

Chhokar Clinic
1906 Warm Springs Road
Columbus, Georgia 31904
Telephone: (706) 322-0528
Fax: (706) 322-2080

R. Chhokar, M.D., F.A.C.C.
S. Mewar, M.D., F.A.C.C.
Z. Bhatti, M.D., F.A.C.C.
V. Patel, M.D., F.A.C.C.

REFERRED BY: _____ INITIAL VISIT DATE: _____

NAME: _____ DATE OF BIRTH: _____

SEX: _____ AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL: _____

ADDRESS: _____

CITY

STATE

ZIP CODE

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____

CITY

STATE

ZIP CODE

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

SPOUSE'S SOCIAL SECURITY: _____ OCCUPATION: _____

WORK ADDRESS: _____

CITY

STATE

ZIP CODE

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PRIMARY INSURANCE: _____ POLICY #: _____

NAME OF INSURED: _____ GROUP #: _____

BIRTH DATE OF INSURED: _____ RELATIONSHIP TO PT: _____

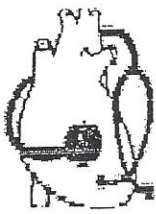
SECONDARY INSURANCE: _____ POLICY #: _____

NAME OF INSURED: _____ GROUP #: _____

BIRTH DATE OF INSURED: _____ RELATIONSHIP TO PT: _____

I HEREBY AUTHORIZE ANY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CHHOKAR & CHHOKAR MD's, PC. I AM RESPONSIBLE FOR ANY CHARGES THAT I MAY HAVE INCURRED FROM TREATMENT WITH CHHOKAR & CHHOKAR. IT IS MY RESPONSIBILITY TO OBTAIN AN INSURANCE REFERRAL FROM MY PCP, IF REQUIRED. IF REFERRAL IS NOT OBTAINED, THE BALANCE WILL BE MY RESPONSIBILITY. I AUTHORIZE CHHOKAR AND CHHOKAR TO FILE A WRITTEN COMPLAINT ON MY BEHALF WITH THE INSURANCE COMMISSIONER IF THIS CLAIM IS NOT PAID WITHIN 30 DAYS. I ALSO AUTHORIZE CHHOKAR AND CHHOKAR TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS.

SIGNATURE: _____ DATE: _____



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***PAYMENT IS REQUESTED AT THE TIME OF SERVICE* THANK YOU**

NAME: _____ Date: _____ AGE: _____

REFERRING PHYSICIAN: _____

IMMEDIATE NEXT OF KIN AND RELATION: _____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY

Check yes or no and give details if you have any history of the following:

DIAGNOSIS	YES	NO	DETAILS
HIGH BLOOD PRESSURE			
DIABETES			
HEART ATTACK			
CONGESTIVE HEART FAILURE			
HEART VALVE DISEASE			
CONGENITAL HEART DEFECT			
RHEUMATIC HEART DISEASE			
CORONARY ANGIOPLASTY			
HEART BY-PASS SURGERY			
HIGH CHOLESTEROL			

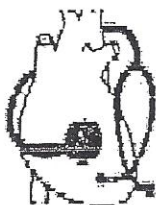
PAST SURGICAL HISTORY

OPERATION	WHEN	WHERE	SURGEON

FAMILY HISTORY

Do you have parents or siblings who have been diagnosed with coronary artery disease before the age of 55-60 or who have died suddenly? Yes _____ No _____ Details _____

List any other hereditary medical problems: _____



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SOCIAL HISTORY

Work History: _____

Caffeine use? Yes _____ No _____ How much? _____ How long? _____

Tobacco use? Yes _____ No _____ How much? _____ How long? _____

Alcohol use? Yes _____ No _____ How much? _____ How long? _____

Possible exposure to toxins? Yes _____ No _____ Details: _____

REVIEW OF SYSTEMS

Chest Pain? Yes _____ No _____ When did the pains start? _____

Location of pain: _____

Describe the pain (sharp, dull, pressure, ect.) _____

Associated symptoms (short of breath, nausea, sweats, ect.) _____

How long do pains last? _____ What makes it worse: _____

What makes pain go away? _____

Are pains increasing in frequency or duration? Yes _____ No _____

Is pain worse with movement of the arms/shoulders? Yes _____ No _____

Is pain worse with taking a deep breath? Yes _____ No _____

Palpitations or flutters? Yes _____ No _____ Are they fast or slow _____

Describe what they feel like: _____

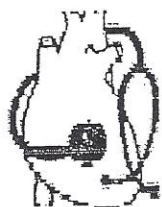
Does it cause dizziness? Yes _____ No _____ Have you ever passed out from them? Yes _____ No _____

How long do episodes of palpitations last? _____

Increasing in frequency or severity? Yes _____ No _____

Congestive heart failure? Yes _____ No _____ When was diagnosis made? PPPPP _____

Do you have shortness of breath? Yes _____ No _____ Details: _____



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Do you have shortness of breath with exertion? Yes _____ No _____ Details: _____

How far can you walk before getting short of breath? _____

Do you have swelling of the feet or ankles? Yes _____ No _____ Are you easily fatigued? Yes _____ No _____

How many pillows do you sleep on at night? _____ Do you wake up at night gasping for breath? Yes _____ No _____

Do you have to sit up at night to breath? Yes _____ No _____

Do you have Peripheral Arterial Disease? Yes _____ No _____

When you walk or exercise, do you experience aching, cramping or pain in your arms, legs, thighs,
or buttocks? Yes _____ No _____

If you answered yes, does the pain subside with rest? Yes _____ No _____

Do you have any painful sores or ulcers on your legs or feet that aren't healing? Yes _____ No _____

Have you experienced TEMPORARY:

	YES	NO
Loss of vision in one eye?		
Slurred speech		
Weakness or numbness of an arm/leg on one side of your body		

Have you had surgery, balloon procedures, or stents to any blood vessels other than your heart? Yes _____ No _____

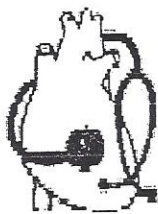
Have you had blockages in your coronary arteries? Yes _____ No _____

Do you have (circle all that apply): High Cholesterol History of smoking High Blood Pressure

Have you had any of the following heart test in the past year, if yes please indicate where and when.

	YES	NO	WHERE/WHEN
EKG			
24 HOUR HOLTER MONITOR			
STRESS TEST			
ECHOCARDIOGRAM			
HEART CATHETERIZATION			

Please bring your medications in the bottle when you come to see the doctor.



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Patient Acknowledgment of Understanding the "Notice of Privacy Practices"

The Chhokar Clinic has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and the practice protecting the patient's privacy. I understand that I have the right to read the "Notice of Privacy Practices" before signing this acknowledgment.

Within this notice of privacy practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to; access to my medical records, restriction on certain uses, receiving an accounting of disclosures as required by law, and requesting communication be by specified methods of communication or alternative location.

I understand that the practice may use/disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses/ disclosures of this information unless permitted. However, I do understand that sometimes the law may require the release of this information without my permission. I also understand that the patient's health information is private and confidential. I understand the Chhokar Clinic works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

This practice has established procedures that help us meet our obligations to the patient. These procedures may include other signature requirements, written acknowledgment, and authorization, reasonable time frames for requesting information, charges for copies and non-routine information needs, ect. I will assist the Chhokar Clinic by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

My signature below indicates that I have been given the chance to review a current copy of our "Notice of Privacy Practices".

Patient or
Legal authorized individual signature

Date of Birth

Please print name

Date