Purushotham & Akther Kotha MD., Inc.

Cardiology & Rheumatology

Patient Medication List

Patient Last & First Name: _____ **DOB:** _____

Date	Medication Name, Strength, Directions	Quantity, refills, Initials

***** Please Complete New Patient Packet a Total of 6 Pages *****

Purushotham & Akther Kotha MD., Inc.

8860 Center Drive Suite # 400
La Mesa CA. 91942

Patient Registration Form

Please Complete all the information below in print, please DO NOT leave any questions Blank.

***PATIENT INFORMATION:**

Last Name: _____ First Name: _____ **DOB:** _____ **Age:** _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Ph: _____ **Mobile:** _____ **Carrier:** _____ Sex **M / F**

Race: _____ Marital Status: **M / D / W/ S** SSN: _____ Language: _____

Ethnicity: _____ Email: _____

***PRIMARY INSURANCE INFORMATION:**

Name: _____ Policy No: _____ Group No: _____

SECONDARY INSURANCE INFORMATION:

Name: _____ Policy No: _____ Group No: _____

***REFERRING PHYSICIAN INFORMATION:**

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

***PRIMARY PHYSICIAN INFORMATION:**

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

***PHARMACY:**

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

***EMERGENCY CONTACT:**

Name: _____ Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Relationship: _____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for surgical or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

***Sign (Patient or Guardian) :** _____

Date: _____

Purushotham Kotha, M.D., F.A.C.C.
Diplomate Subspecialty of Cardiovascular Diseases

Patient History

Name: _____ Date: _____

Referred by:

Please check off any heart problems or symptoms you have experienced:

- ☐ Heart attack
- ☐ Angina
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Abnormal rhythm (arrhythmia)
- ☐ Palpitations, irregular heartbeats
- ☐ Fainting
- ☐ Enlarged Heart
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Heart failure
- ☐ Blue lips or fingernails
- ☐ Leg cramps when you walk

Have you ever had:

- ☐ EKG/ Stress Test
- ☐ An Echocardiogram
- ☐ Cardiac catheterization/ Heart catheterization
- ☐ Coronary bypass surgery
- ☐ Valve surgery
- ☐ An Electro Physiology study or procedure
- ☐ A Pacemaker or Defibrillator

Tell us about your risk of heart disease

Please check if you have:

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Ever smoked
- ☐ Diabetes

Do you exercise (including walking)?

Has a close family member had a heart attack, angina or bypass surgery? If so who?

If you are a woman, have you passed menopause (change of life)? If so at what age?

Do you take estrogen replacement?

Please tell us anything else about your heart:

Please check any symptom you have, so we can find out more about it:

Constitutional:

- ❑ Lack of energy
- ❑ Trouble sleeping
- ❑ Loss of appetite
- ❑ Weight changes
- ❑ Fevers

HEENT:

- ❑ Double or blurred vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hearing problems
- ❑ Buzzing or ringing in ears
- ❑ Allergies
- ❑ Hay fever

Respiratory:

- ❑ Wheezing
- ❑ Cough
- ❑ Coughing blood
- ❑ Asthma
- ❑ Tuberculosis

Digestive:

- ❑ Indigestion
- ❑ Change in bowel habits
- ❑ Bloody or tarry stools
- ❑ Jaundice
- ❑ Liver problems
- ❑ Ulcers
- ❑ Gallstones

Urinary:

- ❑ Frequency
- ❑ Infections
- ❑ Stones
- ❑ Bladder incontinence

Men:

- ❑ Prostate problems
- ❑ Night time urination

Women:

- ❑ Abnormal menstrual problems
- ❑ Possible pregnancy

Musculoskeletal:

- ❑ Joint pains
- ❑ Swelling or redness
- ❑ Arthritis
- ❑ Back pain
- ❑ Muscle aches or tenderness
- ❑ Gout

Dermatological:

- ❑ Rash
- ❑ Itching
- ❑ Any other: _____

Female reproductive:

- ❑ Breast lumps
- ❑ Recent mammogram
- ❑ Pap smear/ pelvic exam

Neurological:

- ❑ Paralysis (even temporary)
- ❑ Stroke
- ❑ Numbness
- ❑ Loss of balance
- ❑ Seizures
- ❑ Loss of memory
- ❑ Headache/ Migraine

Psychiatric:

- ❑ Unusual thoughts
- ❑ Nervousness
- ❑ Suicide attempts
- ❑ Crying or sadness
- ❑ Depression

Endocrinology:

- ❑ Thyroid disorder
- ❑ Diabetes
- ❑ Excess thirst
- ❑ Hunger or malnutrition

Hematology:

- ❑ Bleeding
- ❑ Easy bruising
- ❑ Risk factors for HIV
- ❑ Anemia
- ❑ Cancer

Are you being treated now or have been treated for any illness? Please list them.

_____ _____

_____ _____

Have you had any operations? Any injuries?

_____ _____

_____ _____

Marital Status (please circle): Single/ Married/ Widowed/ Divorced

With whom do you live? _____

Occupation: _____

Leisure activities: _____

Health Habits:

Do you smoke? _____

If so, how many packs per day? _____

For how many years? _____

Do you drink alcohol? _____

If so, how much/often? _____

Do you use any drugs? _____

Check if any close family members (parents, brothers and sisters, children) have/had:

- ❑ Heart problems
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Stroke
- ❑ Cancer

Are there any other health problems in your family?

_____

Are you allergic to any medications? Please list.

_____

What kind of reaction do you have?

- ❑ Hives
- ❑ Itching
- ❑ Skin Rash
- ❑ Difficulty Swallowing
- ❑ Other: _____

Dear Patient,

Welcome to our practice. We intend to provide you with the best care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As our "partner in health," we ask that you to help us in the following ways:

By initialing below each statement you acknowledge these terms:

- I understand my doctor will suggest and explain to me which tests will be appropriate for my current medical circumstances. These tests will be used to help treat and gain a better knowledge of my disease/condition. I acknowledge that the **dr will only contact me about these results if they are of urgent medical need, if not they will be discussed at the follow-up apointment.**

***Patient Initials**_____

- I will schedule visits with my doctor for routine exams when recommended. I understand I should keep up with my follow-up visits so my doctor can continue to monitor and treat my conidtion. **I acknowledge that failure to keep my appointments and maintain communication with my doctors office could result in lapse of treatment/care and that I would be putting my health at risk.**

***Patient Initials**_____

- I understand my rheumatologist is NOT pain management and will not routinely prescribe narcotics/controlled substances. I understand for urgent medical needs I will report to an emergency room or urgent care as this office is a specialty one.

***Patient Initals**_____

No Show Policy

Our clinic understands circumstances may arise that do not allow you to keep your appointment. However, we ask that that you show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. **By initialing below I acknowledge that there is a 35$ no-show fee.**

1st Missed Appointment: You will receive a warning that will be noted in your chart that you are aware of the no-show fee and next time you will be charged.

2nd Missed Appointment: A " NO SHOW FEE" of $35 will be charged.
(Insurance is not responsible for this fee)

***Patient Initials**_____

I will inform my doctor if I decide to not follow her recommended treatment plan. I understand by not following the doctors recommendations I am putting my health at risk. I understand I have the choice to reject treamtent plans, although I must inform the clinic if doing so. **I also understand some treatment plans take time and patience but I am willing to work along side my doctor to find what works best for my current medical circumstance.**

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have with our medical staff. If you need more information about your health or condition, please ask.

_____ _____ _____

***Patient Signature** ***Date** **Physician Signature**

Purushotham & Akther Kotha MD., Inc.

Consent to The Use and Disclosure of Health Information For Treatment, Payment, Or Healthare Operations

***Name :**_____ ***Birth Date:** _____

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment and plans for future care or treatment.

I understand that this information serves as:

- A basis for my treatment plan
- A means of communication between the healthcare professionals who are involved in my care
- A source of information to apply my diagnosis and procedure information to my bill
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare options such as assesing the quality of care and reveiwing the competence of healthcare professionals.

I understand that I have the right:

- To object the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organizzation is not required to agree to the restrictions requested.
- To revoke this consent but it must be done in writing except to the extent that the organization has already taken action.

I request the following restrictions to the use of my health information:

_____

_____

_____

_____

I acknowledge that I was given access to a copy of the Organization's Notice of Privacy Practices for Protected Health Information (PHI) Under HIPAA.

***Patient Name (Printed) :** _____

***Todays Date:** _____

***Patient Or Personal Representative Signature**_____

***Description of Personal Representative's authority to act for the patient**

_____

Office Use Only:

O Accepted

O Denies

_____ _____ _____

Signature Title Date