Dinu Mistry M.D.
341 E. Bannock St.
Boise, Idaho 83712

Patient Last Name: _____First _____MI_____

Responsible Party (if a minor)_____

Address: _____
(Street or PO Box) (City) (State) (Zip)

Home Phone:_____Cell Phone:_____ Work Phone:_____

Date of Birth:_____Social Security No.:_____ Sex:_____

Marital Status: Single Married Widowed Separated Divorced

Employer:_____ Occupation:_____

Spouse's Name:_____ Spouse's Work Phone:_____

Spouse's Employer:_____Spouse's Occupation: _____

Nearest Relative: _____ Phone:_____

Primary Insurance:_____Phone:_____

Address: _____
(Street or PO Box) (City) (State) (Zip)

Subscriber Info:_____
(Name) (Social Security No.) (Date of Birth)

Policy/ID Number:_____Group Number:_____

Secondary Insurance:_____Phone:_____

Address: _____
(Street or PO Box) (City) (State) (Zip)

Subscriber Info:_____
(Name) (Social Security No.) (Date of Birth)

Policy/ID Number:_____Group Number:_____

Reason for Visit (Please be Specific):_____

Referring Physician:_____Patient Referral:_____

Internet/Other:_____

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Medical History

Patient Name:_____Age:_____Height:_____Weight:_____

Please list all physicians you are currently seeing and the reason:_____

_____

_____

Do you currently or have you had any of the following? If yes, please give the date.

Cancer	***Yes***	***No***	***Date_____***	***Asthma***	***Yes***	***No***	***Date_____***
Diabetes	***Yes***	***No***	***Date_____***	***Leukemia***	***Yes***	***No***	***Date_____***
Rheumatoid Arthritis	***Yes***	***No***	***Date_____***	***Bleeding Gums***	***Yes***	***No***	***Date_____***
Lupus	***Yes***	***No***	***Date_____***	***Bleeding Tendency***	***Yes***	***No***	***Date_____***
Goiter	***Yes***	***No***	***Date_____***	***Easy Bruising***	***Yes***	***No***	***Date_____***
Thyroid Problems	***Yes***	***No***	***Date_____***	***Nosebleeds***	***Yes***	***No***	***Date_____***
High Blood Pressure	***Yes***	***No***	***Date_____***	***Colitis***	***Yes***	***No***	***Date_____***
Rheumatic Heart Disease	***Yes***	***No***	***Date_____***	***Diverticulitis***	***Yes***	***No***	***Date_____***
Congenital Heart Disease	***Yes***	***No***	***Date_____***	***Stomach Ulcers***	***Yes***	***No***	***Date_____***
Heart Attack	***Y es***	***No***	***Date_____***	***Bladder Infection***	***Yes***	***No***	***Date_____***
Stroke	***Yes***	***No***	***Date_____***	***Kidney Disease***	***Yes***	***No***	***Date_____***
Epilepsy	***Yes***	***No***	***Date_____***	***Hay Fever***	***Yes***	***No***	***Date_____***
Migraine	***Yes***	***No***	***Date_____***	***Depression/Anxiety***	***Yes***	***No***	***Date_____***
Tuberculosis	***Yes***	***No***	***Date_____***	***Mental illness***	***Yes***	***No***	***Date_____***
Bronchitis	***Yes***	***No***	***Date_____***	***HIV/AIDS***	***Yes***	***No***	***Date_____***
Pneumonia	***Yes***	***No***	***Date_____***	***Hepatitis***	***Yes***	***No***	***Date_____***

List any other medical conditions not noted above: _____

_____

_____

Do you know of any blood relative that currently has or in the past has had any of the above conditions? List and give relationship:_____

_____

_____

When was your last chest X-Ray?_____ Where?_____

When was your last mammogram?_____ Where?_____

Have you had any abnormal mammograms? NO YES When?_____

Any family members who have or have had breast cancer? NO YES Relation?_____

How many pregnancies have you had?_____Live Births?_____Breast fed?_____

Have you ever smoked? NO YES If yes, how much?_____ When did you quit?_____

How many caffeinated beverages do you drink per day?_____ Do you regularly drink alcohol and/or beer? NO YES How much?_____

Have you ever taken any illicit drugs by any route of administration? NO YES What?_____

Are you currently taking any of the following medications?

Aspirin/Bufferin	*NO*	*YES*	*Advil/Motrin/Aleve*	*NO*	*YES*
Cortisone/Steroids	*NO*	*YES*	*Blood Thinning Pills*	*NO*	*YES*
Birth Control Pills	*NO*	*YES*	*Narcotic Pain Pills*	*NO*	*YES*
Diet Pills	*NO*	*YES*			

(Phenteramine, Fastin, Adipex, Ionamin, Fenfluramine, Podimin, Dexfenfluramine, Redux, or any over the counter diet medications)

*List any other medications (including herbal medicines) you are taking:*_____

_____

_____

List any allergies you have to medications, latex or adhesives: _____

_____

_____

*Names and years of operations you have had:*_____

_____

_____

List any cosmetic procedures you have had (including liposuction): _____

_____

_____

*Serious illnesses, injuries, and/or accidents:*_____

_____

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CONSENT TO TREAT

I consent to, and authorize Dr. Mistry to furnish me with necessary medical care. This medical care may include radiology examinations, laboratory testing and/or other diagnostic procedures as may be indicated. I also consent to be photographed as part of my care and to the publication or showing of these photographs for educational reasons only.

RELEASE OF MEDICAL INFORMATION

I consent to, and authorize Dr. Mistry to disclose all or part of my medical records to any mutually agreed upon referring physician.

FINANCIAL RESPONSIBILITY

INSURANCE COVERED PROCEDURES:
I understand I am financially responsible for the payment of medical charges incurred on my behalf with Dr. Mistry. I also understand even though Dr. Mistry's office may submit a claim to my insurance carrier(s), I am responsible for the entire balance. Whenever possible, precertification for procedures will be obtained. ***I understand there is a $500.00 NON- REFUNDABLE deposit required to schedule surgery. I agree to pay my portion of the surgeon's fee two weeks prior to my surgery, up to 100% depending upon my insurance status. I understand the amount due is based upon my insurance plan coverage and benefits, and that the amount due is non-negotiable.*** If the insurance carrier pays in excess of the estimate, I will be refunded the overpayment. Dr. Mistry only contracts with **limited** insurance carriers. These carriers require her to make contractual adjustments. I understand it is my responsibility to verify whether Dr. Mistry is participating with my specific insurance plan. With all non-participating insurance carriers I will be required to pay the balance remaining after insurance makes its payment for the service provided. ***I am aware that I will be billed for the difference between Dr. Mistry's fee and the allowed amount my insurance company pays.*** I understand I will be billed after all insurance payments are received. I am expected to pay the balance in full within three months or make a payment arrangement with Dr. Mistry's billing company. If insurance sends a check directly to me, I will be held responsible for the amount owed to the doctor.

COSMETIC PROCEDURES:
I agree to pay for cosmetic consultations in full at the time of the visit. ***I understand there is a $500.00 NON-REFUNDABLE deposit required to schedule surgery. I understand that final payment for cosmetic surgery is due in full two weeks prior to scheduled surgery.*** I may pay with a credit card (Visa, MasterCard, Care Credit), money order, cashiers check, or personal check.

I have read and understand all of the above listed consents and disclosures.

_____ _____

Patient or Guarantor's Signature Date

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FINANCIAL AGREEMENT

Cancellation Policy

- Patients will be charged for "no show" appointments and appointments cancelled without a 48 hour advance notice. The fee will be charged at the full rate.
- Habitually missing or changing appointments is grounds for dismissal from the practice.
  As a courtesy, we attempt to remind patients by phone of their scheduled appointments. However, it is the patient's responsibility to keep their appointment whether or not a reminder call is received.

Surgical Fees

- Payment is due, in full, two weeks prior to the scheduled surgery date. You may pay with cash, credit card (Visa, MasterCard, Care Credit), money order, cashiers check, or personal check.

- There is a $500.00 deposit required to schedule surgery. **THIS DEPOSIT IS NON-REFUNDABLE**. If you cancel or reschedule surgery within fourteen (14) business days of the surgical date an administrative fee of 20% of the total charge will be withheld from your refund, along with a fee for any service provided (lab work, etc.). If you cancel or reschedule your surgery less than seven (7) business days before your surgical date an administrative fee of 50% of your total charges will be withheld from your refund, along with a fee for any service provided (lab work, etc.). If you cancel surgery less than 48 hours before surgery your surgical fee **will not** be refunded.

- If you pay your surgical fee with a credit card or care credit, the surgery cancellation fees stated above will apply. Additionally, you will be charged a service fee of 2.5% of the total bill for credit card services.

- If rescheduling a surgery more than two (2) times a 50% deposit will be required to hold a new surgical date and ***will be forfeited*** if date needs to change. In addition, such changes could result in dismissal from the practice at the surgeon's discretion.

Returned Checks

- If a check is returned due to insufficient funds, a $35.00 fee will be charged and personal checks will no longer be accepted as payment for future fees.

Dr. Mistry only participates with **limited** insurance plans. Payment of expected insurance fees is due prior to surgery as outlined above.

I certify I am the patient or I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

A photo static copy of this agreement shall be considered effective and valid as original.

DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

MY SIGNATURE BELOW INDICATES I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS STATED IN THIS FINANCIAL AGREEMENT / CANCELLATION POLICY.

_____

Patient Date

_____

Witness Date

PRIVACY NOTICE

The United States government requires us to provide you with this information.
By signing below, you agree that you have received this document and consent to the policies described. If you do not consent, we cannot treat you.

Patient's name (please print)

Patient's date of birth

Guardian / representative (please print)

Authorized signature

Today's date

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AUTHORIZATION TO RELEASE RECORDS

I HEREBY AUTHORIZE RELEASE OF ALL MY RECORDS FROM:

_____

_____

_____

_____

_____

(fax) (phone)

For the period of: _____

For the purpose of: _____

To:

Dinu Mistry M.D.
341 E. Bannock St.
Boise, Idaho 83712

Phone (208) 342-8180 Fax (208) 342-7034

_____ _____
Patient's Name (at time of service) Date of Birth

_____ _____
Patient's Signature Date Signed

_____
Patient's Address