ARCHANA CHANDRA, M.D., P.A.

# 502 North Valley Parkway, Suite 1
# Lewisville, Texas 75067

Name:_____Date of Birth: _____SS#:_____

Gender:_____ Race:_____ Ethnicity:_____ Preferred Language:_____

Home #: (____)_____Cell #: (____)_____ Email: _____

Address: _____City:_____Zip:_____

Employer: _____Position: _____

May we leave a message at home or work in reference to appointments?_____

Whom may we thank for referring you?_____

Pharmacy: _____Phone #: _____

Dentist: _____Phone #: _____

Emergency contact: _____Phone #: _____

Nearest friend not living with you: _____Phone #: _____

Who is responsible for this bill? _____

I agree and understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and completed the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Please list all relatives/friends who may have access to your medical file, or who may call on your behalf.

| Name: | Relationship: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Sign: _____ Date: _____

ARCHANA CHANDRA, M.D., P.A.

502 North Valley Parkway, Suite 1
Lewisville, Texas 75067

# Patient History

Name:_____ Date of Birth:_____

Pharmacy Name and Number:_____

List all current medications and doses:_____

_____

_____

Do you have any allergies?_____

_____

When was your last flu shot?_____ Pneumonia shot?_____

## Medical History

| | Yes | No | Date |
|---|---|---|---|
| Diabetes | | | |
| Hypertension | | | |
| Stroke | | | |
| Heart Attack | | | |
| Irregular Heart Beat | | | |
| Leg Cramps | | | |
| Joint Problems | | | |
| Swelling | | | |
| Echocardiogram | | | |
| Cardiac Catheter | | | |
| Gall bladder | | | |
| Balloon Angioplasty | | | |
| Heart Surgery | | | |
| Pacemaker | | | |
| Flexible Sigmoidoscopy/Colonoscopy | | | |
| Mammogram | | | |
| Pap Smear | | | |
| Bone Density | | | |

Do you have any other medical problems not listed above?

_____

## Risk Factors

Have you ever had your cholesterol checked?____Yes_____No. If yes, what was it? _____
Do you smoke? _____Yes_____No. If yes, _____ packs per day, for _____ years.
Is there any history of heart disease in your family? _____ Yes _____ No. If yes, please list family member and condition:

_____

_____

ARCHANA CHANDRA,M.D.,P.A.

**502 N. VALLEY PKWY, STE. 1**
**LEWISVILLE, TX 75067**

Patient:_____ Claim Group:_____

Employer:_____ SS # / ID #:_____

I hereby instruct and direct _____ Insurance Company to pay by check, made out to and mailed to:

**ARCHANA CHANDRA,M.D.,P.A.**
**502 N. VALLEY PKWY, STE. 1**
**LEWISVILLE, TX 75067**

If my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make out check to me and mail it as follows:

**502 N. VALLEY PKWY, STE. 1**
**LEWISVILLE, TX 75067**

For the professional and medical expense benefit allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. **THIS IS DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I also authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date this _____ day of _____, _____
Day Month Year

_____
Signature of Policyholder

ARCHANA CHANDRA, M.D., P.A.

502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

# PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payments from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have takes action relying on this consent.

Patient name:_____

Signature:_____

Relationship to the Patient:_____

Date: _____

ARCHANA CHANDRA, M.D., P.A.

502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

Please be advised that there is a $ 25.00 charge for all appointments that are considered "NO SHOW". Pri-Med Care does require 24 hours advance notice to cancel an appointment.

Sign: _____ Date: _____

ARCHANA CHANDRA,M.D.,P.A.
502 N. VALLEY PKWY, STE. 1
LEWISVILLE, TX 75067

# CONSENT STATEMENTS

Name:_____ DOB:_____

FOR INJECTIONS:
**I hereby authorize the physicians and/or nursing staff of Archana Chandra,M.D.,P.A. to perform injection(s). I have no known allergies to the medicine/s I am receiving. I was notified of the complications, which include, but are not limited to bleeding, infection, and no pain relief.**

_____ _____
Signature Date

FOR PROCEDURES:
**I hereby authorize the physicians and/or nursing staff of Archana Chandra,M.D.,P.A. to perform procedure(s) (lesions, I&D, and/or laceration). I was notified of the complications, which include, but are not limited to bleeding, infection, and no pain relief.**

_____ _____
Signature Date

FOR DIAGNOSTIC EXAMS:
**I hereby authorize the physicians and/or technicians of Archana Chandra,M.D.,P.A. to perform Ultrasounds, Echocardiograms, Dopplers, U/S Guided Injections, and ABIs. I am not pregnant/nor is there any possibility that I am pregnant at this time. I was notified of any complications that may arise with these diagnostic exams.**

_____ _____
Signature Date