IMPORTANT INFORMATION

PLEASE NOTE WE WILL COLLECT ALL COPAYMENTS AND OR DEDUCTIBLE AMOUNTS PER YOUR INSURANCE COMPANY AT THE TIME OF SERVICE.

WE BILL ALL INSURANCE COMPANIES PER OUR CONTRACT.

YOU MUST HAVE A PICTURE ID AND YOUR INSURANCE CARD IN ORDER FOR US TO COMFIRM YOUR INSURANCE COVERAGE.

IF YOU DO NOT HAVE THIS INFORMATION, WE WILL BE HAPPY TO MAKE ANOTHER APPOINTMENT.

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TO ALLOW TIME FOR PARKING, ELEVATORS AND ASSEMBLY OF YOUR CHART.

THANK YOU

Rodney R. Randall, M.D.

Patient Information

Please **PRINT** Clearly

First Name_____ MI_____ Last Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Social Security #_____ Date Of Birth_____

Marital Status_____ Spouse (Parent If Minor) Name_____

Employer Name_____ Work Phone #_____

Emergency Contact Person: Name_____ Phone #_____

Primary Care – Internal Medicine – Referring Doctor_____

Primary Insurance_____ Phone #_____

I.D/Policy #_____ Group #_____

Policy Holder_____

Policy Holder's I.D #_____ Policy Holder's Date Of Birth_____

Secondary Insurance_____ Phone #_____

I.D/Policy #_____ Group #_____

Policy Holder_____

Policy Holder's I.D #_____ Policy Holder's Date Of Birth_____

Please present all insurance cards and driver license to the Receptionist at this time. Please read the following authorization and sign it for our records. I understand that I am responsible for all charges whether or not paid by the above stated insurance. I hereby authorize this office to release information necessary to secure reimbursement from any insurance company to which I have subscribed. I have read and understand the above and agree to comply.

Signature Of Patient_____ Date_____

RODNEY R. RANDALL, M.D.
OFFICE VISIT
Please Complete Both Sides Of This Form

Name _____ Date _____ Age_____

Allergies to Medications: ☐ no ☐ yes If yes, what type? _____

Type of reaction: ☐ Rash ☐ Nausea ☐ Vomiting _____

Other allergies or reactions: _____

Primary Care or Referring Physician: _____

Chief complaint or Reason for Referral (Reason you are here today) _____

_____

PAST MEDICAL HISTORY

Surgeries/ Hospitalizations and Dates: _____

_____

Medical Problems:	High Blood Pressure	☐ Yes	☐ No
	Diabetes	☐ Yes	☐ No
	High Cholesterol	☐ Yes	☐ No

Other:_____

Have you had an EKG in the last 6 months?	☐ Yes	☐ No
Have you had an Echocardiogram in the last 6 months?	☐ Yes	☐ No
Have you had a Stress Test in the last 6 months?	☐ Yes	☐ No

SOCIAL HISTORY

Occupation: _____ Married? ☐ Yes ☐ No ☐ Widowed

Children? ☐ Yes ☐ No If yes, how many? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount per day and type:_____

_____

Are you a smoker? ☐Yes ☐No If yes, how many packs per day? _____

Do you exercise more than 3 times a week for 20-30 minutes? ☐Yes ☐ No

FAMILY HISTORY (Parents, Grandparents, Siblings and Children)

High Blood Pressure:	☐ Yes	☐ No	family member _____
Diabetes:	☐ Yes	☐ No	family member _____
Coronary Artery Disease:	☐ Yes	☐ No	family member _____
Heart Attack:	☐ Yes	☐ No	family member _____
Bypass Surgery:	☐ Yes	☐ No	family member _____
Angioplasty:	☐ Yes	☐ No	family member _____

REVIEW OF SYSTEMS (Please circle all that apply to you)

HEENT: wears glasses, contact lenses, visual problems, cataracts

Respiratory: asthma, emphysema, bronchitis

Cardiac: heart problems, chest pain, shortness of breath, black outs, rapid heart beat

Abdomen: ulcers, bleeding problems, diverticulitis

Genitiurinary: infections, prostate problems, on prostate medication

Skin: rashes, sores

Neuro: stroke, seizures, depression, anxiety, confusion

Other medical problems: _____

_____

_____

Cancer: Type _____

Thank you, for completing this form.

RODNEY R. RANDALL, M.D.

Patient _____ Primary M.D._____

D.O.B._____ Allergies _____

Phone # that you can be reached at: _____ Height _____

MEDICATIONS

DATE:	MEDICATIONS & DOSAGE:

PATIENT PROCEDURE HISTORY

Patient Name: _____ D.O.B: _____

ECHOCARDIOGRAM AND PLACE OF PROCEDURE	DATE	NUCLEAR STRESS TEST AND PLACE OF PROCEDURE	DATE
HEART CATHETERIZATION AND PLACE OF PROCEDURE	DATE	MISCELLANEOUS	DATE

Rodney R. Randall, M.D.

HIPAA Privacy Policy Effective 04.01.2003

This office may not use or disclose your personal health information without your permission except in cases permitted by law:

1) We may use or disclose your personal health information in order to provide you with services and the treatment you require or request.
2) We may use or disclose your personal health information in order to collect payment for those services.
3) We may use or disclose your personal health information in order to conduct health care operations otherwise permitted or required by law.
4) We are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes.

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke this specific authorization at any time.

This office will contact you to provide appointment reminders and to inform you about your treatment, test results, etc. If you are not the one with whom we speak, messages will be left confirming an appointment and will otherwise direct you to return our call. Please complete the section below that grants/does not grant permission for our staff to discuss matters regarding your health care.

I do <u>not</u> grant permission for my health care management to be discussed with anyone other than myself.

Signature _____ date _____

I <u>do</u> grant permission for my health care management to be discussed with the following person(s):

1) _____ relationship _____

2) _____ relationship _____

3) _____ relationship _____

Signature _____ date _____