CHOPRA UROLOGY
Sameer Chopra MD PLLC
18404 N Tatum Blvd #207
Phoenix, AZ 85032

Phone: 602-777-3113
Fax: 602-726-3008
Email: info@chopraurology.com
website: chopraurology.com

NEW PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)			ADDRESS		
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
BIRTHDAY (M/D/Y)	PATIENT SSN	SEX ☐ Male ☐ Female ☐ Other_____	MARITAL STATUS ☐ Single ☐ Married ☐ Other_____		EMAIL (REQ-PORTAL)
PATIENT EMPLOYER NAME		PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)			EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ☐spouse ☐parent ☐guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)		
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE (Please Initial Before Each Line)**:**

_____I understand that I have medical insurance which is billed on my behalf should pay for the portion of my office visits, procedure and treatment charges at SAMEER CHOPRA MD PLLC.

_____I will inform SAMEER CHOPRA MD PLLC of any changes in my insurance coverage(s).

_____I understand that the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my insurance contract.

_____I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company.

_____I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on SAMEER CHOPRA MD PLLC assign all medical benefits directly to SAMEER CHOPRA MD PLLC for services rendered.

_____I understand when CT or PET/CT scan is ordered by my provider, the radiology service provided and billed to me is separate from SAMEER CHOPRA MD PLLC.

_____SAMEER CHOPRA MD PLLC may request proof of insurance premium payment at times.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

PLEASE PRINT AND COMPLETE ALL ENTRIES	
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	**Date**

Authorization to release health information to:

Name-Emergency Contact (s)		**ADDRESS**	
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ☐ **NEVER** **DATE:**		

Release the following information:

☐ **All Records** ☐ **Chart Notes** ☐ **Radiology Reports** ☐ **Operative Reports** ☐ **History & Physicals**

Name-Additional Contact (s)		**ADDRESS**	
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ☐ **NEVER** **DATE:**		

Release the following information:

☐ **All Records** ☐ **Chart Notes** ☐ **Radiology Reports** ☐ **Operative Reports** ☐ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once SAMEER CHOPRA MD PLLC discloses my health information by my request, I cannot guarantee that 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 laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- I hereby authorize SAMEER CHOPRA MD PLLC to use and disclose my personal health information to the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to 18404 N Tatum Blvd #207 Phoenix Arizona 85302. I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist. I understand that SAMEER CHOPRA MD PLLC will treat the individuals identified on this form as individuals involved directly in my care and as such, SAMEER CHOPRA MD PLLC will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations. I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from SAMEER CHOPRA MD PLLC will not be affected if I refuse to sign this authorization.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- SAMEER CHOPRA MD PLLC share the commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information.
- Please sign the form below to acknowledge that you have received and read our Notice of Privacy Practices.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

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PATIENT HISTORY FORM

To prevent medical errors it is critical you complete this form completely and accurately!

Phone: 602-777-3113
Fax: 602-726-3008
Email: info@chopraurology.com
website: chopraurology.com

First Name: _____ Last Name: _____ DOB: _____ Date: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Preferred Lab: _____

Height: _____ ft _____ in Weight: _____ lbs Age: _____ Occupation: _____

Race: _____ Primary Language: _____ Ethnic Group: _____

How did you hear about our practice:
☐ Referring Physician ☐ Friend ☐ Internet (which site?) _____ ☐ Insurance Company ☐ Other, How? _____

Name of Physician who referred you to this Office: _____

Current Physicians	Address	Phone #	Fax #	Specialty

CHIEF COMPLAINT *(Why do you want to see the doctor?)* _____

How long have you had this complaint? _____

MEDICATIONS *(List all **Prescription** drugs you are taking with dosage and schedule)* ☐ See Attached List

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

*List all **Non-Prescription** drugs:*

Vitamins: _____ Aspirin / Ibuprofen: _____

Other (including supplements): _____

ALLERGIES *(List all allergies to drugs or foods (i.e., sulfa, shellfish))* ☐ No Known Allergies ☐ See Attached List

_____

PATIENT HISTORY *(Do you have any of the following:)*

Asthma ---------- ☐ Yes ☐ No
Atrial Fibrilation---------- ☐ Yes ☐ No
Cancer---------- ☐ Yes ☐ No
Type:_____
CVA / Stroke---------- ☐ Yes ☐ No
Depression---------- ☐ Yes ☐ No
Diabetes---------- ☐ Yes ☐ No
DVT---------- ☐ Yes ☐ No

Glaucoma ---------- ☐ Yes ☐ No
Heart Disease ---------- ☐ Yes ☐ No
Hepatitis ---------- ☐ Yes ☐ No
Hyperlipidemia ---------- ☐ Yes ☐ No
Hypertension ---------- ☐ Yes ☐ No
Liver Disease ---------- ☐ Yes ☐ No
Myasthenia Gravis ---------- ☐ Yes ☐ No
Neurologic Disorder---------- ☐ Yes ☐ No

Osteoarthritis---------- ☐ Yes ☐ No
Peripheral Vascular Disease---------- ☐ Yes ☐ No
Thyroid Disorder ---------- ☐ Yes ☐ No
Tuberculosis ---------- ☐ Yes ☐ No
UTI Recurrent ---------- ☐ Yes ☐ No
Vascular Disease ---------- ☐ Yes ☐ No
No Medical Problems---------- ☐ Yes ☐ No

Other Medical Problems: _____

_____

PREVIOUS SURGERIES: ☐ Yes ☐ No If yes, please complete the below.

Type	Date	Type	Date

Previous Hospitalizations for Medical Problems: ☐ No ☐ Yes. If yes, type and date:_____

_____

FAMILY HISTORY *(Please fill out as complete as possible – # of children, status, check boxes)*

	Status (Alive/Dead)	Age	Prostate Cancer	Kidney Cancer	Bladder Cancer	Breast Cancer	Diabetes	High Blood Pressure	Heart Disease
Daughters (#)			☐	☐	☐	☐	☐	☐	☐
Sons (#)			☐	☐	☐	☐	☐	☐	☐
Father	A/D		☐	☐	☐	☐	☐	☐	☐
Mother	A/D		☐	☐	☐	☐	☐	☐	☐
Grandparent			☐	☐	☐	☐	☐	☐	☐
Sibling			☐	☐	☐	☐	☐	☐	☐
Other Family History?:									

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Children: ☐ Yes ☐ No Boys _____ Girls _____

Exercise?. . . . . ☐ Yes ☐ No Type: _____

Current Tobacco use?..... ☐ Yes ☐ No Prior Tobacco use? ☐ Yes ☐ No

Alcohol use?..... ☐ Yes ☐ No Current Drug use? ☐ Yes ☐ No Type: _____

Caffeine use? (Cups / Day): Coffee: _____ Tea: _____ Cola: _____

REVIEW OF SYSTEMS (Have you currently or recently had)

General
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Gain ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No

Allergy
Drug Allergies ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No

Opthalmologic
Blurred Vision ☐ Yes ☐ No

ENT
Dry Mouth ☐ Yes ☐ No
Nosebleeds ☐ Yes ☐ No

Endocrine
Cold Intolerance ☐ Yes ☐ No
Excessive Sweating ☐ Yes ☐ No
Heat Intolerance ☐ Yes ☐ No

Respiratory
Shortness of Breath ☐ Yes ☐ No

Cardiovascular
Chest Pain ☐ Yes ☐ No
Edema (swelling) ☐ Yes ☐ No

Gastrointestinal
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea ☐ Yes ☐ No

Hematology
Bleeding Problems ☐ Yes ☐ No

Musculoskeletal
Back Pain ☐ Yes ☐ No
History of Gout ☐ Yes ☐ No

Peripheral Vascular
Blood Clots in Legs ☐ Yes ☐ No

Skin
Rashes ☐ Yes ☐ No

Neurologic
Leg or Arm Weakness ☐ Yes ☐ No
Balance Difficulty ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

Psychiatric
Depressed Mood ☐ Yes ☐ No

Date of Last:
Flu Shot _____
Varicella _____
Colonoscopy _____
Dexa Scan _____

Females
Mammogram _____
Annual Pap _____

Form Completed By: _____ Date: _____

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Payment Policy

Patient Name: _____ Date of Birth: _____

_____

We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it carefully, ask us any questions you may have, and sign in the space provided. ***A copy will be provided to you upon request.***

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failing to collect co-payments and deductibles could violate our insurance contracts with federal and private insurance companies.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claim submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. ***You will receive a total of 3 statements over the period of 90 days, via mail or email. Please be aware that if a balance remains unpaid, your account will be managed by the third-party collection agency and the agency will charge 25% administrative fee in addition to your balance due*** (for example, if your balance due is $100, the collection agency will charge $25 admin fee, then the total amount due will be $125.00).

8. Missed appointments. Our policy is to charge in an amount of **$50.00** for missed appointments, not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for your understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understood the above information, and agree to accept the conditions:

_____ _____

Signature of patient or responsible party ***Date***