

**UNITY Healthcare**  
**Notice of Privacy Practices for Protected Health Information**  
**Acknowledgement of Receipt of Notice of Privacy Practices**

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I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Request for Limitations and Restrictions of Protected Health Information** (This only pertains to how our office communicates with you.) PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

It is the office policy of Ravish J. Mahajan, M.D., and staff not to release confidential and/or unauthorized information. When returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence, unless permission is granted as shown below. Information also will not be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself, please complete the following (*We can reach you in an emergency, if we have your cell phone number*):

I hereby authorize Ravish J. Mahajan, M.D., and/or his staff, to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the doctor's office whenever this information changes:

			<u>Phone Number</u>
Home Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Answering Machine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Work Telephone:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Voice Mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cell Phone and/or mail:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pager:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**Please list the names of authorized people:**

Spouse: \_\_\_\_\_

Parent: \_\_\_\_\_

Other (*please list name & relationship*): \_\_\_\_\_

Other (*please list name & relationship*): \_\_\_\_\_

**SIGNATURE OF PATIENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**FINANCIAL INTEREST DISCLOSURE**

Unity Healthcare, LLC ("Unity") holds an investment interest in certain bonds which were issued for financing health care facilities of St. Elizabeth Regional Health. St. Elizabeth Regional Health is owned and operated by the Sisters of St. Francis Health Services, Inc ("SSFHS"). You are free to determine which facility to utilize for health care services and neither Unity nor your physician will discriminate in the care provided to you should you desire to use a non-SSFHS facility.

**Please acknowledge your receipt of this disclosure by signing below.**

**By:** \_\_\_\_\_ **Relation to pt:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Patient, or in case of minor, patient's guardian

**PATIENT HISTORY FORM**

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Date: \_\_\_\_\_

Name: \_\_\_\_\_

<b>• Past Medical History</b>	<b>Yes</b>	<b>No</b>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>
CAD, MI (heart disease) MVP .....	<input type="checkbox"/>	<input type="checkbox"/>
COPD, lung disease .....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure .....	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high BP) .....	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric illness .....	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer .....	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyp .....	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer .....	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome .....	<input type="checkbox"/>	<input type="checkbox"/>

<b>Surgeries</b>	<b>Yes</b>	<b>No</b>
Partial hysterectomy .....	<input type="checkbox"/>	<input type="checkbox"/>
Complete hysterectomy .....	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder .....	<input type="checkbox"/>	<input type="checkbox"/>
Appendix .....	<input type="checkbox"/>	<input type="checkbox"/>
Cesarean section .....	<input type="checkbox"/>	<input type="checkbox"/>
Lysis of adhesions .....	<input type="checkbox"/>	<input type="checkbox"/>
Bladder tack .....	<input type="checkbox"/>	<input type="checkbox"/>
Inguinal hernia (groin) .....	<input type="checkbox"/>	<input type="checkbox"/>
CABG (cardiac bypass) .....	<input type="checkbox"/>	<input type="checkbox"/>
Tonsils/Adenoids .....	<input type="checkbox"/>	<input type="checkbox"/>
Gastric bypass .....	<input type="checkbox"/>	<input type="checkbox"/>
Colon resection .....	<input type="checkbox"/>	<input type="checkbox"/>

**List other Medical history:** \_\_\_\_\_

**List other surgeries:** \_\_\_\_\_

<b>• Family History</b>	<b>Relation</b>	<b>Yes</b>	<b>No</b>	<b>Relation</b>	<b>Yes</b>	<b>No</b>	
Chronic hepatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's, colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>
Liver cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Colon cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
PUD	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other gastro cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syn	_____	<input type="checkbox"/>	<input type="checkbox"/>

**Other relevant family history:** \_\_\_\_\_

<b>• Social History</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
Tobacco	Currently? <input type="checkbox"/>	<input type="checkbox"/>	Alcohol use:	<input type="checkbox"/>
	Quit date _____		Oz. per week _____	Quit date _____
	Packs per day _____		Alcohol or drug rehabilitation	<input type="checkbox"/>
	Total # years _____		Date _____	<input type="checkbox"/>
Diet history	Low fat <input type="checkbox"/>	<input type="checkbox"/>	<b>Last Menstrual Period</b> _____	
	Diabetic <input type="checkbox"/>	<input type="checkbox"/>	<b>Are you pregnant?</b>	<input type="checkbox"/>
	Salt restricted <input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

**Medications:** (List name, dosage, directions) PLEASE BRING ALL OF YOUR MEDICATION BOTTLES FOR EVERY APPOINTMENT

Occupation: \_\_\_\_\_

Previous upper endoscopy: Yes / No Date: \_\_\_\_\_

Previous colonoscopy : Yes / No Date: \_\_\_\_\_

Problems with sedation : Yes / No Date: \_\_\_\_\_

Findings on endoscopy : \_\_\_\_\_

History of endocarditis Yes No

Prosthetic heart valve Yes No

Recent vascular graft (<1 yr) Yes No

Recent joint replacement (<1 yr) Yes No

**Allergies:** \_\_\_\_\_

**Medicine allergies:** \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Nurse Signature

\_\_\_\_\_  
R. Mahajan, M.D. (reviewed)

\_\_\_\_\_  
Date reviewed

