CENTRAL VALLEY ENDOCRINOLOGY

515 Grangeville Blvd.
Hanford, CA 93230

PATIENT INFORMATION SHEET

NAME:_____ **DATE:**_____

ADDRESS:_____ **CITY**_____ **STATE/ZIP CODE**_____

REFERRING PHYSICIAN/SOURCE:_____

HOME PHONE:_____ **CELL PHONE:**_____ **SS#**_____

DATE OF BIRTH:_____ **SEX: M F MARITAL STATUS: M W S D**

EMPLOYER:_____ **ADDRESS**_____ **PHONE** _____

SPOUSE'S NAME:_____ **SPOUSE'S SS#:**_____

SPOUSE'S DOB :_____ **PHONE:**_____

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU:_____

PHONE:_____ ***EMAIL:**_____

RESPONSIBLE PARTY IF UNDER 18:

NAME :_____

ADDRESS:_____ **CITY:**_____ **STATE:**_____

RELATIONSHIP TO PATIENT:_____

PRIMARY INS OR INDUSTRIAL CARRIER:_____

ID#:_____ **GROUP #:**_____

INSURED:_____ **RELATIONSHIP TO PATIENT:**_____

SECONDARY INS _____

ID#:_____ **GROUP#**_____

INSURED:_____ **RELATIONSHIP TO PATIENT:**_____

I REQUEST THAT PAYMENT UNDER MY INSURANCE PROGRAM BE MADE TO EITHER ME OR ON MY BEHALF TO PREM SAHASRANAM, MD FOR ANY SERVICES FURNISHED TO ME BY THE CLINIC. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PURPOSE OF EVALUATING BENEFITS OR PROCESSING OF A CLAIM.

IN THE EVENT THAT I DO NOT PAY FOR SERVICES PROVIDED BY THIS OFFICE AND THE ACCOUNT IS PLACED FOR COLLECTION, I OR WE UNDERSTAND AND AGREE THAT AN ADDITIONAL AMOUNT EQUAL TO 40% OF THE BALANCE OWING AT THE TIME THE ACCOUNT IS PLACED FOR COLLECTION WILL BE ADDED TO THE CURRENT BALANCE OWING. IN ADDITION TO A COLLECTION FEE OF 40% OF THE BALANCE OWED, I OR WE AGREE TO PAY INTEREST AT THE RATE OF 10% PER ANNUM UNTIL THE AMOUNT OWED IS PAYED IN FULL. I OR WE FURTHER AGREE TO PAY ALL ATTORNEYS FEES AND COURT COSTS NECESSARY TO COLLECT THIS BALANCE. I AGREE TO A $25.00 CHARGE FOR A MISSED APPOINTMENT NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE OF THE DATE OF MY SCHEDULED APPOINTMENT. THIS CHARGE CANNOT BE BILLED TO MY INSURANCE.

_____ _____

SIGNATURE (PATIENT OR GUARANTOR IF MINOR) DATE

CENTRAL VALLEY ENDOCRINOLOGY
PREM SAHASRANAM M.D.
515 W GRANGEVILLE BLVD. HANFORD, CA 93230
PHONE: (559) 587 1100 FAX: (559) 587 9044

MEDICAL HISTORY QUESTIONNAIRE FORM

DATE: ____/_____/____

NAME: _____

AGE: _____ HEIGHT:_____ WT:_____

INITIAL HISTORY

1. WHY ARE YOU COMING TO THE DOCTOR? _____
_____

2. REFERRING PHYSICIAN? _____

3. HAVE YOU EVER HAD ANY OF THE FOLLOWING (Please check)?

○ DIABETES ○ HIGH CHOLESTEROL ○ HIGH BLOOD PRESSURE ○ STROKE
○ HEART ATTACK ○ ANGINA ○ THYROID PROBLEMS ○ HISTORY OF RADIATION
○ CANCER (specify:_____) ○ OTHERS_____

3. LIST ANY SURGERIES THAT YOU HAVE HAD:

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

4. LIST ANY PAST HOSPITALIZATIONS:

WHEN:_____ WHY: _____

WHEN: _____ WHY:_____

5. WHAT MEDICATIONS ARE YOU TAKING (If Diabetic, see Diabetes Questionnaire)?

MEDICATION_____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____

6. ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, WHICH ONES? _____

_____

7. FAMILY HISTORY:
A) DO YOU HAVE FAMILY MEMBERS WITH DIABETES? YES NO

IF YES, WHO HAS DIABETES? _____

B) DO YOU HAVE FAMILY MEMBERS WITH A THYROID PROBLEM? YES NO

IF YES, WHO HAS THYROID PROBLEM?_____

C) PLEASE CHECK IF **BLOOD RELATED** MEMBERS OF YOUR FAMILY HAVE HAD ANY OF THE FOLLOWING:

_____ HEART DISEASE _____ HIGH BLOOD PRESSURE _____ OBESITY

_____STROKE _____ HIGH CHOLESTEROL _____ HIGH BLOOD PRESSURE

_____ MENSTRUAL PROBLEM _____ PROSTRATE CANCER _____ BREAST CANCER

_____ ADRENAL PROBLEM _____ PITUITARY PROBLEM _____ BONE PROBLEM

8. IMMUNIZATION: WHEN
FLU SHOT _____
PNEUMO VACC _____

9. SOCIAL HISTORY:
10.
MARITAL STATUS: Single Married Divorced Separated Widowed

DO YOU SMOKE CIGARETTES ?_____ HOW MANY PACKS /DAY?_____

DO YOU DRINK ALCOHOL ?_____HOW MANY PER DAY/WEEK?_____

EDUCATION COMPLETED ? GRADE SCHOOL____ HIGH SCHOOL___ COLLEGE_____

ANY HISTORY OF ILLICIT DRUG USE ?

10. CURRENT SYMPTOMS (Review of Systems):

General:

Weight Gain	YES OR NO (How much? _____)
Weight Loss	YES OR NO (How much? _____)
Weakness	YES OR NO
Fatigue	YES OR NO

Skin:

Hair Loss	YES OR NO
Itching	YES OR NO
Dryness	YES OR NO

Eyes, Ear, Nose & Throat:

Blurred vision (recent)	YES OR NO
Cataract	YES OR NO
Laser Treatment (not LASIK)	YES OR NO (when? _____)

Chest:

Cough	YES OR NO
Shortness of breath	YES OR NO

Cardiovascular:

Chest pain	YES OR NO
Palpitations	YES OR NO
Shortness of breath with exertion	YES OR NO
Shortness of breath while lying flat	YES OR NO
Swelling of the legs/ ankles	YES OR NO
Painful legs while walking	YES OR NO
Foot ulcers	YES OR NO

Gastrointestinal:

Loss of appetite	YES OR NO
Excessive hunger	YES OR NO
Heartburn	YES OR NO
Nausea	YES OR NO
Abdominal pain	YES OR NO
Constipation	YES OR NO
Loose bowel movements (diarrhea)	YES OR NO

Urinary:

Frequent urination	YES OR NO
Problem starting stream	YES OR NO
Incontinence	YES OR NO

Genital:

Libido (desire) Normal or Low

Men:

Erection problems YES OR NO

Women:

Regular periods YES OR NO

No. of pregnancies: _____

Menopause YES OR NO (age at menopause:_____)

If yes: natural or surgical

Age, periods started: _____

Last menstrual period: _____

Musculoskeletal:

Arthritis YES OR NO

If yes: what joints bother you the most: _____

Tendonitis/ Bursitis YES OR NO

Back or neck pain YES OR NO

Neurological:

Frequent headaches	YES OR NO
Burning sensation in the feet & hands	YES OR NO
Numbness in the feet & hands	YES OR NO
Depressed	YES OR NO
Mood swings	YES OR NO

IF YOU ARE SEEING Dr. SAHASRANAM FOR DIABETES, PLEASE FILL OUT THE DIABETES FIRST QUESTIONNAIRE AS WELL

_____ _____

Patient Signature Date

_____ _____

Prem Sahasranam, M.D. (Reviewed with the patient) Date

PREM SAHASRANAM
515 W GRANGEVILLE BLVD.
HANFORD, CA 93230
PH: (559) 587-1100 Fax: (559) 587-9044

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, 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 clinical information to my bill
- A means by which a third-party payer (eg. insurance carrier) can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and outcomes
- **Please make sure you attend your assigned appointment on time, failure to appear on time will result in reschedule for the next available appointment. Notify 24 hours in advance to reschedule appointment desired.**

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

_____ _____
SIGNATURE DATE

_____
PATIENT'S NAME

_____ _____
WITNESS DATE

Acknowledgement of Receipt of Notice of Privacy Practices was not signed as noted below:

____ Patient refused to sign
____ Patient was physically unable to sign

The following attempts were made to obtain signature:

DATE	TIME	EXPLANATION	INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prem Sahasranam, M.D.
515 W Grangeville Blvd Hanford, CA 93230
Phone: (559) 587 1100
Fax: (559) 587 9044

HIPAA Notice of our Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Protected health information is defined as individually identifiable health information that is transmitted or maintained in any form or medium by a covered entity or its business associates, excluding certain educational and employment records.

Uses and Disclosures of Protected Health Information:

Your Protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We may disclose your protected health information from time-to-time to another health care provider (for example, a specialist, pharmacist, or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" who perform various activities (for example, billing, transcription services) for the office. The business associates will also be required to protect your health information. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you.

Required by Law

We may use or disclose your protected health information without your authorization if law or regulation requires the use or disclosure. These situations include as required by Law: Public Health issues as required by Law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the laws on the protection of your health information. Other Permitted and Required Uses and Disclosures: Will be made only with your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has Page 1 of 2 taken an action in reliance on the use or disclosure indicate in the authorization.

Your Rights:

Prem Sahasranam, M.D.
515 W Grangeville Blvd Hanford, CA 93230
Phone: (559) 587 1100
Fax: (559) 587 9044

Following is a statement of your rights with respect to your protected health information.

Right to Inspect and Copy: You may request to inspect and obtain a copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Right to Request Confidential Communications: You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment: If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosures: You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to family members or friends involved in your care, or for notification. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this notice.

Right to Obtain a Copy of this Notice: You may obtain a paper copy of this notice, on request.

FEDERAL PRIVACY LAWS

There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

Complaints

If you believe these privacy rights have been violated, you may file a written complaint with our HIPAA Privacy Officer, or the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

· Make sure that your protected health information is kept private.
· Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
· Follow the terms of the notice currently in effect.
· Communicate any changes in the notice to you.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We educate our staff as to the importance of protecting health care information.

This notice is effective in its entirety as of July 10, 2006.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE

You are asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, health care operations when necessary, and as required by law. Should you have any questions, please ask to speak with our HIPAA Compliance Officer.

The signature below is only acknowledgement that you have received this Notice of Privacy Practices.

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(Patient or Authorized person) Signature and Date Print Name
(relationship if applicable)