DR.DHIR

PATIENT REGISTRATION FORM

Date:_____

NAME:_____ Male Female **DATE OF BIRTH**:_____

ADDRESS:_____

CITY: _____ **STATE:** _____ **ZIP CODE**: _____

PHONE: C:_____ H:_____W:_____

EMAIL:_____ SS#:_____

PHARMACY INFORMATION:_____

RELATIONSHIP STATUS: MARRIED SINGLE DOMESTIC PARTNER DIVORCED WIDOW

EMPLOYER:_____

INSURANCE INFORMATION:

INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

EMPLOYER:_____

INSURANCE COMPANY:_____

INSURANCE GROUP #:_____ MEMBER ID#:_____

IN CASE OF EMERGENCY:

CONTACT NAME:_____

PHONE: _____ RELATIONSHIP: _____

FAMILY PHYSICIAN:_____ PHONE:_____

REASON FOR VISIT:_____

REFERRED BY:_____ RELATIONSHIP:_____

SIGNATURE:_____

PRINTED NAME:_____ DATE:_____

DR.DHIR

PATIENT MEDICAL QUESTIONNAIRE

Medications include Diet/Herbs:

_____
_____
_____
_____
_____
_____
_____

Allergies including food/tape/latex:

_____
_____
_____

Please list any hospitalizations or surgery:

_____
_____
_____

FAMILY HISTORY of Illness:

Mother:_____
Father:_____
Siblings:_____

MEDICAL HISTORY:

Have you had any of the following:

Stroke..... No Yes
Head trauma..... No Yes
Fainting..... No Yes
High Blood Pressure..... No Yes
Diabetes..... No Yes
Abnormal bleeding/clotting..... No Yes
Cancer..... No Yes
Radiation or chemotherapy..... No Yes
Heart Attack..... No Yes
Tuberculosis..... No Yes
Kidney Disease..... No Yes
Thyroid Disease..... No Yes
Arthritis..... No Yes
Asthma..... No Yes
Trauma/facial surgery..... No Yes
Transfusions..... No Yes
Cosmetic Facial Surgery..... No Yes
Facial Paralysis..... No Yes
Pneumonia..... No Yes
Breast Cancer..... No Yes
Rheumatic Fever..... No Yes
HIV/Hepatitis..... No Yes

Do you smoke?..... No Yes
If yes, How much per day_____
Do you drink coffee?..... No Yes
If yes, How much per day_____
Do you drink alcohol?..... No Yes
If yes, How much per day_____
Do you use drugs?..... No Yes
If yes, which drugs?_____

SYSTEMIC REVIEW OF SYSTEMS:

GENERAL:

Fevers..... No Yes
Weight loss..... No Yes
Night Sweats..... No Yes

NEURO:

Headaches/Migraines..... No Yes
Change in vision..... No Yes
Dizziness..... No Yes
Leg pain..... No Yes
Numbness..... No Yes

SKIN:

Skin Cancer..... No Yes
Facial Lesions/Keloids..... No Yes
Jaundice..... No Yes
Hives, Eczema, Rash..... No Yes
Abnormal pigmentation.... No Yes
Infection or boils..... No Yes

CHEST:

Shortness of breath..... No Yes
Wheezing..... No Yes
Chronic Cough..... No Yes
Chest pain..... No Yes
Snoring..... No Yes
Obstructive Sleep Apnea..... No Yes

ENT:

Loss of hearing..... No Yes
Ear drainage..... No Yes
Dizziness..... No Yes
Loss of Smell..... No Yes
Facial Pain..... No Yes
Nasal obstruction..... No Yes
Nasal allergies..... No Yes
Loss of taste..... No Yes
Neck masses..... .No Yes
Hoarseness..... No Yes
Ringing..... No Yes

GI:

Diarrhea.....No Yes
Nausea/Vomiting.....No Yes
Reflux.....No Yes
Blood in Stool.....No Yes
Abdominal pain.....No Yes
Change in caliber of stool.....No Yes

HAVE YOU TAKEN THE FOLLOWING DRUGS?
Please print last date of use.

Aspirin..... Yes No _____
Coumadin..... Yes No _____
Lovenox..... Yes No _____
Ibuprofen..... Yes No _____
Motrin..... Yes No _____
Gingko..... Yes No _____
Garlic Supplement..... Yes No _____
Plavix..... Yes No _____
Biotin..... Yes No _____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION:

_____
_____
_____
_____
_____

SIGNATURE:_____

PRINTED NAME:_____

DATE:_____

DR.DHIR

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. KARAN DHIR, and KARAN DHIR, M.D. P.C. (collectively labeled *"Physician')* agree to maintain Privacy of _____(" *Patient")* as outlined in the HIPAA form. The Physician takes pride in being able to extend a greater degree of privacy than is required by HIPAA. The State and Federal laws are complex for the protection of all patients. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others. In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Physician and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Physician has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage or cast aspersions upon the Physician; and (ii) will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs and/or mass correspondence, however well intended, could severely damage Physician's practice.

Physician feels strongly about Patients' privacy as well as the practices' right to control its public image and privacy. Both Physician and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Physician's last date of service to Patient; or (b) three years beyond any termination of the Physician-Patient relationship. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients.

Patient and physician acknowledge that breach of this agreement may result in serious, irreparable harm; requiring compensation for consequential damages. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

PHOTOGRAPHIC CONSENT: I hereby consent to be photographed for medical and scientific purposes. I understand that I may be photographed before, during, and/or after surgery and that this is an important part of my permanent record.

SIGNATURE:_____

PRINTED NAME:_____