CHHOKAR CLINIC

2300 Manchester Expressway
Suite 1001 - Butler Pavilion
Columbus, Georgia 31904-6802
Phone: (706) 322-0528 Fax: (706) 322-2080

NAME:____

ADDRESS:_______________________________________ SEX:_______

CITY, STATE, ZIP:____________________________________AGE:_______

HM #:________________ CELL #:______________ MARITAL STATUS:____________

DATE OF BIRTH:_____________ SOCIAL SECURITY #:________________________

REFERRED BY:______________________ REF. DR. PHONE #:____________________

EMERGENCY CONTACT:_________________ RELATIONSHIP:____________

TELEPHONE #:___________________ OTHER #:_________________________

EMAIL:_______________________________________

EMPLOYER (F) (P) / STUDENT (Y) (N) WORK PHONE #:_______________

NAME / LOCATION OF EMPLOYMENT / SCHOOL:____________________________

PRIMARY INSURANCE:___________________ POLICY #:_________________

INSURED:_______________________ GROUP #:___________________________

INSURED BIRTHDATE:_______________ RELATIONSHIP TO PT:____________

PRIMARY CARE DOCTOR:__________________ REFERRAL REQUIRED? (Y) (N)

SECONDARY INSURANCE:_______________ POLICY #:_________________________
INSURED:_____________________________ GROUP #:__________________________

INSURED BIRTHDATE:__________________ RELATIONSHIP TO PT:_____________

I HEREBY AUTHORIZE ANY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CHHOKAR CLINIC, I AM RESPONSIBLE FOR ANY CHARGES THAT I MAY HAVE INCURRED FROM TREATMENT WITH CHHOKAR CLINIC. 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 CLINIC 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 CLINIC TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS.

SIGNATURE:___________________________ DATE:__________________
WITNESS: _____________________________ DATE:__________________

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New Patient Registration Form

Date Completed: _______________

***Please bring all current medication bottles with you to EVERY visit.**

Name: ____

Date of Birth: __________________

Allergies: ____

Current / Past Medical History:	**(Y)**	**(N)**	**Brief Detail & When Diagnosed**
--Tobacco: Type _____________	___	___	# of Packs/day: _______ Year quit: _______ How many yrs: _______
--Diabetes	___	___	Type I: _________________ or Type II: _______________________
--High Cholesterol	___	___	____
--High Blood Pressure	___	___	____
--Blood Flow issue in Neck/Legs	___	___	____
--Heart Attack	___	___	____
--Congestive Heart Failure	___	___	____
--Heart Valve Disease	___	___	____
--Coronary Angioplasty	___	___	____
--Open Heart Surgery	___	___	____

Please list any non-heart related medical problems:

____

Surgical History:

Type of Surgery	**Year**	**Where**	**Surgeon**
______________________________	__________	_________________	______________________________
______________________________	__________	_________________	______________________________
______________________________	__________	_________________	______________________________

*Please use back of page if needed to list additional surgeries.

Social History:

Occupation: ____ **Retired: (Y) (N)** **Disabled: (Y) (N)**

Circle what applies:

Marital Status: Single Married Divorced Widow Other ________________________________

Children: # of Sons: _______________ # of Daughters: _____________

Education: Grade school High School GED College Degree: _______________________

Diet: Regular Low Fat Low Salt Diabetic Renal Low Carb Vegetarian Other __________

Exercise: Occasional Regular Active Lifestyle Unable to exercise I don't exercise

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Alcohol Use: (Y) (N) Rare Frequently Social Occassional Daily Year quit: __________________
Caffeine Use: (Y) (N) Chocolate Coffee Soda Tea Tablets
Drug Use: (Y) (N) Current use: (Y) (N) History of abuse: (Y) (N) Type: _____________________

Family History:

Member	**Cardiac Issues?**	**Diagnosis**	**Age at & Cause of Death (if applicable)**
Father	(Y) (N)	__________________	______/__________________________
Mother	(Y) (N)	__________________	______/__________________________
Brothers / Sisters	(Y) (N)	__________________	______/__________________________
Uncles / Aunts	(Y) (N)	__________________	______/__________________________
Grandparents	(Y) (N)	__________________	______/__________________________
___________________	(Y) (N)	__________________	______/__________________________

Please list any other hereditary medical problems or issues: ____
____

Review of Symptoms:

Chest Discomfort: (Y) (N) When did it begin: _______________ How often: ___________________________
How long does it last: __________________________________ Location in body: _________________________
Pain (1 to 10): _____________ Does the pain radiate, where: (Y) (N) ___________________________________
Quality (dull, sharp, etc.): ______________________ What aggravates it: ______________________
What relieves it: ______________________________________
Do you also notice the following: Shortness of breath (Y) (N) Nausea: (Y) (N) Sweating: (Y) (N)

Dyspnea (Shortness of breath): (Y) (N) When did it begin: ___________ How often: _____
How long does it last: _______________ What aggravates it: _______________
What relieves it: _____________________________________
Feels like: Cannot get air in Cannot get air out Pressure in chest Wheezing

Edema (Swelling): (Y) (N) When did it begin: ___________ How often: _______
How long does it last: __________________ What aggravates it: __________________
What relieves it: ______________________________________
Area of swelling: Arms Lower legs Entire legs If 1 leg: (L) (R) Ankles Feet

Palpitations or Flutters: (Y) (N) When did it begin: ___________ How often: _________________________
How long does it last: ____ Severity: Mild Moderate Severe
Gradual or Sudden onset: _________________________ What aggravates it: _______________________
What relieves it: ______________________________________
Do you notice the following: Shortness of breath (Y) (N) Chest Pain (Y) (N) Loss of consciousness: (Y) (N)

Passing out or Nearly passing out: (Y) (N) When this started: ________ How many times: _____

Brief Detail: ____

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Have you had any of the following tests or procedures?:

Procedure / Test	(Y)	(N)	Where (Hosp/Office; City State)	When (Year)
Stress Test	___	___	____	___________________
Echocardiogram	___	___	____	___________________
Holter Monitor	___	___	____	___________________
Event Recorder	___	___	____	___________________
EKG	___	___	____	___________________
Labs (Most Recent)	___	___	____	___________________
Cardiac Catheterization	___	___	____	___________________
Pacemaker / ICD	___	___	____	___________________
Open Heart Surgery	___	___	____	___________________
Other Cardiac Related	___	___	____	___________________
___________________	___	___	____	___________________

Please list any additional information you feel we should know and / or any questions you may want to discuss:

____

____

____

____

Peripheral Vascular Disease (PVD) Self-Test

Your answers to these questions can help you determine if you are at risk.

- ❑ Do you have cardiovascular (heart) problems such as high blood pressure, heart attack, or stroke?
- ❑ Do you have diabetes?
- ❑ Do you have a family history of diabetes or cardiovascular problems (immediate family such as a parent, sister, brother)?
- ❑ Do you have aching; cramping or pain in your legs when you walk or exercise, but the pain goes away when you rest?
- ❑ Do you have pain in your toes or feet at night?
- ❑ Do you have any ulcers or sores on your feet or legs that are slow in healing?
- ❑ Do you smoke?
- ❑ Have you ever smoked?
- ❑ Are you more than 25 pounds overweight?
- ❑ Do you eat fried or fatty foods three times a week or more?
- ❑ Do you have an inactive lifesyle?
- ❑ Has your lifestyle changed due to leg pain?

The more "Yes" answers you have, the more important it is for you to ask your doctor about PVD.

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Acknowledgement of Receipt of "Patient Notice of Privacy Rights"

As our patient, under HIPAA, the new Federal Privacy Act, you have specific privacy rights. We are required by law to attempt to obtain acknowledgement of "Patient Notice of Privacy Rights".

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of out "Patient Notice of Privacy Rights" is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting room.

A summary of your rights includes your right to:

A. Restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
B. Receive confidential communications in an alternate form or location.
C. Inspect, copy and amend protected health information (you may be billed for the cost of copying).
D. Know about any unauthorized disclosure of protected health information.
E. Have a copy of our patient privacy notice.

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from Chhokar Clinic.

___________________ ______________________________ _________________________
Date Patient's Printed Name Patient's Signature

____________________________________ ____
Pt.'s Date of Birth Patient's Representative Signature Relationship to Patient
(Required if patient is unable to sign)

Location Staff Only

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

This notice and acknowledgement was mailed to the patient's home on ____ /____ /____.

This acknowledgement was not obtained because:

___ The patient refused to sign the acknowledgement
___ The patient was undergoing emergency treatment
___ Other

Signature of staff member: ___________________________ Date: _________________________