PATIENT INFORMATION

Patient Name: _____ Date:_____
First *Middle Initial* *Last*

Street Address: _____
NO PO BOX PLEASE *Street* *City* *State* *Zip*

Name of person responsible for payment if other than patient:_____

Sex: F M Are you a student? (part-time full-time) Name of School _____

Employed? Yes No. Name of Employer _____If retired, retirement date: _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____)_____ Email _____

Date of Birth_____ Marital Status: S M W D

Referring Doctor: _____ Phone (_____) _____

Work Address _____
(Street) (City) (State) (Zip)

Emergency contact:_____ Relationship to Patient:_____

Phone (_____)_____

Signature _____ Date:_____

_____
Md. Review

MEDICAL QUESTIONAIRE

Name: _____ Date of Birth: _____

Occupation: _____ Referred by: _____

Please describe main reason for visit: _____

Please list medications which you may be allergic:_____

Please list all medications you are currently taking. Include *over-the-counter medicines*, ***supplements*** and those used only occasionally.

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

How much alcohol do you consume in a week?_____

How much tobacco do you consume in a week? _____

Have you been diagnosed with, treated for, or received any of the following:

	Please Circle	
Heart Disease	yes	no
High Blood Pressure	yes	no
Angina or Heart Attack	yes	no
Heart Rhythm Disturbance	yes	no
Pacemaker	yes	no
Heart Murmur	yes	no
If yes, do you take antibiotics prior to dental procedures	yes	no
Breathing Difficulties	yes	no
Bleeding Disorder or Tendency	yes	no
Kidney Disease	yes	no
Diabetes	yes	no
Diabetes	yes	no
Glaucoma	yes	no
Liver Disease	yes	no
Intestinal Colitis	yes	no
Hepatitis or Yellow Jaundice	yes	no

	Please Circle	
Blood Transfusion	yes	no
Aids or HIV Infection	yes	no
Cold Sores or Fever Blisters	yes	no
Excessive Scarring or Keloids	yes	no
Problems with Healing	yes	no
Dizziness or Fainting	yes	no
Stroke	yes	no
Seizures or Epilepsy	yes	no
Psychiatric Illness or Emotional Problems	yes	no
X-ray Exposure or Radiation Treatments	yes	no
PUBA or UVA Light Treatments	yes	no

If yes,

Type	Location	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any other illness below: _____

_____

Please list any previous hospitalization or surgery with reason and date: _____

_____

_____

MADHAVI KANDULA, M. D. DERMATOLOGY & COSMETIC DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

THE HEALTH INSURANCE PORTABILITY & ACCOUNTING ACT (HIPAA) REQUIRES EACH PATIENT BE PROVIDED WITH OUR "NOTICE OF PRIVACY PRACTICE." PLEASE SIGN & DATE BELOW. A COPY WILL BE FURNISHED TO YOU UPON REQUEST.

This notice refers to your personal medical information, as obtained by Madhavi Kandula, M.D. and/or her representative(s). It will include any written information by you, or any data on your behalf by Dr. Kandula or her representative(s).

Our office, under the guidance of HIPAA, takes reasonable and appropriate measures to protect your privacy with your medical records.

The following are instances where we DO NOT need your separate signed authorization to release medical information:

For purposes of insurance submission - done via electronic claim submission through an electronic claim clearing house (Gateway EDI, Inc.), or by paper to your insurance carrier via mail-this is for purposes of payment of charges, and will be released only to the insurance carrier(s) you have notified us of.

Separate authorization not needed to disclose protected health information to another health care provider for treatment of the patient.

Separate authorization not needed to fax medical information to another physician's office for treatment purposes (example: pathology, lab report to surgeon's office). Please note that we have in place reasonable and appropriate administrative, technical and physical safeguards to protect material transmitting via fax machine.

Any records as demanded by a state or federal court of law, upon presentation of the appropriate legal documentation.

We will obtain a separate signed authorization to release from you in the following instances:

Request for medical information from a new insurance carrier, as in your application for new coverage. This authorization must be current, and very specific as to all medical data or a certain time frame and/or illness.

Separate signed authorization is needed for your request to send copies to another health care provider.

Request for medical information from any legal source, other than that obtained from a court of law with proper documentation (subpoena).

Madhavi Kandula, M.D. :: 10363 Clayton Road :: St. Louis, MO 63131
Phone: (314) 692-0221 Fax: (314) 692-0686

MADHAVI KANDULA, M. D. DERMATOLOGY & COSMETIC DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

As a courtesy to our patients, we utilize a phone "reminder service" to remind patients of appointments. It is a computerized voice stating someone at that phone number has an appointment on a certain date at a certain time. If you do not wish us to send out this reminder, please notify any staff member, we will remove your phone number from the computer system. In order to continue to send reminders, we will need the authorization signed at the end of this notice.

The staff of Madhavi Kandula, M.D.P.C., views your medical records only as required in the daily course of operation–specifically to obtain reimbursement from your insurance carrier, third party, or for treatment purposes (correspondence with other medical professionals, laboratories, pathology labs). All safeguards are in place to keep your records from being viewed by unauthorized personnel.

You have the right to inspect, receive copies, and ask for your file to be amended and to obtain an accounting of disclosures. You may also revoke any prior authorization at any time. Any of these requests should be in writing.

All requests should be faxed to the office of Madhavi Kandula, M.D. P.C. at (314) 692-0221.

PHONE REMINDER AUTHORIZATION:

I authorize Madhavi Kandula, M.D. and any of her representatives, to use an automated telephone system and/or email and to use my phone number, time and date of appointment for the limited purpose of contacting me to notify of a pending appointment. I also authorize Dr. Kandula or her representatives to disclose to third parties who may answer my phone information regarding pending appointments, and to leave a reminder message on any voicemail system or answering machine.

Printed name of Patient	Signature of patient	Date

I hereby acknowledge receipt of this notice, having read all of the above, as witnessed by my signature below.

Printed name of Patient	Signature of patient	Date

I authorize the following family members to receive lab/pathology data, discuss my medical conditions, and make appointments on my behalf:

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Kidney disease	yes	no			
Diabetes	yes	no	X-ray exposure or Radiation treatments	yes	no
Glaucoma	yes	no	PUBA or UVA light treatments	yes	no
Liver disease	yes	no	Skin cancer	yes	no
Intestinal Colitis	yes	no	If yes, Type Location Year		
Hepatitis or yellow jaundice	yes	no			

Please list any other illness below:

Please list any previous hospitalization or surgery with reason and date:

Signature: _____ Date: _____

_____

Md. Review

MADHAVI KANDULA, M. D.

DERMATOLOGY & COSMETIC DERMATOLOGY

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