Care360®

NILOUFER S. DENNIS MD

REGISTRATION FORM

(Please Print)

Today's Date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's LAST Name	**FIRST Name**	**Middle**		**Marital status (circle one)** Single Married Divorced Separated Widowed

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**

Street Address:	**Social Security Number**	**Home Phone:** ( )

Cell Phone: ( )	**City:**	**State:**	**ZIP Code:**

Occupation:	**Employer:**	**Employer Phone:** ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	**Co-pay** $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Care360®

Niloufer S. Dennis MD

Obstetrics, Gynecology, & Infertility

Phone: 800-395-9431

NOTICE TO ALL NEW PATIENTS

Throughout the course of your treatment, you may be making several visits to our clinic. It is our intention to make sure that your visits go as smoothly as possible.

As a medical practitioner, you physician is always ready to provide necessary services to you during your appointed time. There may be occasions, however, when emergency child delivery situations or any other urgent surgical procedure at the hospital may delay or prevent your physician from actually seeing you during your appointed date and time. Under these circumstances, our front office personnel will advise you of the situation and, if warranted by you, assist you in accommodating your future appointment preferences.

We are giving you this notice as a caution in the event that occurrence of any such hospital emergency situations could directly affect your appointment schedule at our clinic.

ASSIGNMENT/AUTHORIZATION I hereby authorize payment of insurance benefits to be made to NILOUFER S. DENNIS, M.D. MEDICAL CORP. for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by insurance. **In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I give my permission to NILOUFER S. DENNIS, M.D. MEDICAL CORP. to verify any information above. I authorize the release of any medical information necessary to process my insurance claims. I agree to release pertinent demographic and insurance information to a specialist and/or health services provider in the event that it is necessary in my course of treatment.** It is my responsibility to confirm with my insurance group that I am able to receive services from this provider, if determined this is a non-participating provider I will be fully responsible for payment of services received.

I certify that the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under the general or special instructions of the physician.

Patient's Name: _____ Date: _____

Patient's Signature: _____

7930 Frost St. #103, San Diego, CA 92123
1351 Broadway Ave., El Cajon, CA 92021
Phone: (800)395-9431 Fax: (888)502-8290

Care360®

Niloufer S. Dennis MD

Obstetrics, Gynecology, & Infertility

Notice of Privacy Practices

To our patients - this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office manager at (800) 395-9431. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office manager at (800) 395-9431. You must provide us with a reason that supports your request for amendment.

Niloufer S. Dennis MD
Obstetrics, Gynecology, & Infertility

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office manager at (800) 395-9431. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. Right to amend your individual medical record. You are allowed to insert an amendment up to 250 words long into your medical record and submit to the office manager/ Privacy Officer.
9. Right to revoke all signed authorizations, including, but not limited to, this Notice of Privacy Practices. Please contact the office manager for proper forms.
If you have any questions regarding this notice or our health information privacy policies, please contact the office manager at (800) 395-9431.

As part of your doctor visit and in conjunction with MedVantx, Inc., you may receive a free initial start of medication from the MedVantx system located here. This free medication is for a full-course of therapy, generally between 14-30 days.
If you receive such an initial start, your doctor will provide MedVantx with your name, phone number, the type of medication you received, the name of your health insurer, and other information. Upon signing this authorization, a MedVantx customer care pharmacy specialist will contact you by telephone to follow up on the medication your doctor provided and

- Answer any question you may have about the medication
- Discuss programs that may exist related to your medication
- Offer you information on how you can obtain low cost prescriptions by mail from MedVantx

MedVantx has a staff of licensed pharmacists and program specialists available for this call. Please note that you are free to choose any retail or mail order pharmacy to fill your prescriptions.

Please acknowledge by signing below that you are authorizing MedVantx to contact you by telephone and to use your information as described above. This signed authorization will remain in effect while you are under the care of Niloufer S. Dennis MD. If you choose not to sign this authorization form, or if you sign it but later cancel it, your treatment and care with Niloufer S. Dennis MD will not be affected. You may request a copy of this authorization form after you sign it.

_____
Signature (if minor, parent's or guardian's signature)

_____
If signature of parent or guardian, please describe relationship to patient

_____
Patient Name Printed Date

Care360®

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1.5% (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is your responsibility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I HAVE READ THE ABOVE AND ACCEPT FINANCIAL RESPONSIBILITY IN FULL FOR THIS ACCOUNT.

SIGNED: _____ **DATE:** _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____ RELATIONSHIP_____

PHONE NUMBER: _____

ADDRESS: _____

Niloufer S. Dennis MD Medical Corporation
Phone: (800) 395-9431 Fax: (888) 502-8290

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PATIENT SELF HEALTH ASSESMENT INITIAL INTAKE

Patient Name _____ Today's Date_____

Date of Birth_____ Age _____ Occupation _____1st Day of Last Period _____

What is the reason for your visit? _____

What allergies do you have currently? (foods, medications, environmental. Or latex)? _____

_____

What medications do you take? (Include over the counter medications, herbal medications, and vitamins) _____

_____

How many times have you ever been pregnant? _____ How many children do you have? _____

How many miscarriages have you had? _____

Age of 1st sexual encounter _____ Number of sexual partners in lifetime_____ Method of Birth Control_____

Are you currently sexually active? _____ Is your partner male or female? _____

Age at 1st period. _____ How often do you have a period? _____

Do you have Pain with Period?_____ How long does your period last? _____

Do you have bleeding/spotting between periods? _____ Do you have any hot flashes?_____

Do you have trouble falling asleep or mood changes? _____

Have you ever had an abnormal pap smear? _____

Have you ever had a pelvic infection (i.e. gonorrhea (GC), chlamydia, herpes, syphilis, trichomonas)?_____

Do you have any major medical problems (i.e. asthma, diabetes, high blood pressure, blood clotting disorders)?_____

_____

What surgeries have you had in the past? _____

_____

When was your last:

Tetanus shot _____ Pap smear _____ Bone Density Scan _____

Mammogram _____ Breast self-exam _____ Dental Check _____

Cholesterol screen _____ Colonoscopy _____

How much tobacco do you use a day? _____ Alcohol? _____

How much caffeine per day (coffee, tea, soda) _____

What street drugs do you use(if any)?_____ How often? _____

Domestic violence: including emotional, physical, and sexual abuse is a serious health threat to women. Is anyone hurting you now in any way?

_____

Niloufer S. Dennis MD
Obstetrics, Gynecology, & Infertility

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PATIENT SELF HEALTH ASSESMENT INITIAL INTAKE

Personal Medical History and Review of Symptoms

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you.

CARDIOVASCULAR

_____ Blood Pressure
_____ Heart

_____ Heart Attack
_____ Chest Pain – angina
_____ Murmur-valve problem

_____ Failure
_____ Blood Vessels

RESPIRATORY

_____ Lungs (Breathing problems, Asthma, TB)
_____ Cough
_____ Wheezing
_____Shortness of breath

GASTROENTEROLOGICAL

_____ Abdomen (constipation, ulcers)
_____Rectum
_____ Liver (hepatitis)

ENDOCRINE

_____ Diabetes
_____ Thyroid

EYES, EAR, NOSE, THROAT

_____ Eyes _____ Ears
_____Nose/Sinuses
_____Mouth _____Throat

GENITOURINARY

_____ Breast _____ Uterus
_____Ovaries _____Kidney
_____ Pelvis Infection _____Vagina
_____ Tubes _____ Cervix
_____ Incontinence

_____

_____

MUSCULOSKELETAL

_____ Joints (arthritis)
_____ Muscles
_____ Bones

DERMATOLOGIC (circle all that apply)

_____ Skin/rashes, moles, ulcers, acne
_____Lymph nodes

NEUROLOGICAL

_____ Loss of sensation
_____ Loss of strength
_____ Memory loss
_____ Dizziness / fainting
_____ Migraines
_____ Seizures

HEMATOLOGIC

_____ Anemia
_____ Blood clots
_____ Easy Bleeding
_____ HIV
_____ Blood transfusion

PSYCHIATRIC

_____ Schizophrenia
_____ Depression
_____ Anxiety
_____ Insomina

NOTES: _____

_____

_____

_____

_____

_____

Niloufer S. Dennis MD
Obstetrics, Gynecology, & Infertility

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Obstetrics, Gynecology, & Infertility

HISTORY **MRN#**

NAME: **DATE OF BIRTH:** **DATE:**

FAMILY HISTORY **IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE**

1) ALCOHOLISM	6) CANCER	11) HEART DISEASE	16) OSTEOPOROSIS
2) ANEMIA	7) DIABETES	12) HYPERTENSION	17) STROKE
3) ASTHMA	8) EPILEPSY	13) KIDNEY DISEASE	18) THYROID
4) ARTHRITS	9) GLAUCOMA	14) MENTAL ILLNESS	19)
5) BLEEDS EASILY	10) HAYFEVER	15) MIGRAINE	20)

1) 2) 3)

MAIN PROBLEMS

Check (✓) and indicate age when you had any of the following symptoms or diseases.
MARK (✖) for current problems.

- ☐ Decreased Hearing
- ☐ Ringing in Ear
- ☐ Ear Infections – *frequent*
- ☐ Dizzy Spells
- ☐ Failing Vision ☐ Eye Pain
- ☐ Double or Blurred Vision
- ☐ Eye Infections – *frequent*
- ☐ Nose Bleeds – *recurrent*
- ☐ Sinus Trouble
- ☐ Sore Throats – *frequent*
- ☐ Hayfever/Allergies
- ☐ Hoarseness – *prolonged*
- ☐ Pneumonia/Pleurisy
- ☐ Bronchitis/Chronic Cough
- ☐ Asthma/Wheezing
- Shortness of Breath:
- ☐ on Exertion ☐ Lying Flat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain – *Walking*
- ☐ Varicose Veins/ Phlebitis
- ☐ Loss of Appetite – *recent*
- ☐ Difficulty Swallowing
- ☐ Indigestion or Heartburn
- ☐ Peptic Ulcers
- ☐ Abdominal Pain – *Chronic*
- ☐ Gall Bladder Trouble
- ☐ Jaundice/Hepatitis
- ☐ Change in Bowel Habits
- ☐ Diarrhea ☐ Constipation
- ☐ Crohn's/ Colitis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Urine Infections – *frequent*
- ☐ Blood in Urine
- Urination ☐ Overnight > twice
- ☐ Painful ☐ Loss of Control
- ☐ Decrease in Force/Flow
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Urethal Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss – *recent*
- ☐ Anemia ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Convulsions/Seizures
- ☐ Stroke
- ☐ Tremor/Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbness/Tingling Sensations
- ☐ Headaches – *frequent*
- ☐ Arthritis/Rheumatism
- ☐ Back Pain – *recurrent*
- ☐ Bone Fracture/Joint Injury
- ☐ Gout
- ☐ Osteoporosis
- ☐ Foot Pain
- ☐ Cold Numb Feet
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Sleeping – *difficulty*
- ☐ Nervousness
- ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness – *excessive*
- ☐ Phobias
- ☐ Mental Illness
- ☐ Chicken Pox
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Contact with Blood or Body Fluids
- ☐ Alcohol
- _____ oz. per week
- ☐ Smoking
- _____ cig. per day
- Number of years _____
- ☐ Coffee / Tea
- # of cups per day _____
- ☐ Advanced Directives

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services.

_____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Niloufer S. Dennis MD (Date)

By: _____
Patient's Representative's Signature (Date)

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Niloufer S. Dennis MD
Obstetrics, Gynecology, & Infertility
Phone: 800-395-9431

DATE: _____

RE / PATIENT AUTHORIZATION FOR USE, DISCLOSURE, OR REQUEST OF HEALTH INFORMATION

EXPLINATION:
This authorization to receive or release medical information is being requested of you to comply with the term of the confidentiality of medical information act of 1981, section 56, of the California Civil Code and HIPPA regulation on 2003.

AUTHORIZATION:

I, Patient name(last, first): _____

* Date of Birth _____ SSN: _____ ID # _____

HEREBY, AUTHORIZE:

* Person(s), organization, others: _____

* Address: Street _____ City _____ State _____ ZIP _____

* Tel #: _____ Fax # : _____

* Signed _____ Witness _____
patient/parent/legal gaurdian patient/parent/legal gaurdian

TO RELEASE ALL of my medical records with no exception to

Niloufer S. Dennis M.D.

7930 Frost St. #103
___ San Diego, CA 92123

1351 Broadway Ave.
___ El Cajon, CA 92021

FAX TO
888-502-8290

EFFECTIVNESS:
This authorization shall be effective immediately and shall be in effect for one calendar year from the date of this release as above.

DURATION OF RESPONSE:
The designated facility should response by mail within 15 calendar days from the date of signing of this document. We will sand a reminder after a week from this document date.

RESTRICTIONS:
I understand that the recipient may not further use or disclose the received medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

CONFIDENTIALITY NOTICE:
This transmission may contain confidential or legally privileged company, employee, or patient health information that is intended only for the individual or entity named in the address. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or reliance upon the contents herein is strictly prohibited, and may violate local, state, or federal law and incur serious penalties, including imprisonment. If you have received this transmission in error; please reply to the sender, so that arrangements can be made for proper delivery or immediate destruction. THANK YOU

Care360®

Niloufer S. Dennis M.D.
Obstetrics, Gynecology and Infertility

Update of Services and Locations

Welcome once again to the office of Dr. Niloufer S. Dennis M.D. We at this time would like to inform you of our recently updated services and locations.

Dr. Dennis completed her Bachelors of Science degree at San Diego State University in 1996. She then went on to graduate from Ross University, School of Medicine in 2002. Dr. Dennis did her internship at Aurora Sinai, in Aurora Wisconsin and completed her residency in the field of Obstetrics and Gynecology in 2007 at Danbury Hospital (an affiliate of Yale University) in Danbury, Connecticut.

Services:

Dr. Dennis is currently licensed to practice medicine in the state of California and has been providing Obstetrical and Gynecologic services in the state of California since 2007. Our goal is to provide the best services to our patients and to abide by all local and state mandates which protect our patient's rights and interests such as Health Insurance Portability and Accountability Act and state regulations. The practice of Dr. Dennis provides the full range of office services. Surgeries are provided by her associates in accordance to probationary mandate by the State of California. It is our goal to continue to provide you and your family with the best Obstetrical and Gynecologic services available.

Locations:

6505 La Jolla Blvd

La Jolla, CA 92037
Telephone 1-800-395-9431

330 South Magnolia #301
El Cajon, CA 92020
Telephone 1-800-395-9431

Please sign below to acknowledge receipt of document:

Patient Name _____ Patient Signature _____