Bharat Dasani, MD *44 RT 23 North,* *Riverdale, NJ 07457* *1081 Parisppany Blvd, Parsippany, NJ 07054*

Today's Date _____ E-Mail Address _____

Last Name _____ First Name _____ Middle _____

Address: _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Cell Carrier: Verizon, AT & T or T-Mobile

Sex M _____ F _____ Age _____ Race _____ Language _____ Date of Birth _____

Employer / School _____
Employer / School Address _____

In Case of Emergency who should be notified _____ Relationship to you _____
Phone Number _____

Primary Insurance

Who is responsible _____ Relation to Patient _____ DOB _____

Insurance Company _____

Policy Number _____ Group Number _____

Secondary Insurance - yes____ no____

Who is responsible _____ Relation to Patient _____
Insurance Company _____
Policy Number _____ Group Number _____

Assigment and Release

I certify that all information provided above is true to the best of my knowledge. I, the undersigned (patient or legal guardian) authorize medical and / or surgical treatment to be rendered by the doctor and his staff. I hereby authorize payment of insurance benefits to be paid directly to Bharat Dasani, MD. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above-named physican may use health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purposes of obtaining payment for services and determing insurance benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative ***Date***

HIPPA - Privacy Practice Acknowledgeement

Notice of Privacy Practices states how we may use and/or disclose your health information. It is our policy not to release confidential medical information unless authorized in writing. I authorize to leave my medical information by the following method and will assume responsibility to notfiy whenever it changes

Preferred Phone # _____ Can we leave a message? Yes _____ No _____

I authorize to discuss my care with No One _____ Spouse _____ Other _____

I have received the notice of Privacy Practice and I have been provided an opportunity to review it

Signature of Patient, Parent, Guardian or Personal Representative Date

Bharat Dasani 44 RT 23 North, Riverdale - 1081 Parsippany Blvd, Parisppany 973-248-1550

Reason for Visit _____

Personal Medical History:

Do you suffer from any of the following or list family members (e.g. Mom / dad)

Hypertension	yes_____ no_____	Family Member _____
Diabetes	yes_____ no_____	Family Member _____
Heart Disease	yes_____ no_____	Family Member _____
Kidney Disease	yes_____ no_____	Family Member _____
Lung Disease	yes_____ no_____	Family Member _____
Cancer	yes_____ no_____	Family Member _____
Ulcer Disease	yes_____ no_____	Family Member _____
Difficulty swallowing	yes_____ no_____	Family Member _____
Heartburn	yes_____ no_____	Family Member _____
Nausea / Vomiting	yes_____ no_____	Family Member _____
Diarrhea	yes_____ no_____	Family Member _____
Constipation	yes_____ no_____	Family Member _____
Diverticulosis	yes_____ no_____	Family Member _____
Crohn's / Colitis	yes_____ no_____	Family Member _____
IBS	yes_____ no_____	Family Member _____
Blood in stool	yes_____ no_____	Family Member _____
Hemorrhoids	yes_____ no_____	Family Member _____
Weight Loss	yes_____ no_____	Family Member _____
Other	_____	

Past Surgical History:

Operation:_____ Hospital_____Year_____
Operation:_____ Hospital_____Year_____
Operation:_____ Hospital_____Year_____

Social History:

Drink alcohol	Yes_____ No_____	if so how often _____
Smoke	Yes_____ No_____	if so how often _____
Coffee	Yes_____ No_____	if so how often _____
Tea	Yes_____ No_____	if so how often _____

Please list your medicines:

_____
_____
_____
_____
_____
_____

Please list your allergies

_____
_____
_____
_____