Purushotham & Akther Kotha MD., Inc.

Cardiology & Rheumatology

Patient Medication List

Patient Last & First Name: _____ DOB: _____
Drug Allergies: _____
Pharmacy Tel & Address : _____

Date	Medication Name, Stenght, 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 & Akther Kotha MD., Inc.

Akther Kotha, MD
Diplomate American Board of Internal Medicine
Diplomate Subspecialty Of Rheumatology

Roshan Kotha, MD
Diplomate American Board of Internal Medicine
Diplomate Subspecialty Of Rheumatology

Kimberly D. Lee NP-C
American Academy Of Nurse Practitioners
Rheumatology Nurse Society

Patient History

Patient Full Name : _____ **Today's Date:**_____

Personal History

Drug Allergies:_____

Are you being treated now or have been treated for any illness? Please list them and the approximate date of onset:

_____ _____
_____ _____
_____ _____

List ALL Surgeries, as well as any MAJOR Injuries/ Fractures:

_____ _____
_____ _____
_____ _____

Please Check off? Circle any or all that you have / had:

□ Diabetes □ High Blood Pressure □ Thyroid Disease
□ Lung Problems □ Heart Disease □ Kidney Problems
□ Liver Problems □ Tuberculosis □ Hepatitis B or C
□ Cancer/ Type: □ Stroke □ Seizures
□ Recurrent Infectious □ Blood Clots □ Cataracts/ Glaucoma

Do You now have or have you had problems with:

□ Unintentional weight loss □ Swollen Glands □ Psoriasis
□ "Butterfly Rash " on Cheeks □ Fingers/ Toes Turning Blue with Cold
□ Joints Pains □ Swelling of Joints □ Chronic Neck Pain
□ Chronic Low Back Pain □ Dry Eyes □ Dry Mouth
□ Oral Ulcers □ Recurrent Sinusitis □ Chest Pain
□ Problems Breathing □ Swelling of feet/ legs □ Heartburn/ Ulcers
□ Chronic Stomach Pain □ Blood in Stool □ Low Platelets
□ Chronic Headaches □ Depression □ Anxiety
□ Major Eye Disease(ex: Uveitis Scleritis)

Family Medical History

Please check off if **ANY BLOOD RELATIVES** has or ever had any of the following & if so, who?(**Mother, Father, Brother/Sister, Children**)

□ Cancer/ Type _____
□ Diabetes _____
□ High Blood Pressure _____
□ Heart Trouble _____
□ Stroke _____
□ Degenerative Arthritis _____
□ Crohn's Disease/ Ulcerative Colitis _____
□ Rheumatoid Arthritis _____
□ Lupus _____
□ Sjogren's Disease _____
□ Other Connective Tissue? Autoimmune Disease _____
□ Psoriasis/ Psoriatic Arthritis _____

Have you ever had any X-rays, MRI's or Scans? Please List.

_____ _____
_____ _____
_____ _____
_____ _____

Do you drink Alcohol? How Much/ Often? _____
Any Drugs use Currently OR in the Past? _____

Please Check One □ **Never Smoked** □ **Quit Smoking** □ **Currently Smoking**

Women:
Last menstrual period: _____
Do you take any form of birth control?
Please List: _____

Pregnancies
Total Pregnancies: _____
Miscarriage/ at how many weeks
_____

Primary Care Doctor : _____
Previous Rheumatologist : _____

Dear Patient,

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

Schedule Visits with My Doctor for Routine Exam and Other Recommended Diagnostic Tests
I understand that my doctor will explain to me which recommended precautionary diagnostic test are appropriate for my age, gender, and person and family history. **These diagnostic test are test that can help tretaand/ or prevent disease and condition.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular routine follow-ups , I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my diagnostic test and to discuss these diagnostic tests.

Keep Follow-Ups Appointments and Reschedule , Missed Appointments
I understand that my doctor will want to know how my condition progress after I leave the office. Returning to my doctors on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, go over previous test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition.

NOTE: Doctor will only call in between appointments if test are of urgent medical attention. Otherwise Test will be discussed during follow-up appointment.

Patient Initials_____

No Show Policy
We understand 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. There will be a fee $35 for each MISSED appointment.

1st Missed Appointment: A staff member will call you at the number listed in you chart, and will use this policy as a reminder.

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

Patient Initials_____

***I understand that your specialist is NOT Pain Management and only specialize in Inflammatory and Autoimmune Disease, therefore you do NOT prescribe NARCOTICS/ CONTROLLED Substances.**

Patient Initials_____

Inform My Doctor if I Decide Not to follow her Recommended Treatment Plan
I Understand that *not* allowing my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow her recommendations so that she may fully inform me of any risk associated with my decision to delay or refuse treatment.

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. If you need more information about your health or condition, please ask.

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

Purushotham & Akther Kotha MD., Inc.

Concent to The Use and Disclosesure of Health Information For Treatment, Payment, Or Healthare Operations

Name :_____
Birth Date: _____ Social Security Number: _____

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

I Understand that this information serves as:

- A basisfor planning my care and treatment.
- A means of communication amoung the many healthcare professionals who contribute to my Care.
- A source of information applying my diagnosis and surgical information to my bill.
- A means by which a third- party payer can verify that services billed were actually Provider.
- A tool for routine healthcare options such as asssessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To abject to 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 Organizations is not required to agree to the restritions requested
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use ofmy health information:

_____

_____

I acknowledge that I have received 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