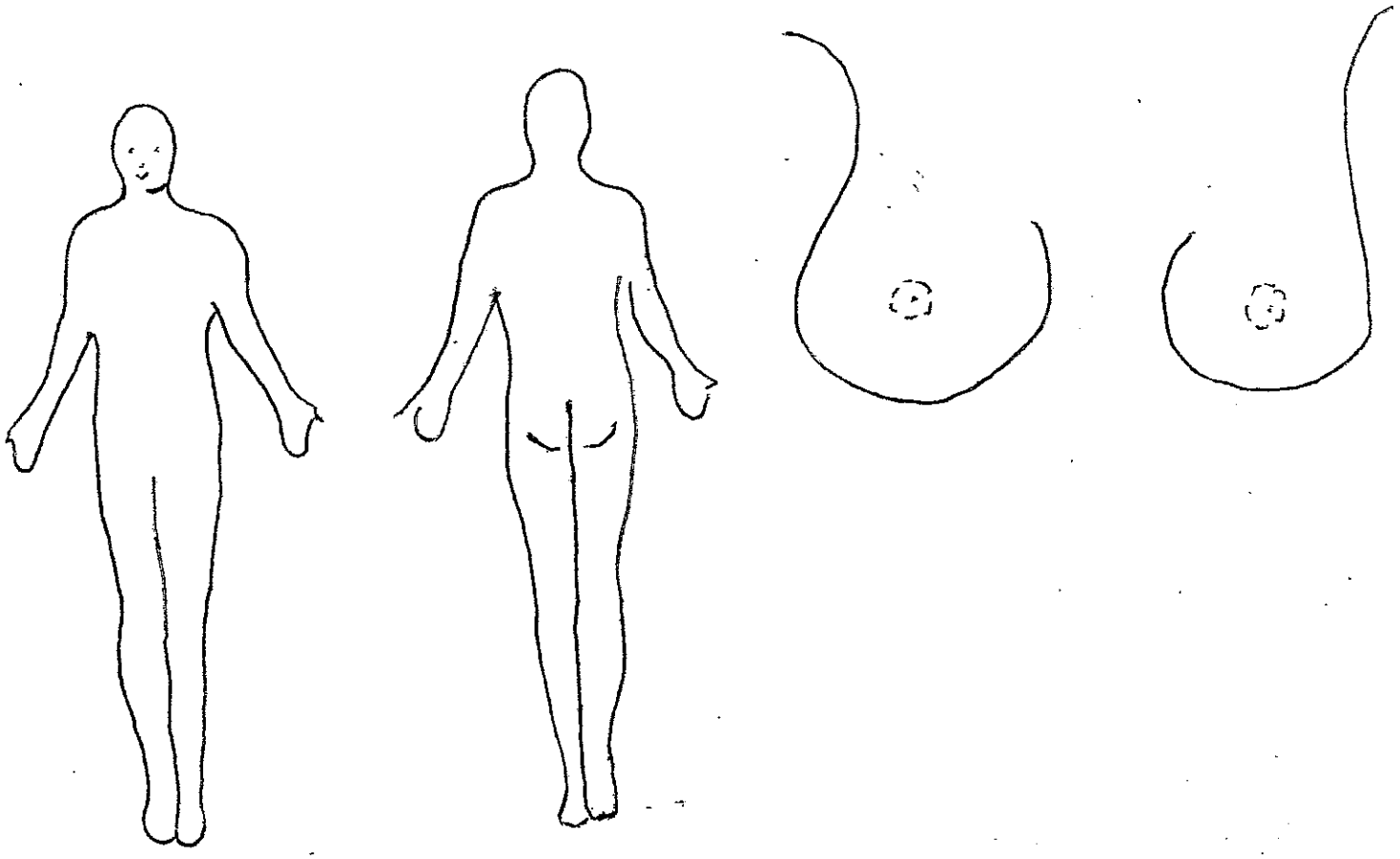
Patient's Name: _____

Family History:

	Alive	Medical Problem	Age of onset
Father			
Mother			
Children			
Sisters			
Brother			
Other			

Phvsical Examination:



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NAME_____ DATE:_____
AGE: _____ DATE OF BIRTH: _____ MARITAL STATUS (Circle) S/ M/ W/ DIV/ SEP.
NUMBER OF CHILDREN: _____ TYPE OF EMPLOYMENT: _____

WHO REFERRED YOU TO THIS OFFICE? (NAME & PHONE NUMBER): _____

REASON FOR VISIT? _____PRIMARY CARE PHYSICIAN* _____

GYNECOLOGIST* _____

ONCOLOGIST* _____
*Please provide Addresses and phone numbers for those Physicians you would like the Reports Sent.

LIST ALL SURGERIES & MEDICAL PROBLEMS AND INJURIES: _____

_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

___ ASTHMA
___ BLEEDING
___ CANCER
___ DIABETES
___ GLAUCOMA
___ HIV
___ HEART DISEASE
___ HIGH BLOOD PRESSURE
___ KIDNEY DISEASE
___ LIVER DISEASE
___ PLEURISY
___PNEUMONIA
___ RHEUMATIC FEVER
___ TUBERCULOSIS
___ STOMACH ULCER
___ YELLOW JAUNDICE

PLEASE CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

___ HEADACHES
___ VISION
___ HEARING
___ DIZZY SPELLS
___ CHEST PAIN
___ COUGH
___ SHORTNESS OF BREATH
___ SWELLING OF ANKLES
___APPETITE LOSS
___WEIGHT CHANGE
___CONSTIPATION
___ DIARRHEA
___ URINARY FREQUENCY
___ PAINFUL URINATION
___ URINARY URGENCY
___ DIFFICULTY WALKING
___ LEG CRAMPS
___ VARICOSE VEINS

ARE YOU PRESENTLY ANTICOAGULATED? Y / N IF SO, WHAT DRUG? _____
ARE YOU REGULARLY TAKING ASPIRIN OR AN ASPIRIN RELATED PRODUCT? Y/ N
WHAT DRUG? _____ HOW OFTEN? _____

LIST ALL OTHER MEDICATIONS (including vitamins) YOU RE PRESENTLY TAKING:

_____
_____
_____

LIST ANY DRUG ALLERGIES: _____

DO YOU WEAR DENTURES? Y / N GLASSES? Y / N CONTACTS : Y / N
DO YOU SMOKE ? Y / N WHAT? _____ HOW MUCH? _____ YEARS QUIT? _____
DO YOU DRINK ALCOHOLIC BEBERAGES? Y / N WHAT? _____ HOW MUCH? _____

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Breast Examination – History Sheet

Patients Name: (Last, First) _____ Date of Birth:(MM/DD/YY)_____

Referring Physician:_____ Primary Care Physician: _____

Gynecologist: _____ Oncologist: (If Applicable) _____

GYN History:
Menarche (Age at Onset): _____
Menopause (Age ended- If applicable): _____
Date of Last Menstrual Period: _____
Number of Pregnancies: _____

Family History: Have any family members been diagnosed with breast cancer? Y / N

Relation:	Maternal (M)/ Paternal (P)	Age of Onset	Please Check ( )
Mother			
Sister			
Daughter			
Grandmother			
Aunt			
Niece			
Cousin			
Other			

Surgical History: Have you had any of the following procedures done? Y / N

Procedure:	Right	Left	Date of Procedure
Breast Biopsy			
Mastectomy			
Lumpectomy			
Cyst Aspiration			

Medical History: Have you ever had any of the following treatments? Y / N

Treatment	Yes	No	Length of Treatment
Birth Control Pill Use			
Estrogen Replacement Therapy			
Tamoxifen			
Radiation Therapy			
Chemo Therapy			

Signs & Symptoms: Are you having any of the following Symptoms? Y / N

Symptoms	Right	Left	Related to Menstrual Cycle (Y/N)
Breast Pain			
Breast Lumps			

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INFORMED CONSENT & INSURANCE AUTHORIZATION

I _____ understand that I will be treated by Dr. Alli who is licensed by the state of New Jersey to Practice Medicine and Surgery.

I further understand that for the proper treatment of my medical condition, I might require further diagnostic testing, medications, or referrals to other specialists.

It is the doctor's responsibility to provide sufficient information about my treatment, medications, and follow up care which then becomes my responsibility to comply with. Should I choose not to comply with these recommendations, I understand that the results and consequences will be solely my responsibility.

It is the policy of this office to require payment for services at the time that services are provided.

By signing this document, I am stating that I understand these policies and that I will comply with them.

I request that payment of authorized insurance benefits (including Medicare, if applicable) be made on my behalf to Dr. Alli, for any services furnished to me by this provider. I authorize this provider to release to the above named insurance companies and their agents, any information needed to determine these benefits, and/or benefits payable for related service.

SIGNATURE OF PATIENT _____

PRINT NAME _____ DATE _____

RELATIONSHIP IF AUTHORIZED PERSON _____

AFFIDAVIT

I) I, _____ hereby state that I am not enrolled in any other medical insurance under my name.

OR

II) I, _____ hereby state that I am covered as a dependant under _____

POLICY HOLDER'S NAME: _____

RELATIONSHIP: _____

INSURANCE CARRIER: _____

POLICY NUMBER: _____

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Notice of Privacy Practices Acknowledgement

Dr. Padma Alli
Alli Surgical Associates
557 Broad Street, Room 22
Bloomfield, NJ 07003

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____
_____

FINANCIAL POLICY

We are committed to providing you with best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

By signing below you agree to be financially responsible for medical services provided.

If you have Health Insurance, provide us with a current insurance card. You are responsible for payment of any co-pay, deductible, co-insurance amount or non-covered services.

Payment is expected at the time of the visit/service. We accept cash, credit card and checks.

Initial _____

We also require credit card information and authorization. Charges or refunds to your credit card will ONLY be made once your insurer has provided us with your EOB (explanation of benefits).

Failure to provide current insurance or credit card information will result in service charges to your account.

Patient Name: _____
Name on Credit Card: _____
Credit Card: DISCOVER____, AMEX____, MC____, VISA_____
Credit Card Number: _____
Expiration Date: _____
CVV number: _____
I authorize payment of any amount due after insurance adjudication. (i.e.: co-payment changes, co-insurance amount, deductible).

Patient/Cardholder Signature: _____
Date: _____
E-mail address: _____

Patient Signature: _____ **Date:** _____