R.V. RAO, M.D., M.S. (Surg) F.A.C.S., F.I.C.S. 50

Diplomate American Board of Surgery
General Surgery and Vascular Surgery

PATIENT REGISTRATION

DATE

NAME

MARITAL STATUS S M W D SEP

DATE OF BIRTH

STREET ADDRESS

CITY STATE, ZIP

PHONE (HOME) (WORK)

OCCUPATION/ EMPLOYER

SPOUSE'S NAME

DATE OF BIRTH

OCCUPATION/ EMPLOYER

PHONE

IF UNDER 18 PARENT / GUARDIAN

EMERGENCY CONTACT (OTHER THAN SPOUSE)

PHONE

ADDRESS

RELATION

S S #

DRIVER'S LICENCE #

REFERRED BY

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)

RELATIONSHIP

BILLING ADDRESS

PHONE #

PAYMENT REQUIRED AT TIME OF SERVICE – UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY

ADDRESS

EFFECTIVE DATE

SUBSCRIBER'S NAME

I D #

GROUP #

BENEFIT CODE

2) INSURANCE COMPANY

ADDRESS

EFFECTIVE DATE

SUBSCRIBER'S NAME

I D #

GROUP #

BENEFIT CODE

MEDICARE #

MEDICAID I D #

OTHER COVERAGE

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. RAO ________________, for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. RAO ________________, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE • MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf

A photocopy of these assignments shall be valid as the original

PATIENT (please print)

DATE

PARENT / GUARDIAN (please print)

SIGNATURE

FORMEDIC 1994 12D WORLDS FAIR DR. SOMER:

INFORMATI FOR YOUR PHYSICIAN

Please answer the follow. _ questions prior to your first examination
It will help your physician to know not only about your health but also about your family and relatives

TODAY'S DATE

NAME	ADDRESS

TELEPHONE NUMBER	DATE OF BIRTH	AGE	PLACE OF BIRTH	RACE OR NATIONALITY OF PARENTS

RELIGION	EDUCATION (Highest level attained)	OCCUPATION ►	HOW LONG

PRESENT MARRIAGE (Year married)	PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U S AND CANADA?

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE ►	☐		☐		☐	
DECEASED ►	☐		☐		☐	

BROTHERS ►	NO ALIVE	HEALTH	NO DECEASED	CAUSE OF DEATH
SISTERS ►	NO ALIVE	HEALTH	NO DECEASED	CAUSE OF DEATH
CHILDREN ►	NO ALIVE	AGES & HEALTH	NO DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS **YOU** HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble ☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease ☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC ?

☐ No ☐ Yes ► LIST

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

☐ NO ☐ Yes ► LIST

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes	IN THE PAST? ☐ No ☐ Yes	TYPE AND DAILY AMOUNT	HOW LONG?

DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes ►	TYPE	WEEKLY AMOUNT	HOW LONG?

DO YOU DRINK COFFEE? ☐ No ☐ Yes ►	WEEKLY AMOUNT	HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE ☐ Regular ☐ Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes	ORAL CONTRACEPTIVES? ☐ No ☐ Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ► DATE.

DRESSED WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician)	DATE

#20195 Medical Arts Press Mpls MN 5542

MEDICAL RECORD

NAME AGE SEX S M D W

ADDRESS

SPONSOR

OCCUPATION REF. BY ACKN

CHIEF COMPLAINT

DATE OF ONSET ALLERGIC

PRESENT ILLNESS

PAST HISTORY

ACCIDENTS

OPERATIONS

FAMILY HISTORY

MOTHER		FATHER	
BROTHERS		SISTERS	
HEART DIS.	DIAB.	HTN	MALIG
TB	EPILEP	BLOOD	GOUT
OBESITY	ALLERGIC	NEPH	MENTAL

SOCIAL HISTORY

HABITS: cigarette alcohol coffee

MEDICATIONS

REVIEW OF SYSTEMS

BODY WT SKIN, HAIR, NAILS

NERVOUS

EENT

CARDIOVASCULAR

RESPIRATORY

GASTROINTESTINAL

GENITO URINARY

MUSCULO SKELETAL