B.V. CHANDRAMOULI, M.D., MPH, FACC, FSCAI

B.V. Chandramouli, M.D., Inc
1555 East Street, suite 100
Redding, CA 96001

OFFICE POLICIES

In effort to make your visit with us as easy as possible we ask that you make note of the following office policies. We thank you in advance for your cooperation

Please notify of us of any changes to the following at the time of your visit :

1. Address
2. Insurance information
3. Medical illness, injury, or surgery since your last visit
4. Medications added or discontinued since your last visit

Please notify us of a cancellation at least **24 hours** in advance. There will be a **$250 charge if you are scheduled for a nuclear study and you no show for the appointment. This charge will cover Isotope cost which will be wasted.**

Please allow **48 hours** for prescription refill requests to be completed.

All **co-pays** and deductibles are due at the time of visits.

There will be a **$25** charge for returned checks.

Sincerely,

The Staff

B.V. Chandramouli, M.D. MPH, FACC, FSCAI

Taking Care of Your Heart

Last Name ________________	First Name ________________	Middle Initial ________

Gender:

Male		Female	

Date of Birth: ______________________

Social Security Number: ____

Address: ____
Street Address

____
City, State, Zip

Tel: ( ) _________-____________ Cell: ( ) _________-____________

Work: ( ) _________-____________ E-Mail: ________________________

Referring Doctor: ____

In case of emergency, Please list the nearest relative or friend not living at the same Address we may contact:

Name____________________ Relation______________ Phone ________________

Please bring a copy of your insurance cards to be copied.

I authorize any and all medical benefits to be paid directly to Dr. B.V. Chandramouli, M.D., Inc. I Authorize the release of any medical information necessary to process medical claims. A copy of this authorization shall be valid as the original during entire course of treatment.

Patient Signature ________________________________ Date: ____________

Symbol means that you can complete this section on the patient portal web-site also.

Please list medications (including non-prescription medications and nutritional supplements) you are CURRENTLY taking:

Name	Pill strength	Amount at a time	How often?
e.g: Aspirin	*81 mgs*	*1 tablet*	*once a day*
e.g: Fish Oil	*Unknown*	*1 Capsule*	*twice a day*
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Others: ______________________________

Please tell us if you are or if you have in the past suffered from any of these conditions:

- ☐ High Blood pressure
- ☐ Diabetes
- ☐ Seizures/Epilepsy
- ☐ Poor Circulation
- ☐ Had heart stents placed
- ☐ Angina
- ☐ Heart Failure
- ☐ Irregular Heartbeats
- ☐ Kidney Failure
- ☐ Had Heart Bypass
- ☐ Heart Attack
- ☐ Overweight
- ☐ Fainting Spells
- ☐ Liver Disease
- ☐ Had Pacemaker or defibrillator Implanted
- ☐ Stroke
- ☐ Cancer
- ☐ Ulcers
- ☐ ______

Please list medication and substance allergies and the reaction you had? ☐ None

Medication/Substance	Reaction
e.g.: Penicillin	*Throat swells*
____________	____________
____________	____________
____________	____________
____________	____________

Please tell what surgeries you had so far for any conditions:

Year	Type of surgery
Example: 1986	*Appendix removed*
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

Please tell about your close relatives:

Father ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

Mother ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

Brother #1 ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

Brother #2 ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

Sister #1 ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

Sister #2 ☐ Alive ☐ Passed away. Age: _____ Major Health Problems: ____________

I have _______ **brother(s)** and _______ **sister(s).** I have ______ **son(s)** and _______ **daughter(s).**

☞ **Please tell us tell us about yourself, family, employment and habits:**

I am: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Decline to state
I live with: ☐ Spouse/Partner ☐ Kids ☐ Parents ☐ Alone ☐ Friends ☐ Pet(s)
I am: ☐ Retired ☐ Disabled ☐ Working FT ☐ Working PT ☐ Unemployed

If working, I am employed as: ____________________

Education: ☐ School ☐ GED ☐ College ☐ Post-Grad. ☐ Trade School
Exercise: ☐ None ☐ Walk ☐ Go to gym ☐ Yoga/Stretch ☐ Swim
Alcohol use: ☐ Don't drink ☐ Social ☐ Heavy: ____________________ per day
In the past year, I have used: ☐ Marijuana ☐ Meth/Speed ☐ Cocaine ☐ Heroin ☐ None
I had problems with: ☐ Alcohol abuse ☐ Drug abuse ☐ Prescription drug abuse ☐ None
Smoker?: ☐ Daily ☐ Yes, but not every day ☐ Past Smoker ☐ Never smoked ☐ Decline to state
If ever smoked: Age started smoking __________ Yrs. **Type of material:** ☐ Cigarettes ☐ Cigar ☐ Pipe
Packs per day ______________ **Tried to quit?** ☐ Yes ☐ No **If yes, age quit smoking** _______ Yrs
Planning to quit? ☐ Yes ☐ No
Modalities to help quit smoking: ☐ Hypnosis ☐ Support Group ☐ Nicotine Patch
☐ Nicotine gum ☐ Prescription Medication (*Chantix, Zyban* etc) ☐ Self determination

Comments: ____________________

☞ **Within the past year, have you suffered from the following?**

Constitutional:	☐ Fever	☐ Appetite loss	☐ Weight gain	☐ Weight loss
Dermatology:	☐ Rash	☐ Dry skin	☐ Skin Infections	
Ophthalmic:	☐ Poor vision	☐ Blurred vision	☐ Double vision	☐ Bright lights bother
ENT:	☐ Trouble swallowing		☐ Cold	☐ Cough
ENT:	☐ Hearing loss		☐ Ringing in ears	☐ Sore throat
Respiratory:	☐ Shortness of breath		☐ Wheezing	☐ Pneumonia
Cardiology:	☐ Chest pain	☐ Dizziness	☐ Palpitations	☐ Leg swelling
GI:	☐ Stomach pain	☐ Blood in stools	☐ Constipation	☐ Diarrhea
GI:	☐ Difficulty swallowing		☐ Heartburn	☐ Nausea/Vomiting
Musc/Skeletal:	☐ Weakness	☐ Joint pain	☐ Joint stiffness	☐ Joint swelling
Musc/Skeletal:	☐ Leg cramps	☐ Muscle spasms		
Neurology:	☐ Headaches	☐ Can't sleep	☐ Memory loss	☐ Seizures
Neurology:	☐ Tingling/Numbness		☐ Tremors	☐ Weakness in limbs
Hematology:	☐ Abnormal bleeding		☐ Easy bruising	☐ Enlarged nodes
Psychology:	☐ Anxiety	☐ Depression	☐ High stress level	☐ Anger
Females:	☐ Weak bladder		☐ Post-Menopausal	☐ Diminished libido
Males:	☐ Difficulty- urination		☐ Difficulty- erections	☐ Diminished libido
Endocrine:	☐ Excessive sweating		☐ Easy Fatigue	☐ Thyroid problems
Allergy:	☐ Itchy or red eyes		☐ Runny nose	☐ Skin itch/scratch

Comments: ____________________

My Height: ______________ Feet __________ Inch **My Weight:** ______________ Lbs.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: ______________________________ Date_______________

Relationship (If not signed by patient): ______________________________

I wish to place the following restrictions on disclosure of my health information_______
____

Please name all person(s) we can contact to discuss your medical information:

Name:______________________Relationship__________Phone_________

Name: ______________________Relationship __________Phone_________

Name: ______________________Relationship __________Phone_________

Following HIPPA patient confidentiality regulations, please check how you would like us to address you:

_____Mr. And/or ______________First Name
_____Mrs. ______________Last Name
_____Ms ______________Other Name

Signature:
______________________________ Date_______________