Vishwa Kapoor, M.D., FAAP
General Pediatrics
1550 Pepper Dr, Suites B & C, El Centro, CA 92243
Ph (760) 592-4961 Fx (760) 592-4964

Patient Demographics

Patient Name: _____ D.O.B.: _____

Sex: M ___ F___ Patient's Social Security: _____ Today's Date: _____

Ethnicity: _____ Language: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Mother's Name: _____ Phone: _____

Mother's Employer: _____ Work Phone: _____

Father's Name: _____ Phone: _____

Father's Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Insurance Information

Name of Insurance: _____ Policy #: _____ Group #: _____

Insurance Address: _____

Insurer's Name: _____ Relationship to Patient: _____

Insurer's D.O.B.: _____ Insurer's Social Security: _____

Insurer's Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

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Important Office Policies

- **Release of Medical Information:**
  I authorize Vishwa Kapoor, M.D. to release medical records concerning my child to any physician, hospital or agency involved in the care of my child.

- **Assignment of Medical Benefits:**
  I authorize my insurance carrier to assign all surgical and/or medical benefits, if applicable, to Vishwa Kapoor, M.D. I also authorize release of medical information necessary to process all medical insurance claims.

- **Payment Policy:**
  Co-Payments are to be collected at the time services are received. We accept cash, checks, Visa, & Master Card. All medical services provided are directly billed to the insurance. If our physician is contracted with your insurance carrier, we will accept their contracted negotiated rate for charges billed. However, you will be responsible for any balance deemed patient responsibility or non-covered benefit by your insurance and will be billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office

- **Cancellation Policy:**
  Our office requests that if an appointment needs to be cancelled, we receive notice no later than 4 hours prior to the appointment time. We reserve the right to charge a $25.00 "No-Show" fee that would be collected at your next appointment.

- **Referral Policy:**
  I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE POLICES.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic

I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restrictions, they must follow the restriction(s)

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

My Rights:

- I understand this authorization is voluntary. Treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for:
    1) Obtaining information in connection with eligibility or enrollment in a health plan
    2) determining an entity's obligation to a claim or,
    3) creating health information to provide to a third party
- I may revoke this authorization at any time, provided that I do so in writing and submit it. The revocation will take effect when Vishwa Kapoor, M.D., FAAP, Inc. receives it, except to the extent that Vishwa Kapoor, M.D., FAAP, has already relied on it.
- I am entitled to receive a copy of this authorization.

Signature: _____ Date: _____

Print Name: _____ Relationship to Patient: _____

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Authorization to release medical information to NON-PARENT

Patient Name:_____ DOB:_____

I, _____ (Parent/Legal Guardian), give my consent to _____ (Non-Parent), to take my child to be treated by Dr. Kapoor and staff. I am also authorizing Dr. Kapoor and staff to release any pertinent medical records/treatment for the care of my child.

Parent Signature: _____ Date: _____

Non-Parent Signature: _____ Date: _____

Relationship to Patient: _____

*This authorization is good from now to one year after signature and date, unless a written revoke is submitted by parent/legal guardian.

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Authorization for Use or Disclosure of Protected Health Information

I hereby grant permission for mu medical records as checked below to be released:

From: _____(Physician, Clinic, or Institution)

Address: _____

City: _____ State: _____

Ph# _____ Fx# _____

Patient Name: _____ D.O.B.: _____

Address: _____ City: _____

State: _____ Zip Code: _____

For the purpose of (Please check all that apply):

_____ Continuity of medical care _____ Insurance purposes

_____ Coordination of medical care by different providers _____ Legal purposes

Please release all checked items:

_____ Complete medical records _____ Radiology reports _____ Physicals

_____ Consultation notes _____ ER notes _____ Labs _____ Billing

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

_____

Release To: Vishwa Kapoor, M.D., FAAP, Inc.
1550 Pepper Dr. Suite B & C
El Centro, CA 92243
Phone: (760) 592-4961
Fax: (760) 592-4964

Signature of parent or legal guardian: _____ Date: _____

Print Name of parent or legal guardian: _____ Relationship to Patient: _____

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Pediatric Health History / Historia De Salud Pediatrica

Patient Name/Nobre del Paciente: _____ DOB/Fecha de Nacimiento: _____

Birth History / Historial De Nacimiento:

Hospital/State/Country where child was born: Hospital/Estado/País hijo nació:	Delivery Type / Weeks of Gestation Tipo de Parto/ Semanas de Gestacion	Was baby discharged with mother? Fue dado de alta el bebé con la madre? ( ) Yes/Si ( ) No/No
Birth Measurements/Medidas de Nacimiento: lbs. Oz. / Length/Estatura:	Neonatal Problems/Problemas de Neonatales:	Duration of baby's hospital stay/Duración de la estancia hospitalaria del bebé:

Medical History / Historial Medico:

Allergies / Alergias:		
Hospitalizations / Hospitalizaciones:		
Surgeries / Cirugias:		
Significant Illness / Enfermedades significantes:		
Medications / Medicamentos:	**Strength / Dosis:**	**Directions / Instrucciones:**

Patient Medical History / Historial Medico del Paciente:

Child	Fam	History/Historial:	Child	Fam	History/Historial:	Child	Fam	History/Historial:
		Alcoholism/Alcolismo			Ear infection/Infecciones del Oído			Mumps/Paperas
		Anemia			Eczema			Pneumonia/Neumonía
		Asthma/Asma			Hay Fever/Fiebre del Heno			Seizures/Convulsione
		Birth Defects/Defectos de Nacimiento			Headaches/Dolores de Cabeza			Sickle Cell Disease /Tait (rasgo)
		Bladder Infection/Infecciones de la Vejiga			Hearing Problems/Problemas de Audicion			Sinus problems/Sinusitis
		Cancer			Heart Disease/ Enfermedad del corazón			Stroke/Infarto
		Chicken Pox/Varicela			Heart Murmur/Soplo en el corazón			Thyroid Problems/ Problemas de Tiroides
		Deafness/Sordera			High Blood Pressure/Presion Alta			Tuberculosis
		Diabetes			Kidney Disease/Enfermedad Renal			Vision Problems/ Problemas de la Vision
		Drug Abuse/Abuso de Droga			Mental Retardation/Retraso Mental			Weight Problems/Problemas de Peso
		Other/Otro:			Other/Otro:			Other/Otro:

Social History /Historial Familiar:

Mother/Madre:	Age/Edad:	Lives in Home/Miembros del Hogar: ( ) Yes/Si ( ) No/No
Father/Padre:	Age/Edad:	Lives in Home/Miembros del Hogar: ( ) Yes/Si ( ) No/No
Sibling/Familiar:	Age/Edad:	Lives in Home/Miembros del Hogar: ( ) Yes/Si ( ) No/No
Sibling/Familiar:	Age/Edad:	Lives in Home/Miembros del Hogar: ( ) Yes/Si ( ) No/No
Sibling/Familiar:	Age/Edad:	Lives in Home/Miembros del Hogar: ( ) Yes/Si ( ) No/No

Provider Name/Signature: Vishwa M. Kapoor, M.D. Date: _____