**HEMET VALLEY UROLOGY MEDICAL CENTER, INC.**
**Girdhari S. Purohit, M.D., F.A.C.S. - Arthur L Dick, M.D., F.A.C.S.**
1225 E. Latham Ave. Suite B, Hemet, CA 92543 -Tel: 929-2800 929-2303

# Registration Form

Name: (Last) ________________________ (First)__________________________SSN:________-________-___________

Address:_______________________________________ City:______________________ State:________ Zip:__________

Home Phone: ____________________________ Cell:______________________ Birth Date:____/______/______

Sex: MALE or FEMALE Age: ________ Height:_______ft_____in Weight:___________Race:_______________

Primary Language:________________________ Ethnic Group:_____________________

Employer:___________________________________________________ Emergency Contact:________________

Phone:___________________________ Email Address:______________________________________________

**PRIMARY INSURANCE:**

Person Responsible for Account: Last Name:______________________ First Name:_______________________

Relationship to Patient:_______ Birth Date:____/______/______ SSN:________-________-___________

Address (if different from patient's):____________________________________________ Phone:____________________

City:_____________________________ State:_______ Zip:_______________

Person Responsible Employed by:______________________________________Occupation:_______________________

Insurance Co:_______________________________________________ Subscriber ID#:__________________

Insurance Phone:_________________________

**ADDITIONAL INSURANCE:** YES_________ NO_________

Person Responsible for Account: Last Name:______________________ First Name:_______________________

Relationship to Patient:_______ Birth Date:____/______/______ SSN:________-________-___________

Address (if different from patient's):____________________________________________ Phone:____________________

City:______________________ State:_______ Zip:_______________ Occupation:_______________________

Person Responsible Employed by:______________________________________Subscriber ID#:___________________

Insurance Co:_______________________________________________ Insurance Phone:________________________

**ASSIGNMENT AND RELEASE:**

I, the undersigned certify that I (or my dependent) have insurance coverage with and assign directly to Girdhari S. Purohit, M.D. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:__________________________________ Relationship:_______________ Date:________

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Name:_______________________________________________ Date:___________________

Referring Doctor:______________________________ Family Doctor:________________________

Why are you seeing the doctor today? ______________________________________________

How long have you had this problem? ______________________________________________

What improves or worsens the problem/pain? ________________________________________

Are there any symptoms that go along with the problem/pain? ___________________________

Is the problem/pain continuous or does it come and go? _______________________________

Describe the pain (sharp/dull, etc.) _________________________________________________

Have you tried any medicine/treatment for this problem/pain? ___________________________

Have you received your flu shot for this year (Y / N), if No, why not? _____________________

**Pharmacy Name:**______________________________ Phone:_____________________

How did you find out about our practice (please an X on the one that applies):

____Referring Physician ______Friend ____Yellow Pages ___Insurance Company ____Internet ______Other

**SOCIAL HISTORY:**
Please provide the following information:

**Marital Status** (Please indicate years):
___ Single, ____Married, ____Separated, ____Divorced, ____Widowed, ____Life Partner, ____Common Law Spouse

**How Children do you Have** - *Please indicate # of each, if you have any:*
____Sons, ____Daughters, ____Stepchildren, ____Adopted, ____Foster Parents, ____ Grandparents

**Occupation** - *Please an X on the one that applies:*
___None, ___Laborer, ___Truck Driver, ___Tradesman, ____Clerk, ___Administrative, ___Executive, ___Professional, ___Part-Time, ___Retired, ___Other

**Hobbies -** *Please place an X in any that apply to you:*
___None, ____Golf, ____Tennis, ____Computers, ____Basketball, ____Football, ____Swimming, ____ Soccer, ____Baseball

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**Alcohol Consumption:**
_____None; _____Yes; Occasional/Social: # of drinks per day _____;

**Tobacco per day:**
____None; _____Yes: #Packs/day _____ or # Cigarettes/day; _____Smokeless Tobacco

If *you* previously stopped smoking, When?_____/_____/_______

**Recreational Drugs:**
_____None; If yes, please list:_______________________________________________________

**Caffeinated Beverages:** ___None; _____Low; ____Moderate; _____Excessive
Recent Foreign Travel: _____None, Americas _____________________; Worldwide _________________________

**REVIEW OF SYSTEMS:** ***Please place an X to all that apply to you.***

| *Check All That Apply* ✓ | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ✓ | **Constitutional** | ✓ | **Neurological** | ✓ | **Gastrointestinal** | ✓ | **Musculoskeletal** | ✓ | **Genitourinary** | ✓ | **Genitourinary (cont'd)** |
| | Appetite Changes | | Balance Problems | | Abdominal Cramps | | Arthritis | | Back Pain | | Urologic Cancer |
| | Anorexia | | Disoriented | | Abdominal Pain | | Back Pain | | Bedwetting | | Urologic Surgery |
| | Aches and Pains | | Dizzy Spells | | Acid Reflux | | Gout | | Blood in Urine | | Vaginal Bleeding |
| | Easy Bruising | | Headache | | Bloody Stools | | Joint Pain | | Dribbling | | Vaginal Discharge/ Problems |
| | Fever | | Lack of Alertness | | Change in Bowel Habits | | Muscle Cramps | | Burning on Urination | | Weak Stream |
| | Fatigue | | Leg or Arm Weakness | | Constipation Diarrhea | | Muscle Weakness | | Erection Problems | ✓ | **Respiratory** |
| | Generalized Weakness | | Memory Loss | | Flatulence Gas | | Neck Pain/Stiffness | | Flank Pain | | Asthma |
| | Insomnia | | Numbness/Tingling | | Hemorrhoids | ✓ | **Cardiovascular** | | Hematuria | | Emphysema-Bronchitis |
| | Night Sweats | | Stroke | | Indigestion/Heartburn | | Chest Pain/Angina | | Hesitancy | | Environmental Allergies |
| | Sleep Apnea | | Speech Problems | | Irregular Bowel Movements | | Dyspnea on Exertion | | Kidney Failure | | Frequent Cough |
| | Swollen Glands | | Tremors | | Nausea/ Vomiting | | Edema Heart Attack | | Kidney Infections | | Pneumonia |
| | Weight Gain | ✓ | **Endocrine** | | Rectal Bleeding | | Heart Failure | | Kidney Stones | | Shortness of breath |
| | Weight Loss | | Diabetes | | Tarry Stool | | Heart Murmur | | Leak After Voiding | | Tuberculosis |
| ✓ | **Eyes** | | Excessive thirst | ✓ | **Skin** | | High Blood Pressure | | Nocturia | | Wheezing |
| | Blind | | Pituitary Disease | | Acne | | Irregular Heart Beat | | Nocturnal Enuresis | ✓ | **Hematological/Lymphatic** |
| | Blurred Vision | | Thyroid Disease | | Boils | | Mitral Valve Prolapse | | Not Emptying | | Swollen Glands |
| | Double Vision | | Tired/Sluggish | | Changing Moles | | Orthopnea Pain/Cramps | | Painful Ejaculation | | Blood Clotting Problem |
| | Glaucoma | | Too Hot/Cold | | Persistent Itch | | Hips/Legs | | Stranguria | | Bleeding Problem |
| | Pain | ✓ | **Ear / Nose / Throat** | | Pigment Change | | w/exercise | | Stones | | Hepatitis |
| | Worsening Eyesight | | Ear Infection | | Skin rash | | Palpitation | | Suprapubic Pain | | HIV (AIDS) |
| ✓ | **Allergic/Immunologic** | | Sinus Problem | | | | Skipped Heart Beats | | Urgency | | Sickle Cell |
| | Animal Allergies | | Sore Throat | | | | Swelling | | Urinary Frequency | ✓ | **Psychologic** |
| | Drug Allergies | | | | | | | | Urinary Hesitancy | | Anxiety |
| | Environmental Allergies | | | | | | | | Urinary Incontinence | | Depressed |
| | Food Allergies | | | | | | | | Urinary Tract Infections | | Generally satisfied with life |
| | Seasonal Allergies | | | | | | | | Urine Retention | | |

**Other:** ______________________________________________________________

______________________________________________________________

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## PAST MEDICAL HISTORY: *If you have or have had any of the following diseases or conditions, Please place an X next to it:*

*Check All That Apply* ✔

| ✔ | Cardiovascular | ✔ | Endocrine/Metabolic | ✔ | GI | ✔ | GU | ✔ | Neurological/Psychological | ✔ | Respiratory |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Anemia | | Diabetes Mellitus, non- insulin dependent | | Cholecystitis | | AIDS | | ADD | | Asthma |
| | Angina | | Diabetes Mellitus, insulin dependent | | Cholelethiasis | | Bladder Outlet Obstruction | | ADHD | | Bronchitis |
| | Anorexia | | Diabetes Mellitus, uncontrolled | | Chronic Liver Disease | | Bladder Stone | | Alcoholism | | Chronic Lung Disease |
| | Aortic Aneurysm | | Goiter | | Colitis | | Bladder Infection | | Alzheimer's Disease | | COPD |
| | Aortic Regurgitation | | Gout | | Constipation | | Chronic Renal Disease | | Anxiety | | Emphysema |
| | Aortic Stenosis | | Hyperthyrodism | | Colon Condition | | Chronic Renal Insufficiency | | Bi-polar Disorder | | Lung Disease |
| | Arrhytmla | | Hypothyrodism | | Crohn's Disease | | Chronic Renal Failure | | Chronic Fatigue Syndrome | | Pneumonia |
| | Atrial Fibrillation | | Impaired Glucose Tolerance | | Diarrhea | | Crossed Fused Ectopia | | Depression | | Pulmonary Embolism |
| | Bleeding Disorder | ✔ | **General** | | Diverticulitis | | Hematuria | | Eating Disorder | | Tuberculosis |
| | Cardiomyopathy | | Allergies | | Diverticulosis | | Impotence of Organic Origin | | Epilepsy | ✔ | **Tumors** |
| | Cerebrovascular Disease | | Electrical Injury | | GERD | | Interstitial Cystitis | | Herniated Disc | | Brain Cell Carcinoma |
| | Claudication | | Exposure to Chemicals | | Hemorrhoids | | Irradiation Therapy | | Mental Illness | | Brain Tumor |
| | Congenital Heart Disease | | Hepatitis A | | Hepatic Failure | | Kidnev Cancer | | Migraine | | Breast Cancer |
| | Congestive Heart Failure | | Hepatitis B | | Hepatitis | | Kidney Disease | | Multiple Sclerosis | | Cervical Cancer |
| | Coronary Artery Disease | | Hepatitis C | | Hiatal Hernia | | Kidney Infection | | Nervous Breakdown | | Colon Cancer |
| | Deep Vein Thrombosis | | Hypercholestolemia | | Inflammatory Bowel Disease | | Kidnev Stones | | Organic Brain Syndrome | | Fibrocystic Breast Disease |
| | Endocarditis | | Hyperlipidemia | | Liver Disease | | Libido Decreased | | Parkinson's | | Gastric Cancer |
| | Enlarged Heart | | Infectious Disease | | Pancreatitis | | Nephrolithiasis | | Polio | | Laryngeal Cancer |
| | Heart Attack | | Lipid Disorder | | Peptic Ulcer (Duodenal) | | Nephrotic Syndrome | | Seizures | | Lung Cancer |
| | Heart Block | | Malaise | | Rectal Fissure | | Neurogenic Bladder | | Spinal Cord Injury | | Lymphoma |
| | Heart Disease | | Obesity | | Stomach Ulcer | | Orchitis | | Stroke | | Melanoma |
| | Heart Murmur | | Paget's Disease | | Ulcerative Colitis | | Penile Discharge | | Suicide Attempt | | Ovarian Cancer |
| | Heart Valve Problem | | PCKD | ✔ | **HEENT** | | Polycystic Disease | ✔ | **GYN/OB** | | Pancreatic Cancer |
| | Hemophilia | | PCO | | Blindness | | Polycystic Kidney Disease | | Breast Cancer | | Rectal Cancer |
| | Hypertension, well controlled | | Raynaud's Syndrome | | Cataracts | | Prostate Cancer | | Breast Disease | | Rectal Cell Cancer |
| | Hypertension, progressive | | Sleep Apnea | | Deviated Septum | | Radiation or Nuclear Exposure | | Endometriosis | | Sarcoidosis |
| | Hypertensio, severe | ✔ | **Musculoskeletal** | | Deafness | | Recurrent UTI | | Menopause | | Testicular Cancer |
| | Leukemia | | Arthritis | | Ear Infections | | Renal Cell Cancer | | Menstrual Problems | | Transitional Cell CA Bladder |
| | Mitral Insufficiency | | Back Pain | | Glaucoma | | Renal Failure | | Osteoporosis | | Transitional Cell CA Ureter |
| | Mitral Stenosis | | Carpal Tunnel Syndrome | | Hay Fever | | Renal Insufficiencv | | Ovarian Cancer | | Uterine CA |
| | Mitral Valve Prolapse | | Claudication | | Menniere's | | Testicular Cancer | | Uterine Fibroids | | |
| | Rheumatic Fever | | Fibromyalgia | | Mumps | | Transplant Recipient | | | | |
| | Sickle Cell Anemia | | Mortons Neuroma | | Sinusitis | | Transitional Cell CA Bladder | | | | |
| | Stroke | | | | Tinnitis | | Transitional Cell CA Ureter | | | | |
| | Thrombophlebltis | | | | Vertigo | | Undescended Testicle (Birth) | | | | |
| | Varicose Veins | | | | | | Urinary Tract Infection | | | | |
| | Ventricular Arrhythmia | | | | | | Venereal Disease | | | | |

**Other:** ______________________________________________

______________________________________________

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## Medication Worksheet

____________________________________
**Patient Name**

__________________________
**Date**

**Medications: Please List All Medications, Dosage & Frequency**

1.____________________________________________________________

2.____________________________________________________________

3.____________________________________________________________

4.____________________________________________________________

5.____________________________________________________________

6.____________________________________________________________

7.____________________________________________________________

8.____________________________________________________________

9.____________________________________________________________

10.___________________________________________________________

11.___________________________________________________________

12.___________________________________________________________

**ALLERGIES:**________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

## PATIENT AUTHORIZATION RELEASE OF HEALTH INFORMATION & CONTACT CONSENT

I, ___________________________________, do hereby give consent to Dr. Girdhari S. Purohit, & Dr. Arthur Dick and / or his office staff to contact me regarding lab results, x-ray results, referrals, appointments, and all medical information via;

__________**Message with Spouse**

__________**Caretaker**

__________**Family Member (children, etc.)**

__________ **Mail**

__________**Answering Machine**

__________ **DO NOT CONTACT ANYONE OTHER THAN MYSELF**

_____________________________________      ______________________

**Patient Signature**      **Date**

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# NOTICE OF HOSPITAL OWNERSHIP OR INVESTMENT

THIS "NOTICE OF HOSPITAL OWNERSHIP OR INVESTMENT' IS PROVIDED BY GIRDHARI S. PUROHIT, M.D. IN ORDER TO ASSIST YOU IN MAKING AN INFORMED DECISION REGARDING YOUR CARE. THIS NOTICE DISCLOSES THE FOLLOWING INFORMATION:

- GIRDHARI S. PUROHIT, M.D., OR AN IMMEDIATE FAMILY MEMBER OF GIRDHARI S. PUROHIT, M.D., HAS AN OWNERSHIP OR INVESTMENT INTEREST IN HEMET VALLEY MEDICAL CENTER AND MENIFEE V ALLEY MEDICAL CENTER, AND YOUR TREATING PHYSICIAN(S) MAY ALSO HAVE AN OWNERSHIP OR INVESTMENT IN HEMET V ALLEY MEDICAL CENTER AND MENIFEE VALLEY MEDICAL CENTER
- PLEASE REVIEW THE.AITACHED UST OF THE HEMET VALLEY MEDICAL CENTER'S AND MENIFEE VALLEY MEDCIAL CENTER'S OWNERS OR INVESTORS WHO ARE PHYSICIANS. THE LIST OF PHYSICIAN OWNERS IS ALSO AVAILABLE ON THE HOSPITALS' WEBSITE WWW.PHYSICIANSFORHEALTHYHOSPITALS.COM
- YOU ARE FREE, HOWEVER, TO CHOOSE ANY OTHER PROVIDER FOR THE PURPOSE OF OBTAINING THE SERVICES ORDERED OR REQUESTED BY YOUR PHYSICIAN (EXCEPT AS YOUR CHOICE MAY BE LIMITED BY THE TERMS OF YOUR HEALTH COVERAGE.)
- WE VALUE OUR RELATIONSHIP WITH YOU.

**I HAVE READ AND UNDERSTAND THE ABOVE NOTICE:**

**Patient Signature:** ___________________________________

**Patient Name:** ______________________________________

**Date:** ______________________________________________