VENU PRABAKER, M.D. Inc.

DBA HealthCare Medical Group of La Mesa

Today's date:	Email Address:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer phone no ( )	

Referred to clinic by (please check one box) :	❑ Dr.	❑ Insurance Plan	❑ Hospital	

❑ Family	❑ Friend	❑ Zoc Doc	❑ Close to home/work	❑ Other _____

Family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes	❑ No

Please indicate primary insurance	❑ Medicare	❑ Medi-cal	❑ MultiCulture	❑ Mercy Physicians	❑ SCMG

❑ Secure Horizons	❑ United Heath Care	❑ Health Net	❑ Blue Cross/Shield	❑ Cash	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Primary Pharmacy (Location & Phone number):				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required processing my claims.

Patient/Guardian signature _____ Date _____

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MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME (Last, First, M.I.):	□ M □ F	**DOB:**
DATE OF LAST PHYSICAL EXAM:		

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio

Immunizations and dates:		
	□ Tetanus	□ Pneumonia
	□ Hepatitis	□ Chickenpox
	□ Influenza	□ MMR Measles, Mumps, Rubella

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS		
Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION?	☐ Yes	☐ No

Please turn to next page

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug	Strength	Frequency Taken
ALLERGIES TO MEDICATIONS		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	□ Sedentary (No exercise)					
	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				□ Yes	□ No
	If yes, are you on a physician prescribed medical diet?				□ Yes	□ No
	# Of meals you eat in an average day?					
	Rank salt intake	□ Hi	□ Med	□ Low		
	Rank fat intake	□ Hi	□ Med	□ Low		
Caffeine	□ None	□ Coffee	□ Tea	□ Cola		
	# Of cups/cans per day?					
Alcohol	Do you drink alcohol?				□ Yes	□ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				□ Yes	□ No
	Have you considered stopping?				□ Yes	□ No

	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			**Children**	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRAND MOTHER** Maternal		
	☐ M ☐ F		**GRAND FATHER** Maternal		

	□ M □ F		**GRAND MOTHER** Paternal		
	□ M □ F		**GRAND FATHER** Paternal		

MENTAL HEALTH

Is stress a major problem for you?	□ Yes	□ No
Do you feel depressed?	□ Yes	□ No
Do you panic when stressed?	□ Yes	□ No
Do you have problems with eating or your appetite?	□ Yes	□ No
Do you cry frequently?	□ Yes	□ No
Have you ever attempted suicide?	□ Yes	□ No
Have you ever seriously thought about hurting yourself?	□ Yes	□ No
Do you have trouble sleeping?	□ Yes	□ No
Have you ever been to a counselor?	□ Yes	□ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	□ Yes	□ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	□ Yes	□ No
Have you had a D&C, hysterectomy, or Cesarean?	□ Yes	□ No
Any urinary tract, bladder, or kidney infections within the last year?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Any problems with control of urination?	□ Yes	□ No
Any hot flashes or sweating at night?	□ Yes	□ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	□ Yes	□ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□ Yes	□ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	□ Yes	□ No
If yes, # of times _____		
Do you feel pain or burning with urination?	□ Yes	□ No
Any blood in your urine?	□ Yes	□ No
Do you feel burning discharge from penis?	□ Yes	□ No
Has the force of your urination decreased?	□ Yes	□ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	□ Yes	□ No
Do you have any problems emptying your bladder completely?	□ Yes	□ No
Any difficulty with erection or ejaculation?	□ Yes	□ No
Any testicle pain or swelling?	□ Yes	□ No
Date of last prostate and rectal exam?	□ Yes	□ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

□ Skin	□ Chest/Heart	□ Recent changes in:

☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for allowing Venu Prabaker M.D., Inc. to assist you with your medical care**.** In the Interest of good health care practices, it is desirable to establish a credit policy to avoid Misunderstandings. Our primary responsibility is to help our patients experience good health And we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible. As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. Insurance reimbursement is A contract between you, your employer and your insurance carrier. **You are responsible for any charges, or portions of charges that your insurance does not cover including any deductibles. Co-Pays are due at the time of service and must be collected**. You will begin receiving monthly statements with any balances after your insurance company has been billed. **Please contact the office at 619-698-0606 if you are not able to keep your scheduled appointment. Appointments should be cancelled at least 24 hours in advance, to avoid a $10/$25 fee depending on type of service**.

( ) I, understand I have insurance coverage, and authorize direct payment from my insurance carrier to Venu Prabaker M.D., Inc.

Note: You are responsible for knowing your coverage benefits. Venu Prabaker M.D., Inc. will make every effort to inform you if a service is not covered by your insurance.

( ) I, do not have insurance coverage and understand that I am responsible for payment of all charges. Your 1st initial visit as a self-pay patient will be $125 any visit there after will be $95 to be paid at the time of the visit. These payments will be applied toward your balance.

***I have read this policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account.**
IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING RESONABLE ATTORNEY FEES. This will ensure that our responsible patients will not be penalized to cover costs incurred by

those who do not pay on time.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____DATE: _____
*Payment plans are available by request based on your current financial situation.

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HIPAA Privacy Right

Patient Information

I give Health Care Medical Group of La Mesa, my consent to use or disclose my
protected health information to carry out my treatment, to obtain payment from
insurance companies, and for health care operations like quality reviews.

I have been informed that I may review Health Care Medical Group of La Mesa
Notice of Privacy Practices (For a more descriptions of uses and disclosures)
before signing this consent.

I understand that Health Care Medical Group of La Mesa has the right to change their Privacy Practices and that I May obtain any revised notices at
HealthCare Medical Group of La Mesa.

I understand that I have the right to request a restriction of how my protected
health information is used. However, I also understand that Health Care Medical of La Mesa is not required to agree to the request, if health Care Medical Group of La Mesa agrees to my requested restrictions, they must follow
The restrictions(s).

I also understand that I may revoke this consent at any time, by making a
request in writing, except for information already used or disclosed.

I give my health care provider permission to share or discuss my health information with the following person(s).

Please Print Names of person(s)

1. _____
2. _____
3. _____

Signature _____ Date _____

VENU PRABAKER, M.D. Inc.
DBA HealthCare Medical Group of La Mesa

Informed Consent Agreement
for Treatment of Intractable Pain with Narcotics

I, _____, have agreed to use the following narcotic medications as part of my treatment for_____
Of which I have been diagnosed with.

This diagnosis has been confirmed in consultation with _____MD/PA.

I agree to the following guidelines:

1. I will obtain all my prescriptions through _____ and will fill all my prescriptions at _____.

2. I will take this medication only as prescribed by my provider. I will not vary the dosage or interval without authorization from my provider.

3. I will not request any pain medications or controlled substances from other providers except during an acute emergency, and only then can another provider prescribe narcotic medications for me. If this occurs, I will notify this other provider of the existence of this contract as soon as possible and of all other medications I am taking.

4. I understand that in the event of an emergency, this provider should be contacted and the problem will be discussed with the emergency room or other treating physician. I am

responsible for signing a consent to request record transfer to this doctor. No more than three days of medications may be prescribed by the emergency room or other physician without my Provider's approval.

5. I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

6. Due to the potential for misuse, I know that I will be unable to obtain replacement of lost or stolen medications. I will arrange for refills only at prescribed intervals and will not ask for refills earlier than agreed, not afterhours, on holidays or on week-ends, ONLY during regular office hours.

7. I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

8. I agree to see _____ for on-going case management and will Schedule regular appointment as long as I am taking this narcotic medication.

9. I agree to participate in psychiatric or psychological assessments, if necessary.

10. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue.

11. I authorize my provider and my pharmacy to cooperate fully with any city, state or federal law Enforcement agency, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to the pharmacy. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

12. I understand that I will consent to random drug screening if requested by my provider to determine my compliance with my program of pain control medicine.

13. If I do not follow this guidelines I understand that my treatment will be terminated including further care from this clinic.

I understand this medication may not eliminate my pain but may reduce it to a level that is tolerable and improves what I am able to do each day. I agree that the daily Use of these drugs increases certain risks and I have discussed the risks, benefits and Alternatives to narcotic treatment with my provider. I have had an opportunity to ask Questions and receive answers to those questions to my satisfaction.

I agree to follow these guidelines. A copy of this document has been given to me.

This Agreement is entered into on this _____day of _____, 201_____.

Patient signature: _____

Physician/Medical provider signature: _____

Witnessed by: _____ Date: _____