NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: ________________________________ DOB:__________________ Sex: ☐ M ☐ F
(Last) (First) (MI)

Address: ____

City, State, Zip: ____

Phone (Home):______________ Phone (Work):______________ Phone (Cell): ______________

SSN #: ______________________________ Occupation: ______________________

Email:______________________________ Marital Status: ______________________

Employment status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ On Disability ☐ Other: ____________

Emergency Contact:__________________ Relationship:______________ Phone:__________________

Referring Physician:__________________ Primary Care Physician:______________________

Preferred Language:__________________________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

☐ White ☐ Other

PRIMARY INSURANCE INFORMATION

Insurance Name:______________________________ Member ID:__________________________

Employer Name:____

If patient is not the primary subscriber, please fill the following

Subscriber Name: __________________________ DOB: ______________ Sex: ☐ M ☐ F

Address: __________________________________ City, State, Zip: __________________________

Phone (Home):______________ Phone (Work):______________ Phone (Cell): ______________

SSN #: __________________________________ Relationship to Patient:__________________

SECONDARY INSURANCE INFORMATION

Insurance Name:______________________________ Member ID:__________________________

Employer Name:____

If patient is not the primary subscriber, please fill the following

Subscriber Name: __________________________ DOB: ______________ Sex: ☐ M ☐ F

Address: __________________________________ City, State, Zip: __________________________

SSN #: __________________________________ Relationship to Patient:__________________

I attest that the information given above is correct and true to best of my knowledge. I hereby authorize direct payment of surgical/medical benefits to Vani Velkuru, M.D. Inc. for services rendered by AAC. I authorize AAC to release all information necessary to my insurance carriers to secure the payment. I understand that I am financially responsible for all charges incurred whether or not covered by my insurance.

In order to better serve our patients, we require at least one working day notice to reschedule or cancel your appointment. Missed appointments will be charged $35. Thank you for your consideration

Signature:__________________________________ Date (MM/DD/YY): ______________

VANI VELKURU, M.D.
Phone: (510) 991 7508
Fax: (510) 991 7503
Email: contact@theaaclinic.com

HIPAA PATIENT CONSENT FORM

PATIENT CONSENT TO THE USE/DISCLOSURE OF THE PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I, ____, understand that as part of my health care, Advanced Arthritis Clinic, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third party payer can verify services billed were actually provided, and ,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of the organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I also understand that I may revoke this consent in writing at any time, except to the extent that AAC has already taken action in reliance thereon.

I acknowledge that I have received from AAC, a copy of the Notice of Privacy Policies with the effective date of June 20th 2011. The Practice may condition treatment upon execution of this consent.

I authorize AAC, to download my medication history from Surescripts.

Signature of Patient/Representative:___________________________________ Date:__________

Printed Name:____

Relationship to the patient:____
(If other than patient)

VANI VELKURU, M.D.
Phone: (510) 991 7508
Fax: (510) 991 7503
Email: contact@theaaclinic.com

Authorization to Release Protected Health Information
(HIPAA Compliant Request for Information/Medical Records)

I hereby give permission to release my, below checked, Protected Health Information (PHI) also known as My Medical Records to Advanced Arthritis Clinic

Be certain that information is accurate and complete. ***Incomplete authorizations are invalid.***

____

Name of Medical Office/Company/Entity you want to send records to AAC.

____

Street Address

____

City State ZIP Code

____

Phone Number Fax Number

☐ Release a copy of my entire chart including X-rays and lab reports
☐ Release records for this specific date of service______________________________
☐ Release specific information ____

I am requesting my PHI to be disclosed for reason___________________________

I understand this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.

I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient Name _________________________________Date of Birth ________________

Patient Signature ____________________________________ Date ________________

Witness Signature ____________________________________ Date ________________

PATIENT MEDICAL HISTORY FORM

Name:____

General Questions

Describe briefly your present symptoms

___

___

___

Date symptoms began: ____________________

Diagnosis:____

Previous treatment for this problem : ☐ Physical therapy ☐ Surgery ☐ Injections ☐ Medications ☐ Chiropractic

Past Medical History

☐ Anemia	☐ Asthma	☐ Bad headaches	☐ Cancer
☐ Epilepsy	☐ Heart problems	☐ High Blood Pressure	☐ Blood clot
☐ Mental illness	☐ Pneumonia	☐ Rheumatic fever	☐ Tuberculosis
☐ Stomach ulcers	☐ Stroke	☐ Arthritis	☐ Osteoarthritis
☐ Spinal disorder	☐ Osteoporosis	☐ Gout	☐ Childhood Arthritis
☐ Ankylosing spondylitis	☐ Lupus or SLE	☐ Rheumatoid arthritis	☐ Diabetes Mellitus

Other:____

Previous Surgeries

1	
2	
3	
4	
5	

Family History

☐ Bleeding Tendency	☐ Cancer	☐ Cataracts	☐ Stroke
☐ Heart Disease	☐ High Blood Pressure	☐ Kidney disease	☐ Mental illness
☐ Diabetes	☐ Lung Disease	☐ Epilepsy	☐ Blood clot
☐ Osteoarthritis	☐ Osteoporosis	☐ Lupus or SLE	☐ Gout
☐ Spinal Disorder	☐ Tuberculosis	☐ Arthritis	☐ Ankylosing Spondylitis
☐ Childhood arthritis	☐ Rheumatoid Arthritis	☐ Diabetes Mellitus	

Other:____

PATIENT MEDICAL HISTORY FORM

Personal Questionnaire (Circle One)

Do you drink caffeinated beverages	NO	YES
Do you smoke	NO	YES
Do you drink alcohol	NO	YES
Do you exercise regularly	NO	YES
Do you get enough sleep at night	NO	YES
Are you pregnant	NO	YES

Allergies (To What and Reaction)

1	
2	
3	
4	
5	

Present Medications (Drug Name and Dosage)

1	
2	
3	
4	
5	

Past Medications (Drug Name and Dosage)

1	
2	
3	
4	
5	

Review of Systems

Constitutional Symptoms

Recent weight change	NO	YES	Amount of weight change (lbs)		
Fatigue	NO	YES	Weakness	NO	YES
Night Sweats	NO	YES	Fever/chills	NO	YES
Other					

PATIENT MEDICAL HISTORY FORM

Eyes

Pain	NO YES	Redness	NO YES
Loss of vision	NO YES	Double or blurred vision	NO YES
Dryness	NO YES	Feels like something in eye	NO YES
Itching in eyes	NO YES		
Other			

ENT/Mouth

Ringing in ears	NO YES	Deafness/hearing loss	NO YES
Nosebleeds	NO YES	Loss of smell	NO YES
Dryness in nose	NO YES	Runny nose	NO YES
Sore tongue	NO YES	Bleeding gums	NO YES
Sores in mouth	NO YES	Loss of taste	NO YES
Dryness in mouth	NO YES	Frequent sore throats	NO YES
Hoarseness	NO YES	Difficulty in swallowing	NO YES
Other			

Respiratory

Cough	NO YES	Wheezing	NO YES
Coughing of blood	NO YES	Shortness of breath	NO YES
Difficulty in breathing at night	NO YES	Swollen legs or feet	NO YES
Other			

Cardiovascular

Irregular heartbeat	NO YES	Sudden changes in heart beat	NO YES
High Blood Pressure	NO YES	Chest pain	NO YES
Heart Murmurs	NO YES		
Other			

PATIENT MEDICAL HISTORY FORM

Gastrointestinal

Nausea	NO YES	Abdominal Pain	NO YES
Vomiting	NO YES	Jaundice/Hepatitis	NO YES
Constipation	NO YES	Diarrhea	NO YES
Blood in Stool	NO YES	Heartburn	NO YES
Other			

Genitourinary

Difficult urination	NO YES	Blood in urine	NO YES
Urinary frequency	NO YES	Cloudy, smoky urine	NO YES
Kidney Stones	NO YES	Pus in urine	NO YES
Discharge from Penis	NO YES	Discharge from vagina	NO YES
Night time urination	NO YES	Vaginal Dryness	NO YES
Pain or burning on urination	NO YES	Number of pregnancies	
Number of miscarriages?			
Other			

Skin

Easy Bruising	NO YES	Color changes of hands/feet in the cold	NO YES
Sensitive to Sunlight	NO YES	Rash	NO YES
Redness	NO YES	Nodules / bumps	NO YES
Tightening of the skin	NO YES	Hair loss	NO YES
Other			

Musculoskeletal

Morning stiffness	NO YES	How long?	
Joint pain	NO YES	Muscle Weakness	NO YES
Muscle pain or tenderness	NO YES	Joint Swelling	NO YES
Back Pain	NO YES	Deformities of the joints.	NO YES
Neck pain	NO YES		
Other			

PATIENT MEDICAL HISTORY FORM

Neurological system

Epilepsy/seizures	NO YES	Muscle Weakness	NO YES
Headaches	NO YES	Dizziness	NO YES
Fainting	NO YES	Muscle spasms	NO YES
Sensitivity or pain of hands/feet	NO YES	Memory Loss	NO YES
Other			

Psychiatric

Anxiety	NO YES	Agitation	NO YES
Depression	NO YES	Difficulty falling asleep	NO YES
Difficulty staying asleep	NO YES	Inadequate Personal relationships	NO YES
Other			

Endocrine

Excessive thirst	NO YES	Other	

Hematologic/Lymphatic

Swollen glands	NO YES	Tender glands	NO YES
Anemia	NO YES	Bleeding tendencies	NO YES
Other			

Allergic / Immunologic

Frequent sneezing	NO YES	Migraine Headaches triggered by Allergies	NO YES
Other			

Health maintenance

Date of last dental examination	
Date of eye examination	
Date of last chest X-ray	
Date of last bone densitometry (DEXA Scan)	
Date of last TB test	