R.B. KOLACHALAM M.D.
GENERAL SURGERY

Patient Information

(Please Print and Circle or check the appropriate response)

Patient's Name:

____

DOB: _____________________________

*Address:*___________________________

City: _______________ *Zip:* ___________

Home Phone: ______________________

Cell: ______________________________

*Work:*______________________________

Email Address:

____

Patient's SSN:

____

Male ___________ Female____________

Retired: _NO YES_

Marital Status: Married Single

Widowed Divorced Domestic Partner

Emergency Contact Person:

Name:

____

Relationship: _____________________

Home Ph: ________________________

Cell: ____________________________

Work: ___________________________

Insurance Information

(Please Print and Circle or Check the appropriate response)

Name of Primary Insurance:

____

Primary Policy Holder:

____

DOB: _____________________________

SSN: _____________________________

Relationship: Self Spouse Dependent

Contract /Member ID Number:

____

____

Group Number:

____

Pharmacy Information

(Please Print)

Name of Pharmacy:

____

Ph Number: _______________________

Address (or cross roads):

____

____

City: ______________________________

State: _____ Zip: __________________

Please Complete this form by circling all that applies to your health:

Tobacco Use:	Yes	No
Latex Allergy:	Yes	No
Pacemaker:	Yes	No
Are you currently taking blood thinners:	Yes	No

Circle all that pertains to *your* health:

Alcohol Abuse	Headaches	Esophageal Reflux
Constipation	Urinary Incontinence	Migraine Headaches
High Cholesterol	Atrial Fibrillation	Bradycardia
Pacemaker	Dizziness	Emphysema
Anemia	Insomnia	Nose Bleeds
Cancer	Incontinence	Bowel Disorders
High Blood Pressure	Acid Reflux	Gallstones
Sleep Apnea	Depression	Pancreatitis (Chronic)
Arthritis	Kidney Stones	C-Section
Hemorrhoids	Allergies	Poor Hearing
Stroke	Drug Use	Weight Gain
Asthma	Multiple Sclerosis	Diabetes Type 1
Diverticulosis	Blood Clots	Diabetes Type 2

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Family History:

(Please Circle All That Applies)

FATHER:	MOTHER:	SIBLING:
Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes
Back Problems	Back Problems	Back Problems
Heart Disease	Heart Disease	Heart Disease
Hypertension	Hypertension	Hypertension
Stroke	Stroke	Stroke

Please List all Known Drug Allergies & Reactions

Drug	Reaction

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Please List ALL Current Medications With Dosages

Medication	Dosage

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Please List Surgical History along with the month and year of the surgery

Surgical History

(Please write your dates under each procedure that pertains to you, and circle L for Left & R for Right)

- *Appendectomy* ____________________
- *Cholecystectomy* ____________________
- *Colostomy* ____________________
- *Ganglion Cyst* ____________________
- *Gastric Bypass* ____________________
- *Hysterectomy (vaginal)* ____________________
- *Inguinal Hernia Repair* ____________________
- *Laminectomy* ____________________
- *Knee Replacement (L) &/or (R)* ____________________
- *Lumpectomy* ____________________
- *Hip Replacement (L) &/or (R)* ____________________
- *Tonsillectomy* ____________________

Please List Any Additional Surgeries Not Listed Below

Surgery	Date

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PLEASE KEEP THIS NOTICE

NOTICE OF PRIVACY PRACTICES FOR:

R.B. KOLACHALAM, MC, PC

This notice describes how medical information about you may I'le used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information in some cases. Your "protected health information", means any of your written or oral health information that is created or received by your health care provider and that relates to your past, present, or future physical or mental health or condition.

I. **Uses and Disclosure of Protected Health Information (PHI)** The practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your PHI may be used or disclosed only for these purposes unless the practice and or provider has obtained your authorization for the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State Law. Disclosures of your protected PHI for the purpose described in this notice may be made in writing, orally, or by facsimile.

   a) **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care of any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your PHI to a pharmacy to fill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home, we may also disclose your PHI to a'l outside treatment provider for purpose of treatment activities of the other provider.
   b) **Payment:** Your PHI will be used, as needed to obtain payment for services that we provide. This may include certain communication. to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to obtain prior approval authorization for the

hospitalization. We may also disclose PHI to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your PHI to your insurance company to demonstrate medical necessity; as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

c) **Operation:** We may use or disclose your PHI as necessary for our own health care operations in order to facilitate the function of the practice and to provide quality care to all patients. Health care operations include such activities as:

- *Quality assessment and improvement activities*
- *Employee review activities*
- *Training programs including those in which a students, trainees, or practitioners in health care learn under supervision*
- *Accreditation, certification, licensing or credentialing activities*
- *Review and auditing, including compliance review, medical reviews, legal services, and maintaining compliance programs*
- *Business management and general administrative activities*

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations

d) **Other uses and Disclosures:** As part of treatment, payment, and healthcare operations, we may also use or disclose your PHI for the following purposes: To remind patient of an appointment To inform patient of potential treatment alternatives or options To inform patient of health related benefits or services that may be of interest To contact patient to raise funds for the practice or an institutional foundations, related to the practice. **If** patient does not want to be contacted regarding fund raising, please contact our privacy officer.

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HIPPA Notice and Acknowledgment

I acknowledge that I have received the preceding Notice of Privacy Practices

______________________________	______________________________
Patient Signature	Date
Personal Representative to Patient Signature	Date
Representative Name (please print)	Relationship to Patient (list above)

IF there is a person you would like our office to be able to speak with regarding any medical information, such appointments, prescriptions, surgeries, etc please list below. This will give our office permission to discuss any of your personnel medical information with. Thank you!

Name:

Relationship:

Contact Number:

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PRIMARY CARE PHYSICIAN

Last Name First Name

Phone Number Fax Number

NURSING HOME

IF ANY:

Address

Phone Number Room #

Contact Person (Nurse)

REFERRING DOCTOR

Last Name First Name

Phone Number Fax Number

KOLACHALAM SURGERY

26850 Providence Parkway Suite #460

Novi Mi 48374

Tel: 248-662-4272 Fax: 248-662-3020

www.kolachalamsurgery.com

OTHER CARE PROVIDERS

Last Name First Name

Cardiologist

Last Name First Name

OBGYN

Last Name First Name

Oncologist

Last Name First Name

Other