SV OB/GYN
Hitesh Narain, M.D., FACOG
Vanessa Valenti, RPA-C
Raphael O'Sei, M.D., FACOG

SV PROFESSIONAL CENTER
155 E.Woodside Ave
E. Patchogue, NY 11772

Last Name	First Name
Date of Birth	Allergies
SS#	Date of First Visit
Street Address	Apt. Number
City, State	Zip Code
E-Mail Address	Insurance
Insured Party	Relation to Insured
Group No.	Ins. Phone #
Home Phone #	Occupation
Employer	Work Phone #

PREVIOUS SURGERIES

SURGERY	DATE

OBSTETRICAL HISTORY

EVENT	DATE	EVENT	DATE

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PATIENT QUESTIONNAIRE

Welcome to SV Professional Center! Please take a few minutes to answer the questions listed below. These questions will help Dr. Narain and staff in providing the best care possible. This information is confidential and will be used only to benefit your health.

Name:

_____

LAST FIRST MIDDLE

Date of Birth: _____

Address: _____

Referred by: (Please fill in):

Marital Status: S M D W (circle one)

Patient's place of employment: _____

Business Phone Number:

_____

Business Address: _____

Spouse's Name: _____ Spouse's Occupation_____

Spouse's DOB: _____ Spouse's SSN#_____

Spouse's Employer: _____

Medications that you are currently taking, includes aspirin/Tyenol/Vitiams, etc.

Please check all boxes below that apply to you.
Do you have or have you ever had:

____Anorexia	____Anxiety Disorder	____Anemia
____Appendicitis	____Asthma	____Bleeding Disorders
____Breast Problems	____Brain Disorders (including injury)	
____Breathing Problems	____Cancer	____Cataracts
____Chemotherapy	____Chicken Pox	____Chlamydia
____Concussion	____Cysts	____Deafness
____Depression	____Diabetes	____Down's Syndrome
____Hearing Problems	____Eating Problems (such as Bulimia)	
____Edema	____Fractures/Trauma	____Glaucoma
____Gout	____Growth Problems	____Headaches
____Heart Disease	____Hernia	____Herpes
____High Blood Pressure	____Immunodeficiency	____Infertility
____Lupus	____ Liver Problems	____Menopause Problems
____Menstrual Problems	____Nerve Problems	____Kidney Problems
____Stomach Problems	____Skin Disorders	____Pregnancy
____Chronic Pain	____Seizure Disorder	____Abnormal Pap Smear
____Paralysis	____Infections, Severe	____Scoliosis
____Sickle Cell Anemia	____Thalassemia	____Abnormal Clotting
____Toxemia	____Tuberculosis	____Turners Syndrome
____Ulcer	____Hives	____Hepatitis
____Bruising Problems		

____Other (Please List)_____

Please list any medical problems that run in your family:

_____

_____

_____

Thank you for taking the time to fill out this questionnaire. Please feel free to ask any questions that you may have.

_____ _____

Date Patient's Signature

_____

Doctor's Signature

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GUARANTEE AGREEMENT

For and in consideration of services rendered by **SV OB/GYN** to the patient whose name appears below, the undersigned (jointly of severally, if more that one) hereby promise(s) to pay to **SV OB/GYN** any copayment, coinsurance or fees required by my coverage with any insurer/HMO/ or other third party payor. In addition, I promise to pay for all services (together with all collection costs) which I am advised by **SV OB/GYN** prior to receiving them that such services are not covered by my benefit plan with any insurer/HMO/ or other third party insurer. However, I/we understand that I/we will have no responsibility to pay for any procedure/service/ device which is included in another claim paid by any insurer/ HMO/ or third party payor of the same service date or which is included in the overall " bundled" payment of any such procedures/ service. I/We further understand that all bills are payable and become due upon presentation.

I/We assign to SV **OB/GYN** all monies and/ or benefits to which I/we may be entitled from my coverage with any insurer/HMO/third party payor, government agencies, or those who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependants.

I/We hereby authorize and direct **SV OB/GYN** release to any insurer/HMO/ third party payor, governmental agencies, or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

Please note that if you fail to cancel your appointment without 24 hours notice you will be charge a $25.00 fee.

_____
Signature of Patient or Authorized Representative

_____ _____
Date Witness

SV OB/GYN
Patient Policy

In an effort to maintain the highest quality of medical care we would like to share our patient policies with you.

These guidelines are strictly adhered to in order to maintain a superior level of care for you, and your family. However, should you require special assistance in the instance of an emergency, we will perform our very best to accommodate you as expeditiously as possible.

We require 24 hours cancellation notice prior to your scheduled appointment. Failure to notify our office of a cancellation will result in a twenty-five ($25) dollar fee to the patient's account.

We WILL NOT discuss your medical record with anyone, unless you have given permission in writing on our HIPAA form. No exceptions.

SV OB/GYN does not write prescriptions for pain medications, or any other controlled substance at the initial visit for a new patient. No exceptions.

The patient must notify our office of any change of address, telephone numbers, or insurance information.

The patient is responsible for knowing their insurance coverage and limitations. If the patient does not have out-of network benefits, or is not covered for specific services, the patient will be charged accordingly for the visit, as well as any diagnostic charges if applicable. These are payable at time of service.

If you are running low on you medications, you must make an appointment. We do not call in any refills for any medication. No exceptions.

We are not a walk-in facility. Appointments are required. We will do our best to accommodate a walk-in patient, however those patients that do have appointments will be examined first.

If you would like any copies of your chart, there is a fee of $.75 per page.

I have read, and understand the above,

_____ _____

Patient/Patient Guardian Date