Vinod Sancheti, MD, Internal Medicine
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25 Mule Rd, Suite B8, Toms River, New Jersey 08755
307 Route 70, Suite 1A, Lakehurst, New Jersey 08733
TEL. 732-240-4000 Fax 732-240-1441 www.drsancheti.com

Dear New Patient,

I'd like to take a moment to welcome you as a new patient. Thank you for choosing us. We look forward to partnering with you to address your health concerns, and we will do all we can to ensure your satisfaction.

Please fill out the enclosed forms as you prepare for your upcoming appointment. Be sure to bring the following items:

- Your insurance card
- A picture ID
- A list of medications (including bottles)
- Any previous health records
- A list of all the doctors you have seen previously

We are delighted to welcome you to our practice!

Yours in Health and Wellness,

Dr Vinod Sancheti and staff

PATIENT REGISTRATION

DATE: _____

Last Name: _____ First Name: _____ Middle initial: _____

Street Address: _____

Billing Address: _____

City: _____ State: _____Zip Code: _____

Phone No.:( ) _____Cell Phone No.:( ) _____Email: _____

Date of Birth: _____ Marital Status: M S W D

Social Security Number: _____

Employer: _____ Employer Ph No.: _____

Employer Address: _____

INSURANCE INFORMATION

Primary Name: _____

Address: _____

Identification Number: _____ Group Number: _____

Policyholder's Name: _____ Date of Birth: _____

Employer: _____

Secondary Name: _____

Address: _____

Identification Number: _____ Group Number: _____

Policyholder's Name: _____ Date of Birth: _____

Employer: _____

Person Responsible For Payment:

Last Name: _____ First Name: _____ Middle initial _____

Street Address: _____

City: _____ State: _____Zip Code: _____

Insurance Authorization and Blanket Assignment (please read and sign):

I request that payments from insurance be made to Vinod Sancheti MDPA for any bills related to services rendered to me by this practice. I also authorize Vinod Sancheti MDPA to furnish information to insurance carriers concerning my illness and treatments. I here by also assign all payments for medical services rendered to me or my dependents to Vinod Sancheti MDPA, and I understand that I am responsible for any amounts not covered by insurance.

Release of Information:

I understand that once this facility discloses my health information by my request, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization. I may request at any time to obtain a copy of the records with a written request.

Date: _____Signature: _____

307 Route 70, Suite IA, Lakehurst, NJ Phone: 732-657-8138 Fax: 732-240-1441

Vinod Sancheti MD Board Certified in Internal Medicine

Medical History Form

Name: Age:

Past Medical History (List in order of occurrence, starting with the most recent):

Problem/Diagnosis	**Approx. Year of Onset**
1	
2	
3	
4	
5	

Past Surgical History (List in order of occurrence, starting with the most recent):

Surgery/Procedure	**Approx. Year of Surgery**
1	
2	
3	
4	

Family History (List major medical problems, if any. Please include current age or age at death):

First Name & Age	Deceased?	Medical Conditions/Cause of Death
Father		
Mother		
Brothers:		
1		
2		
3		
Sisters:		
1		
2		
3		

Social History

- **Do you smoke now?**
  Yes ☐ No ☐
  Have you ever smoked in the past?
  Yes ☐ No ☐
  If yes, how much and for how long?
  Packs per day: _____
  For how long: _____

- **Do you consume alcohol?**
  Yes ☐ No ☐
  If yes, how much and how often?

- **Have you ever used recreational drugs?**
  Yes ☐ No ☐
  If yes, please explain:

- **Do you have a living will?**
  Yes ☐ No ☐

Current Medications (If a medication is stopped only temporarily, please list it below):

Drug Name	Dosage (mg)	Directions / Number of Pills Daily
1		
2		
3		
4		
5		
6		
7		

Allergy Information (Please list any adverse reactions you've had to medications, iodine, or shellfish. Explain below.)

Allergy	Reaction (e.g., Rash, Diarrhea, etc.)
1	
2	
3	

Last Complete Physical Date: _____

Note to Patient: This is a confidential record of your medical history and will be kept in this office. The information contained here will not be released to any person or facility except when you have authorized to do so.

Medical information

Date of last flu shot: _____

Date of last pneumonia shot: _____

Date of shingles shot: _____

Date of tetanus shot (Td/Tdap): _____

Date of colonoscopy/Cologuard: _____

Date of endoscopy: _____

Date of last eye exam: _____

Last date for mammogram: _____

Last date of bone density: _____

List All Doctors Seen in the Past (Including Specialists):

Name	**Tele/Fax**
1	
2	
3	
4	

(By filling the information, you give us the right to request medical records for the use of treatment)

Signature: _____ Date:_____

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TEST REPORT POLICY

This is to inform you that we call all our patients when we on for results on tests we have ordered, such as blood test reports, X-ray reports, or any other test report. We try to call patients as soon as possible, even though test result is norrnal.

If you had any test ordered by our physicians and you do not hear from our offce about the results within one week, then it is possible that the results had not yet been received by our offce.

You are advised to then call us back for results of your tests; we are not responsible for any missed diagloses, or damage done due to absent reports.

It is also important that you understand and follow our advice about having laboratory test, X-ray, or any other tests, done as soon as possible. You are also advised to follow our recommendations to see specialist if needed for further check up, work up, or treatment. If you do not follow our advice about recommended treatment or tests, we are not responsible for any consequences this may cause.

Upon your visit you can ask us to clarify our advice or recommendations.

I have read and understand the above policy

Patients Name: _____

Signature of Patient: _____

Date: _____

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DR. VINOD SANCHETI

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTICE TO PATIENT:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature **date** **Witness** **date**

I Authorize Dr. Sancheti and any staff member to call me on my cell phone no. that I have provided and to disclose this no. to anyone medically necessary. I am aware that I could be charged by my carrier for this call.

Signature: _____ Date: _____

In addition, per regulations of HIPPA, I give my permission as the patient of Vinod Sancheti MD to give the name listed below to be considered my P.O.A or to be contacted in case of emergency.

Name: _____ Ph#_____

Address: _____

This person may also receive results of any test results _____(Initials)_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The Patient refuses to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details.)

Signature **Date**

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal NOT state law.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our front desk for a copy of the request form. You may also request access by sending us a letter to the address at the end of this notice. Once approved an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $20.00 per hour including the time required to locate and copy your health records. If you want the copies to be mailed to you, postage will be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our front desk for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your health care information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for your treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore this information may not be available.)You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment, or healthcare operations. You can request non-routine information going back 6 years starting on April 14, 2003. Information Prior to that date would not be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Expect in emergencies) Please contact our front desk if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS: You have the right to file a complaint with us if you feel we have not complied with our Privacy policies. Your complaint should be directed to our front desk. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with the **U.S. Department of Health and Human Services.**

HOW TO CONTACT US

Practice Name: DR. VINOD SANCHETI M.D

Telephone: 732-240-4000

Address: 25 Mule Road, Suite B8, Toms River, NJ