GEORGIA RENAL & HYPERTENSION CENTER

Vishal Ratkalkar, M.D.
928 S. Park Avenue
Carrollton, GA 30117
Phone: (678) 664-1545

Patient Demographics

Last Name: _____ First Name: _____ MI: _____

Age: _____ Birthdate: _____ SS #: _____ Sex: M F

Single Married Widowed Divorced Referred By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer/School: _____

mergency Contact: _____ Relationship: _____ Phone #: _____

Primary Care Physician Name and Phone: _____

Pharmacy Name: _____ Location: _____ Phone #: _____

Insurance Information

imary Insurance: _____ ID #: _____ Group #: _____

olicyholder Name: _____ Birthdate: _____ Relationship: _____

condary Insurance: _____ ID #: _____ Group #: _____

olicyholder Name: _____ Birthdate: _____ Relationship: _____

Patient Authorization

I authorize the release of any medical information necessary to process my claim. I authorize payment of medical benefits to the physican for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance.

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

Patient Health History

Name: _____ Date: _____

Which of the following illnesses have you or any of your blood relatives had?

	I HAVE HAD	MY BLOOD RELATIVE HAS HAD
Chicken Pox		
Measles		
Mumps		
Rubella (German Measles)		
Rheumatic Fever		
Tuberculosis		
Thyroid Disease		
Asthma		
Diabetes		
Epilepsy/Convulsions		
Rheumatism/Arthritis		
Heart Disease		
Lung Disease		
Hepatitis/Jaundice		
Kidney Infection/Stone		
Bladder Infection/Stone		
Sexually Transmitted Disease		
Tumor/Cancer		
Anemia		
Stroke		
Alcoholism		
Pneumonia		
Gall Bladder Disease		
Hypertension/High Blood Pressure		
HIV/AIDS		
Skin Disease		
Hay Fever		
Depression		
Sickle Cell Anemia		

PLEASE LIST ALL ALLERGIES:

_____

_____

Medical Records Release

Patient Name: _____ Date of Birth: _____

For the purpose of continuation of medical care, I hereby request to have my medical information as described below, including but not limited to office progress notes, reports from labs and other studies, summaries of treatment, consultation reports, and verbal/telephone/e-mail contact, released to:

Georgia Renal & Hypertension Center
928 S. Park Avenue
Carrollton, GA 30117
Phone: 678-664-1545 Fax:

The type and amount of information to be used or disclosed is as follows:

☐ Most recent history and physical

☐ Most recent discharge summary

☐ Laboratory results from _____ to _____

☐ X-ray and imaging reports from _____ to _____

☐ Consultation report

☐ Entire record

☐ Other:

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Services Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. This release will continue until termination of treatment unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Medical Record Services.

_____ _____

Signature of Patient/Authorized Person Date