SHYAMALI M SINGHAL, M.D.

PATIENT INFORMATION

TODAY'S DATE ______________________ Referring Physician ______________________________

______________________ ______________________ ______________

PATIENT'S LAST NAME FIRST NAME MI

Date of Birth ____________ Social Security # ______________________ Sex: M ( ) F ( )

Marital Status: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Other ______________________

Home Phone __________________ Cell Phone __________________ Email ______________

Work Phone ______________ Employer ______________________________

Address ______________________ ______________ __________ ______________

House # and Street City State Zip Code

This address is for billing and insurance purposes. Please be specific.

INSURANCE

PRIMARY INSURANCE ______________________________ ID# ______________________

Primary Insured ______________________ Date of Birth ______________ Relationship ____________

Second Insurance ______________________________ ID# ______________________

Primary Insured ______________________ Date of Birth ______________ Relationship ____________

For HIPPA purposes another person who can discuss my account on my behalf ______________________

Relationship ______________________ Phone number ______________________________

In case of Emergency notify: Name ______________________________ Relationship ____________

Day Phone ______________ Cell Phone ______________ Work Phone ______________________

CO-PAYMENT IS DUE AT TIME OF SERVICE--STATEMENT OF RESPONSIBIITY—OFFICE POLICY

I have given this office my correct insurance information. I agree that it is solely my responsibility to notify the office of changes in coverage, address, and telephone numbers. Should the information provided be incorrect, I agree to be responsible for any and all amounts billed to me. I also understand and agree that I am responsible for services that my insurance plan does not cover, including out of plan services. Moreover, I understand that I will be charged for late cancellation of appointments or "no-shows" as well as a $10.00 invoicing fee for non-payment of my co-pay at time of service. Finally, in signing this document I give this office permission to release my medical records to my insurance carrier upon their request.

PLEASE PROVIDE INSURANCE CARD. Date ____________ ______________________________

Patient or Responsible Party Signature

Patient Health History

Patient Name ______________________________ Date ______________

Age ______ Birthdate ________________ Date of Last Physical Exam ______________

What is the reason for this visit? ____

Race ______________ Ethnicity ____________ Preferred Language ____________________

Check symptoms you currently have or have had in the past year.

GENERAL
- ❑ Change in weight
  Loss or Gain (circle one)
- ❑ Change in moles
  Describe: ____________
- ❑ Sore that won't heal
- ❑ Fatigue
- ❑ Weakness
- ❑ Fevers
- ❑ Chills
- ❑ Rash/itching/dryness
- ❑ Change in hair
  Describe: ____________
- ❑ Change in nails
  Describe: ____________

EYE/EAR/ NOSE/THROAT
Eyes:
- ❑ Change in vision
  Describe: ____________
- ❑ Eye pain
- ❑ Redness
- ❑ Tearing
- ❑ Double Vision

Ears:
- ❑ Loss of hearing
- ❑ Tinnitus
- ❑ Vertigo
- ❑ Earache
- ❑ Discharge

Nose:
- ❑ Hay Fever
- ❑ Nosebleed

Mouth:
- ❑ Change in teeth
  Describe: ____________
- ❑ Bleeding gums
- ❑ Sore Throat
- ❑ Hoarseness

Throat:
- ❑ Difficulty swallowing (dysphagia)
- ❑ Lumps
- ❑ Goiter
- ❑ Throat pain
- ❑ Throat stiffness

RESPIRATORY
- ❑ Cough
  - ❑ Blood
  - ❑ Sputum

  Color ____________

  Quantity ____________
- ❑ Dyspnea
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis/TB

CARDIOVASCULAR
- ❑ High BP
- ❑ Low BP
- ❑ Murmurs
- ❑ Orthopnea
- ❑ Nocturnal dyspnea
- ❑ Swelling of ankles (edema)
- ❑ Chest pain
- ❑ Irregular Heart Beat (palpitations)
- ❑ Leg Cramps (claudication)
- ❑ Varicose veins
- ❑ Vein Inflammation (thrombophlebitis)

GASTRO-INTESTINAL
- ❑ Change in appetite
  Loss or Gain (circle one)
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Bloating
- ❑ Lactose Intolerance
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Liver/gallbladder problems
- ❑ Jaundice/hepatitis

MUSCLE/JOINT/BONE
- ❑ Joint pain
- ❑ Back Pain
- ❑ Swelling/bruising
- ❑ Joint stiffness
- ❑ Arthritis
- ❑ Gout
- ❑ Cramps
- ❑ Proximal weakness
- ❑ Functional limit

ENDOCRINE
- ❑ Excessive hunger (polyphagia)
- ❑ Excessive thirst (polydipsia)
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Excessive sweating (diaphoresis)
- ❑ Thyroid problem
- ❑ Diabetes
- ❑ Skin color change
  Describe: ____________
- ❑ Excess hair growth

NEURO/PSYCHOLOGY
- ❑ Headache
- ❑ Seizures
- ❑ Numbness/tingling
- ❑ Anxiety
- ❑ Stress
- ❑ Depression

GENITO-URINARY
- ❑ Painful urination (dysuria)
- ❑ Blood in urine
- ❑ Nocturia
- ❑ Excessive urination (polyuria)
- ❑ Change in urination
  Describe: ____________
- ❑ Lack of bladder control/incontinence
- ❑ Urinary Tract Infection
- ❑ Kidney stones

REPRODUCTIVE
- ❑ Breast lump
- ❑ Breast pain
- ❑ Breast discharge

Women only:
- ❑ Pregnancy complication
- ❑ Currently pregnant
- ❑ Bleeding between periods
- ❑ Abnormal Pap Smear

Date of last:

Period ____________

Pap Smear ____________

Mammogram ____________

# of children ____________

OTHER ____________

____

Check conditions you currently have or have had in the past year.

❑ AIDS	❑ Chemical Dependency	❑ High Cholesterol	❑ Prostate Problem
❑ Alcoholism	❑ Chicken Pox	❑ HIV Positive	❑ Psychiatric Care
❑ Anemia	❑ Diabetes	❑ Kidney Disease	❑ Rheumatic Fever
❑ Anorexia	❑ Emphysema	❑ Liver Disease	❑ Scarlet Fever
❑ Appendix	❑ Epilepsy	❑ Measles	❑ Stroke
❑ Arthritis	❑ Glaucoma	❑ Migraine Headaches	❑ Suicide Attempt
❑ Asthma	❑ Goiter	❑ Miscarriage	❑ Thyroid Problems
❑ Bleeding Disorders	❑ Gonorrhea	❑ Mononucleosis	❑ Tonsillitis
❑ Breast Lump	❑ Gout	❑ Multiple Sclerosis	❑ Tuberculosis
❑ Bronchitis	❑ Heart Disease	❑ Mumps	❑ Typhoid Fever
❑ Bulimia	❑ Hepatitis	❑ Pacemaker	❑ Ulcers
❑ Cancer	❑ Hernia	❑ Pneumonia	❑ Vaginal Infections
❑ Cataracts	❑ Herpes	❑ Polio	❑ Venereal Disease

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:	Disease	Relationship to you	Maternal/ Paternal
Father					❑	Arthritis		M / P
Mother					❑	Asthma		M / P
Brothers					❑	Cancer		M / P
					❑	Chemical Dependency		M / P
					❑	Diabetes		M / P
					❑	Gout		M / P
Sisters					❑	Hay Fever		M / P
					❑	Heart Disease		M / P
					❑	Strokes		M / P
					❑	High Blood Pressure		M / P
Children					❑	Kidney Diseases		M / P
					❑	Tuberculosis		M / P
					❑	Other		M / P

MEDICATIONS List medications you are currently taking. Provide Details. Name, strength, directions, and date when medication was started.

Pharmacy Name________________________ Phone____________

City________________________________

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, please give approximate dates____________________________

SURGERIES	DATE	OUTCOME

HOSPITALIZATIONS / SERIOUS ILLNESSES / INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications, if any

ALLERGIES To medications or substances

HEALTH HABITS Check (✓) which substances you use and describe how much you use

❑	Caffeine	
❑	Tobacco	PPD: Years:
❑	Alcohol	
❑	Other	
❑	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following

❑	Stress
❑	Hazardous Substances
❑	Heavy Lifting
❑	Other
❑	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

________________________________ Signature ________________ Date

________________________________ Reviewed By ________________ Date

BREAST QUESTIONNAIRE

Today's date ____________________ Your age ______________

Current problem/concern: ☐ Lump ☐ Abnormal imaging ☐ Pain ☐ Nipple discharge ☐ 2nd opinion ☐ Other__________
Which breast: ☐ Left ☐ Right ☐ Both Does it vary with menses? ☐ Yes ☐ No How? __________
When noticed? __________ By whom? ____________________ Do you do SBE ☐ Yes ☐ No How often? __________

Have you had a biopsy for this? ______ Result? ______________________________

Has it changed? ☐ Yes ☐ No How? ______________________________

Have you had other breast problems? ☐ Yes ☐ No

What? ______________________________ Was biopsy done? ☐ Yes ☐ No

What side? ______________________________ When? ______________________________

Where? ______________________________ Results ______________________________

Have you had breast cancer in the past? ☐ Yes ☐ No When?

Type ______________________________ Treatment ______________________________

Chemotherapy? ☐ Yes ☐ No Radiation? ☐ Yes ☐ No

When and where were your last three mammograms? ______________________________

____

GYN History

Age when you started menstrual periods __________

pregnancies ______ # deliveries ________ # miscarriages ______ # abortions __________

Age at first pregnancy _____ Age at first live birth ____ Breast fed? ☐ Yes ☐ No How many? _____ How long? ________

Do you still have periods? ☐ Yes ☐ No Start date last menses ______________________________

Date of last PAP ____________________ Any history of abnormal PAP? ☐ Yes ☐ No

Current birth control method ______________________________

Ever take birth control pills? ☐ Yes ☐ No When/how long? ______________________________

Ever take fertility drugs? ☐ Yes ☐ No What/when/how long? ______________________________

Have you reached menopause? ☐ Yes ☐ No

Age at menopause? _______ ☐ Natural ☐ Surgical ☐ Chemo induced

☐ Ovaries removed: ☐ both ☐ one ☐ Hysterectomy - reasons for ______________________________

Ever take Hormone replacement / Estrogen/Progesterone? ☐ Yes ☐ No What/when/how long?

Have you ever taken anti-estrogens? ☐ Yes ☐ No

☐ Tamoxifen ☐ Arimidex ☐ Others ______________________________

When/how long/why? ______________________________

Notes: ____

____

____

____

____

Family History Screening Questionnaire

Are you adopted? Yes____ No_____

Please list all of the blood relatives in your immediate family who have had any form of cancer (mother, father, sister, brother, son, daughter):

Relationship to You	*Type of Cancer (e.g., breast, uterus, colon, etc.)*	*Approximate Age at Diagnosis*

Please list all of the blood relatives on both sides of your extended family who have had any form of cancer (aunt, uncle, cousin, niece, nephew, grandparent):

Your Mother's Side Of The Family

Relationship to You	*Type of Cancer (e.g., breast, uterus, colon, etc.)*	*Approximate Age at Diagnosis*

Your Father's Side of the Family

Relationship to You	*Type of Cancer (e.g., breast, uterus, colon, etc.)*	*Approximate Age at Diagnosis*

Are you Ashkenazi Jewish? Yes_____ No______

Your Mother's Ancestry (e.g., Italian, Cambodian, Swedish, etc.)

____

Your Father's Ancestry ______________________________

Patient Label

Shyamali Singhal, MD, PhD

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

I understand that the physician is licensed and regulated by the Medical Board of California.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHYAMALI SINGHAL, MD, PhD

I understand that, under the Health Insurance Probability & 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 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 assessment and physician certifications.

I have received, read, and understand 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 healthcare operations. I also understand that 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:

Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can obtain this information.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosis, and providing treatment. Such disclosures may include the results of laboratory tests and procedures made available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments. Your health information may be used to seek payment from your health plan, from other sources of coverage such as other insurers, or from credit card companies that you use for paying services. An example would be your health plan may request and receive information on dates of service, services provided and medical condition being treated.

Health care operations. Your health information may be used as necessary to support the daily activities of Shyamali Mallick Singhal, M.D., Ph.D.

As an example, information on the services you received may be used to support financial reporting, projections, and steps for evaluating and promoting quality care.

Legal. Your health information may be disclosed to public health agencies as required by law. An example would be if we are required to report some communicable diseases to the state's public health department.

Other uses and disclosures requiring authorization. Disclosure of your health information or its use for any purpose other than that above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. This decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notification to revoke your authorization.

Additional Uses of Information

Your health information will be used by our staff to send you appointment reminders. Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to receive a printed copy of this notice.
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.

Shyamali Mallick Singhal, M.D., Ph.D. Duties

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulations. Upon request, we will provide you with the revised notice at the time of your office visit. These will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

For more information about HIPAA:

US Department of Health & Human Services
202-619-0257
Toll Free: 1-877-696-6775