K. Kay Durairaj, MD, FACS, A Medical Corporation

New Patient Registration Form

Today's Date: _____

PATIENT INFO:

Last Name: _____ First Name: _____ MI: _____ Sex: F / M

Age: _____ DOB: _____ SSN: _____-_____-_____ DL#: _____

Address: _____ Suite/Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Height: _____ Weight: _____ Email: _____

Ethnicity: _____ Race(s): _____ Please Indicate: Hispanic / Non-Hispanic

Preferred Language: _____ May we leave detailed health messages on your voicemail?: Y / N

Contact Restrictions?: Y / N If Y, please specify: _____

WORK INFO: (If patient is a minor, give patient/guardian employment information)

Are you employed?: Y / N If Y, please specify name of employer: _____

Occupation/Job Description: _____ Work Phone: _____

Work Address: _____

INSURANCE INFO:

Primary Insurance: _____ Type: PPO Other: _____

Secondary Insurance: _____ Type: PPO Other: _____

OTHER INFO:

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

If married, spouse name: _____ Phone: _____

If minor, parent name: _____ Phone: _____

How were you referred to our office?: _____

Primary Care Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above insurance companies, and assign directly to Dr. Durairaj all insurance benefits, if any, otherwise payable to me for service rendered. I understand Dr. Durairaj may use my healthcare information and may disclose it to the above-named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Parent, Guardian, or Personal Representative Date

Name: _____ **DOB:** _____ **Date:** _____

MEDICAL HISTORY:

What are your medical concerns today?: _____

_____

_____

List any medical conditions, major illnesses, or injuries: _____

_____

List any medications you are taking: _____

_____

List any surgeries you have had: _____

_____

Any adverse reactions to anesthesia?: Y / N If Y, please specify: _____

List any drug/food allergies: _____

_____

Type of allergic reaction experienced: _____

List any major medical problems of family members: _____

_____

SOCIAL HISTORY & LIFESTYLE:

Marital Status: Single Married Divorced Widowed

Have you received radiation in the past?	Y	N	If Y, please specify: _____
Do you smoke cigarettes/chew tobacco?	Y	N	Or, quit date: _____
Do you drink alcohol?	Y	N	If Y, number of drinks per day: _____
Do you take recreational drugs?	Y	N	If Y, please specify: _____

Other health info: _____

SKIN QUESTIONNAIRE:

____ History of skin cancer or melanoma	____ Acne	____ Prominent scar
____ Dark spots on skin	____ Loose skin	____ Mole removal
____ Thinning of eyebrows/lashes/hair	____ Oily skin	____ Excessive veins
____ Injectable treatments and dermal fillers	____ Wrinkles	____ Tired or droopy eyes

What skin procedures and/or treatments have you had in the past?: _____

What products are you currently using on your skin? (Your skincare regimen): _____

_____

Do we have your approval to send you information on products and services, including sales and special offers?: Y / N

Name: _____ **DOB:** _____ **Date:** _____

REVIEW OF SYSTEMS: (Please check all that apply)

Cardiac:
____ Chest pain/discomfort/pressure/burning
____ Sweats
____ Trouble breathing lying down
____ Palpitation (racing/skipping heartbeat)
____ Fainting
____ Light-headedness
____ Hypertension
____ Heart attack

Vascular:
____ Leg pain/cramps
____ Edema (swelling of hands/feet)

Constitutional:
____ Weight gain
____ Weight loss
____ Fever

Head/eyes/ears/nose/throat:
____ Visual changes
____ Decreased hearing
____ Tinnitus/ringing in ears
____ Dry eyes
____ Ocular pain
____ Throat pain

Respiratory:
____ Snoring
____ Hemoptysis (coughing up blood)
____ Dyspnea (shortness of breath)
____ Cough
____ Wheezing
____ Trouble breathing at night

Gastrointestinal
____ Nausea
____ Reflux (heartburn)
____ Vomiting
____ Anorexia
____ Abdominal pain
____ Change in bowel habits
____ Constipation
____ Dark or tarry stool
____ Hemorrhoids

Endocrine
____ Goiter (enlarged thyroid)
____ Diabetes

Psychiatric
____ Depression
____ Hallucinations
____ Anxiety
____ Claustrophobia

Hematologic
____ Acute anemia
____ Thrombocytopenia
____ Abnormal bruising
____ Leukemia
____ Lymphoma
____ Past blood transfusions

Reproductive
____ Use of oral contraceptives/estrogen
____ Miscarriage
____ Abortion

Skin
____ Rash
____ Open sores/wound
____ Nodules/skin lesions
____ Psoriasis
____ Skin cancer

Musculoskeletal
____ Arthritis
____ Going swelling or pain
____ Myalgia (muscle weakness)

Genitourinary
____ Hematuria (blood in urine)
____ Nocturia (frequent nighttime urination)
____ Erectile dysfunction
____ Incontinence
____ Sexually transmitted infection(s)
____ Bladder infections

Neurologic
____ Dizziness/vertigo
____ Memory loss
____ Seizures
____ Headaches
____ Stroke
____ Tremors

Name: _____ **DOB:** _____ **Date:** _____

QUESTIONNAIRES

SLEEP APNEA (Please check all that apply)

1. Please check all that apply.
   - ____ I've been told to stop breathing while asleep
   - ____ I've fallen asleep or nodded off while driving
   - ____ I've woken up suddenly with shortness of breath
   - ____ I've woken up suddenly gasping
   - ____ I've woken up suddenly with my heart racing
   - ____ I feel excessively sleepy during the day
   - ____ I snore, or I've been told I snore
   - ____ I've had weight gain and I find it difficult to lose
   - ____ I grind my teeth at night or clench my jaw.
   - ____ I've taken medication for high blood pressure
   - ____ I've been diagnosed with high blood pressure
   - ____ I kick or jerk my legs while sleeping
   - ____ I feel burning, tingling, or crawling when I wake
   - ____ I wake up with headaches during the night
   - ____ I wake up with headaches in the morning.
   - ____ I have trouble falling asleep.
   - ____ I have trouble staying asleep once I fall asleep.
   - ____ I have restless disturbed sleep.
2. How many hours of sleep do you get each night?:
   _____ hours _____min.
3. How many times do you awaken each night?:
   _____ times

HOARSENESS

1. Please indicate the level of your voice use:
   - ____ Elite vocal performer (singer, actor)
   - ____ Vocal professional (teacher, lawyer)
   - ____ Professional voice user (clergyman, lecturer)
   - ____ Non-vocal professional (techincal, clerk)
2. My voice problem came on:
   - ____ Slowly
   - ____ Suddenly

   My voice problem is:
   - ____ Constant
   - ____ Often
   - ____ Occasional
   - ____ Rare

   My voice problem is:
   - ____ Worsening
   - ____ Staying the same
   - ____ Starting to improve

   My voice is worse:
   - ____ In the morning
   - ____ Later in the day after use
   - ____ Same all day
3. Please check your symptoms and/or issues:
   - ____ Hoarseness, harsh, or scratchy sound
   - ____ Fatigue, where voice tires or changes quality
   - ____ Complete loss of voice at times
   - ____ Double tone during speaking or singing
   - ____ Pain/aching in throat or neck with long voice use
   - ____ Voice breaks or cracks in certain pitches
   - ____ Decrease in vocal range
   - ____ Bitter/acidic taste/burning sensation in throat
   - ____ Sensation of a lump/something stuck in throat
   - ____ Cough or frequent throat clearing
   - ____ Nasal or sinus drainage down back of the throat
   - ____ Changes in the skin or hair
   - ____ Thyroid problems
   - ____ Heartburn, acid reflux, hiatal hernia
4. Are you exposed to significant amounts of smoke, fumes, and/or chemicals?: Y / N
5. Are you known to speak extensively or excessively on a regular basis?: Y / N
6. How long have you had a voice problem?: _____
7. Normal voice periods last for how long?: _____
8. Things I know of that make the problem worse: _____
9. Things I know of that make the problem better: _____

Name: _____ **DOB:** _____ **Date:** _____

Patient-Provider E-mail Agreement

Email offers an easy way for patients and doctors to communicate. In many circumstances, it can have advantages over office visits and telephone calls. But remember, there are **differences**. E-mail is not the same as calling our office; you can't tell when your message will be read, or if your doctor is in the office. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care. It will further assist us if you could identify the nature of your request in your e-mail subject line. Below are our rules for e-mail contact.

- E-mail is never, ever appropriate for urgent or emergency problems! Please use the telephone or go to your nearest hospital's emergency room for emergencies.
- E-mail is great for asking little questions that don't require much discussion. Appropriate uses also include prescription refill requests, referral/appointment scheduling requests, and billing/insurance questions.
- E-mails should not be used to communicate sensitive medical information.
- E-mail is not confidential. My staff may read your e-mails to handle routine, non-clinical matters. If sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of your medical record; a copy may be printed and saved in your chart.
- E-mail is not suitable for seeing me. If you think you might need to be seen, please call for an appointment.
- E-mails may be forwarded to my staff for handling, if appropriate.
- Remember, e-mail services such as Google, Yahoo, Hotmail, and various other providers do not promise complete privacy. They are not HIPAA-compliant and are not encrypted.
- Finally, either one of us can revoke permission to use the e-mail system at any time.

I DO want to communicate with Dr. Kay Durairaj's office electronically. This includes occasional informational newsletters. I have read the above information, and understand the limitations of security on information transmitted. I understand that Dr. Kay Durairaj may not be able to communicate with me electronically about my specific condition if I live outside the state in which she is licensed. Should you choose to communicate with us via e-mail, please add our email address, **info@beautybydrkay.com** to your address book.

_____ _____

Email address Name

_____ _____

Signature DOB

Name: _____ **DOB:** _____ **Date:** _____

Group Financial Policy

We wish to inform you in advance of our office's financial policies. Patients are responsible for knowing their own insurance coverage, presenting their medical insurance ID card, and paying their co-pay before being seen. There are thousands of plans under one insurance company name. It is impossible for our office to know the terms of each plan. Our goal is to assist you to the best of our ability using the information provided to us. It is extremely important that you give us current, accurate, and complete information at the time of service to avoid any misunderstanding or confusion. If your insurance does not pay because you did not provide correct information before receiving services, you will be billed. Regardless of your insurance coverage, you are financially responsible for services rendered. Since each insurance company and individual plans may be different, and insurance plans will not guarantee payment/coverage of benefits, we do not know what they will or will not pay until we receive the explanation of benefits. Many questions about billing are answered in this financial policy. Please take the time to read and sign this notice. Thank you.

Private Pay & Co-Pay Options (due at at the time of service): For the payment convenience, we accept Visa, MasterCard, Amex, Discover, and cash. Please not that "Private Pay" includes patients, as well as patients without insurance cards and patients with insurance we do not participate with. For these patients, payment is expected on the day that you see the doctor or receive care.

Medicare: We are participating providers with the "tradition" or "regular" Medicare Part B. We are not contracted with Medicare Advantage PPO plans. Ultimate financial responsibility lies on the subscriber. In addition, we are not contracted with Medicare Advantage HMO. We accept Medicare's fee schedule ("assignment") for traditional Medicare only, which pays 80% of the allowed charge. You are responsible for the remaining 20%, and any non-covered services. If you have any plan other than straight Medicare, we may not be able to see you under your plan. We need to verify your Medicare plan before you are seen, and we advise you to confirm your plan type before coming in to avoid any inconvenience. If you have a secondary insurance to Medicare (known as MediGap or supplemental), you are responsible for providing a current, valid insurance card at the time of service. We will bill as a courtesy if it doesn't cross over from Medicare to your supplemental insurance. We also accept Medicare/Medical plans. Only if the secondary plan has not been turned over to another carrier, such as Healthnet.

Medical Insurance: We do participate with most major, medical PPO plans and accept their allowed rate, if we are contracted. Your current insurance card must be present at the time of service. Please note that inclusion in a provide directory or insurance plan list, does not mean we are currently contracted with an insurance plan. We do not participate in Covered California plans.

Additional Test of Procedures (shots, injections, ear cleaning, scopes): Consultations and exams do not include special tests or procedures. These tests are billed separately from the exam, and some insurance plans apply such test or procedure to a deductible (for which you are responsible) even though you may not have a deductible of the physician services/exam. Scopes and ear cleaning are considered office surgeries and fall under surgery/copays and deductibles. Other non-covers items include shots/injections. The cost of some medications like Depo-Medrol, Solu-Medrol, and Kenalog are not reimbursed adequately by insurance. The insurance company does not cover our cost price, so you will be asked to pay to cover this medication cost. We collect a portion from you and bill the insurance company for the part that they cover, the administering of the shot.

_____ _____

Signature Date