Dr. Bawa & Associates, P.A.
Board Certified, Internal Medicine
155 Crystal Beach Drive, Suite 121, Destin, FL 32541
Phone: 850-424-7320 Fax: 850-424-7322

PATIENT REGISTRATION FORM

Patient Information

Name: (Last)_____ (First) _____(M.I.)_____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph: (_____)_____Work Ph: (_____)_____Cellular Ph: (_____)_____
Date of Birth: ____/____/_____Age: _____ Gender: M ☐ F ☐ Social Security #: _____-_____-_____
Email Address: _____ Marital Status: _____
Employer: _____ Occupation: _____
Purpose of Today's Visit_____
How did you hear about our office? (circle one) Internet Radio TV Billboard
Physician (name) _____ Friend (name) _____
Pharmacy of choice:_____

Primary Insurance Information

Policy Holder's Name (Last)_____ (First) _____(M.I.)_____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Date of Birth: ____/____/_____Age: _____ Gender: M ☐ F ☐ Social Security #: _____-_____-_____
Insurance Company_____
Group #_____Policy/Contract/ID #_____
Insurance Address_____City_____State_____Zip_____
Co-pay $_____

Secondary Insurance Information

Policy Holder's Name (Last)_____ (First) _____(M.I.)_____
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Date of Birth: ____/____/_____Age: _____ Gender: M ☐ F ☐ Social Security #: _____-_____-_____
Insurance Company_____
Group #_____Policy/Contract/ID #_____
Insurance Address_____City_____State_____Zip_____
Co-pay $_____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Nitin Bawa MD, P.A., to provide to my insurance company all information necessary to process this claim. I hereby authorize and direct my insurance carrier to pay directly to Nitin Bawa MD, P.A., any benefits due me under my insurance plan. I understand that it is my responsibility to obtain proper referral authorization. I agree that interest shall accrue at a rate of 1.5% monthly on any unpaid balance beginning 60 days from the date original invoice.

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the notice of privacy practices supplied by Nitin Bawa Professional Associates.
(NOTE: Privacy practices are in the plastic sheets attached to the clipboard.)

Patient or Guarantor Signature: _____Date: _____/_____/_____
(If patient is minor, signing also gives authorization to treat).
Relationship to Patient: _____

Dr. Bawa & Associates

MEDICAL HISTORY FORM

ALLERGIES

Do you have any allergies to any medications?

If YES please list below. NONE

MEDICATION	ADVERSE REACTION

MEDICATIONS

What medications do you take regularly? NONE

MEDICATION	DOSE	HOW MANY TIMES PER DAY?
**Please continue medication list on the other side of form if needed*		

MEDICAL HISTORY

Do you have or have you had any of the following conditions? NONE

CONDITION	CURRENT	PAST	COMMENTS
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Back Pain			
Bladder or Kidney Problems			
Blood Clot in legs/lung			
Blood Transfusion			
Cancer			
Cataracts			
COPD			

Depression/Anxiety			
Diabetes			
Drug or Alcohol Problem			

CONDITION	CURRENT	PAST	COMMENTS
Emphysema			
Erectile Dysfunction			
GERD			
Gout			
Gynecological Conditions			
Heart Arrhythmia			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Incontinence/Overactive Bladder			
Irritable Bowel Syndrome			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Seasonal Allergies			
Seizures			
Sexual Transmitted Disease			
Skin Conditions			
Sleep Apnea			
Stroke			
Thyroid Problems			
Other:			

SURGICAL HISTORY

NONE

SURGICAL PROCEDURE	YES	YEAR	COMMENTS
Appendectomy			
Back Surgery			
Biopsy			
Breast Surgery			
Gallbladder Removal			
Coronary Bypass			
Heart Surgery (other than coronary bypass)			
Hip Surgery			
Cataract			
Hysterectomy (total, including ovaries)			

Hysterectomy (partial, ovaries left)			
Knee Surgery			
Ovary Removal			
Sinus Surgery			
Prostate Surgery			
Gastric Bypass			
Other:			

SOCIAL HISTORY

Current Every Day Smoker	YES	NO	Current Some Day Smoker	YES	NO
Former Smoker	YES	NO	Never Smoked	YES	NO
Other Tobacco Use	YES	NO	Alcohol Use	YES	NO
Past Drug Use	YES	NO	Sexually Active	YES	NO
Current Drug Use	YES	NO	Seat Belt Use	YES	NO
Exercise	YES	NO	Following Diet	YES	NO
Caffeine Use	YES	NO	Employed	YES	NO

FAMILY HISTORY

Has either parent or sibling ever had? NONE

CONDITION	WHO?	COMMENTS
Alcoholism/Drug Abuse		
Alzheimer's		
Autoimmune Disease		
Asthma		
Bleeding or Clotting Disorder		
Cancer		
Heart Disease		
Depression		
Diabetes		
Emphysema		
Genetic Disorder		
Glaucoma		
Hepatitis		
High Blood Pressure		
High Cholesterol		
Thyroid Disease		
Macular Degeneration		
Osteoporosis		
Other:		

REVIEW OF SYMPTOMS

Do you currently have any of the following problems?

GENERAL/CONSTITUTIONAL		
Fever or Chills	YES	NO
Night Sweats	YES	NO
Unexplained Weight Loss	YES	NO
Depression	YES	NO
Anxiety	YES	NO
Unexplained Fatigue	YES	NO
Other:		

HEAD, EYES, EARS, NOSE, THROAT		
Headache	YES	NO
Eye pain or Irritation	YES	NO
Tearing or Discharge	YES	NO
Nasal or Sinus Discharge	YES	NO
Sinus pain or pressure	YES	NO
Dizziness	YES	NO
Sore Throat	YES	NO
Other:		

CARDIOVASCULAR		
Chest pain or pressure	YES	NO
Chest tightness	YES	NO
Palpitations	YES	NO
Edema	YES	NO
Other:		

RESPIRATORY		
Shortness of Breath	YES	NO
Chest Congestion	YES	NO
Cough	YES	NO
Other		

GASTROINTESTINAL		
Nausea	YES	NO
Vomiting	YES	NO
Abdominal Pain	YES	NO
Other:		

GENITOURINARY		
Difficulty Urinating	YES	NO
Decreased Urination	YES	NO
Blood in Urine	YES	NO
Painful Urination	YES	NO
Urinary Frequency	YES	NO
Other:		

MUSCULOSKELETAL		
Joint swelling	YES	NO
Joint stiffness	YES	NO
Muscle or joint pain	YES	NO
Other:		

INTEGUMENTARY		
Hives/urticarial	YES	NO
Skin Cancer	YES	NO
Pain	YES	NO
Other:		

NEUROLOGICAL		
Seizures	YES	NO
Tingling or numbness	YES	NO
Tremors	YES	NO
Other:		

MUSCULOSKELETAL		
Spontaneous or excessive bleeding	YES	NO
Slow to heal	YES	NO
Other:		

Dr. Bawa and Associates

Appointment Guidelines

Since providing quality treatment for all of our patients, in a timely manner is a major focus of our practice philosophy, and because last minute cancellations can cause hardships for many individuals, we would like to clarify our appointment guidelines. It is our sincere hope you will accept these guidelines and join us in our efforts to provide quality time for you and each valued patient in our practice.

(Initial Please)

_____Please give us a 24 hour notice to cancel an appointment otherwise there is a $25 cancellation fee. If you have an emergency please let us know and we will see if we can waive the fee. If you consistently miss an appointment or cancel at the last minute we will have no choice but to disengage you from the practice.

_____Patients who habitually do not show up for appointments may be required to pay a reservation fee to make future appointments or may be discharged as patients

_____Patients who are fifteen (15) minutes late to a schedule appointment may not receive all scheduled treatment and/or may be asked to reschedule the entire appointment.

Procedure for Refill Requests

(Initial Please)

_____ Refills: Please call the pharmacy to electronically send us a refill request for all non-restricted medications. If you have been seen in the last six months, we will authorize the refills. If it is 6-12 months, we will use our judgement and might refuse it we think you need to be seen.

_____**Refills of Restricted (Scheduled) Medications:** You will need any appointment. Please schedule an appointment for things like Phentermine, Adderall, Xanax, Ambien and the like. We are not a chronic pain management facility and we cannot refill pain medications.

I agree to the above instructions for Appointments and Refills

_____

Signature

Dr. Bawa & Associates

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. 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 to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

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

Date:	Initials:	Reason:

Dr. Bawa & Associates

Authorizations & Assignment of Benefits

I authorize my insurance company, attorney, or any third party payor to pay directly to Nitin Bawa Professional Associates and its subsidiaries Dr. Bawa & Associates' clinics: Seagrove, Destin, and Fort Walton Beach, all charges submitted for services rendered to me by staff members of the above listed clinic(s). I understand that I will be held responsible for any and all charges not paid by my insurance company. Should my account become delinquent, I understand that it may be turned over to a collection agency, and additional fees and interest may be added. I authorize Dr. Bawa & Associates to release all information necessary concerning my medical condition to my insurance carrier or attorney for the purpose of processing a claim. I further authorize the use of this signature on all insurance submissions. This authorization and assignment of benefits will remain valid until I notify Dr. Bawa & Associates in writing of its cancellation. A photo copy of this authorization shall be as valid as the original.

I authorize electronic prescription history to be downloaded from other sources, as available.

I understand that there may be times that NBPA may need to refer me to another physician/provider for further medical care. I authorize NBPA to release the medical records and/or information needed in order to facilitate any referrals.

I give permission for NBPA to leave a message for me on my phone: YES NO
I give permission for NBPA to contact me by e-mail: YES NO

I give permission for NBPA to discuss my medical care, appointments, financial information regarding my account, and any other issues related to my care with the following person(s):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I also acknowledge that I was given the HIPAA Notice of Privacy Policy to read and I understand that if I want a copy, one will be provided to me. I also understand that this authorization will remain in effect unless terminated by me in writing.

Patient's Printed Name:_____

Patient's signature: _____