Jashvantlal K. Thakkar, M.D., F.A.C.C.

Adult Cardiology

Suite 102 ° 331 Laidley Street ° P.O. Box 3739 ° Charleston, WV 25337

Telephone (304) 342-8579

PATIENT INFORMATION

Name	Date of Birth	Social Security Number
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		Number of Children
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Oth Pacific Islander ☐ White ☐ Other Race		Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Language	Preferred Contact Method	
Home Address (e.g., P.O. Box or Street, City, State, Zip)	Mailing Address (if different)	
Home Phone	Work Phone	Cell Phone
Occupation	If retired, previous occupation:	Email Address
Referring Physician	Primary Care Physician	Other Physician(s)/Specialist

We encourage every adult to have an advance directive. This names someone you trust to make decisions if you are unable to say what you want. Do you have an advance directive? ☐ Yes ☐ No (If yes, please bring a copy to our office.)

Would you like free assistance from our hospital affiliate in completing an advance directive? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Name of Contact	Relationship to Patient	
Address (if different than above)		
Home Phone	Work Phone	Cell Phone

PERMISSION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/FRIENDS

The following person(s) have permission to access my medical records, to receive information about me and my medical history, and to speak to the physician on my behalf.

Name	Relationship	Phone

INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No	Primary Insurance:	Secondary Insurance:

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Name of Patient:	

ALLERGIES

List all medication or food allergies, as well as you reaction.

CURRENT MEDICATIONS

List ALL current medications including over the counter medications/vitamins/herbals/supplements.

Medication Name	Dosage	# Times Daily

PREFERRED PHARMACY

Please give Pharmacy Name, Address and Phone Number

MEDICAL PROBLEMS

☒	Condition	Year	☒	Condition	Year
	Angina			Thyroid Disease Hyper? Hypo?	
	Coronary Artery Disease			Liver Disease	
	Heart Attack			Kidney Disease	
	Heart Failure (CHF)			Arthritis	
	Heart Valve Disease			Migraine Headaches	
	Type:			Seizures	
	High Blood Pressure			Stroke	
	High Cholesterol			Anemia	
	Irregular Heart Rhythm			Bleeding/Clotting Disorder	
	Type:			Cancer	
	Peripheral Vascular Disease			Type:	
	Asthma			GERD	
	Lung Disease (COPD)			Depression	
	Tuberculosis			Emotional/Behavioral Illness	
	Colitis			Explain:	
	Stomach Ulcer			AIDS/HIV	
	Gout			Other	
	Diabetes? Type I? TypeII?			Explain:	

Name of Patient:	

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PREVIOUS SURGERIES

Surgery
1
2
3
4
5

FAMILY MEDICAL HISTORY

(Does anyone in your *immediate family* have the following? Who?)

☒	**Condition**	**Who?**	☒	**Condition**	**Who?**
	Coronary Artery Disease			Cancer (type)	
	Heart Attack			Diabetes	
	Sudden Cardiac Death			COPD	
	High Blood Pressure			Stroke	
	High Cholesterol			Aneurysm:_________	
	CHF/Heart Failure			Other	

Father's cause of death	Age	Mother's cause of death	Age

SOCIAL HISTORY

Do you exercise regulary? ◻ Yes ◻ No	Type of exercise? How often?

Tobacco Use

(Cigarettes, cigars, pipes, and smokeless tobacco)

◻ Never		
◻ I quit (Year:_________)	Packs/day?	How long?
◻ I still smoke	Packs/day?	No. of years?
◻ Smokeless Tobacco	No. of cans/day?	No. of years?

Alcohol and Drug Use

How often do you drink?	◻ Never	◻ Occasionally	◻ Socially	◻ Daily	◻ Weekly
No. drinks per week?	◻ Beer	◻ Red Wine	◻ White Wine	◻ Liquor	

Any alcohol-related legal, personal or health problems?	◻ Yes	◻ No
Previous DT's or Seizures?	◻ Yes	◻ No
Treatment for any alcohol-related problem?	◻ Yes	◻ No
Any drug-related legal, personal or health problems?	◻ Yes	◻ No

Name of Patient:	

FINANCIAL POLICIES

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Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and the financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies or your insurance coverage and your financial responsibilites.

Professional Fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support costs associated with providing and coordinating your care. We will be happy to provide you with detailed fee information at any time.

Patient Paymnets: Co-pays, deductibles, services not covered by your insurance plan or outstanding balances are due at the time of your appointment. We accept cash, checks, and VISA, MasterCard, and Discover. Returned checks will be subject to a fee of $25.00 charged by this office for each check returned to us by your bank. Please let us know if you are having a particular financial problem and we will try our best to be understanding. Please feel free to discuss mutually acceptable payment arrangements with our billing office.

Insurance Payments: We participate and accept assignment of payment with most major insurance plans in the area. Even though we may submit insurance claims on your behalf, your insurance coverage is a contract between you and your insurer and you are still responsible for

REFERRAL REQUIREMENTS

If my insurance company requires a referral, I understand that I am responsible for obtaining the referral. If the referral is no obtained, I can be held responsible for payment in full for services rendered on the date of service.

NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or been offered a copy of Jashvantlal K. Thakkar, M.D. Notice of Privacy Practices (available in our office) and understand that the Notice may change at any time. I give consent to Jashvantlal K. Thakkar, M.D. to obtain my prior medical records from outside practices and send office notes to other physicians to coordinate care on my behalf.

Patient Name:	Signature of Patient or Legal Representative	Date

DEEMED CONSENT FOR MEDICAL CARE

I voluntarily consent to medical care by Jashvantlal K. Thakkar, M.D. that may include examinations, tests, photographs, and treatments by physicians and stafff. No promises have been made to me as to the results of treatments or examinations.

CONSENT FOR REVIEW OF PRESCRIPTION HISTORY

I authorize Jashvantlal K. Thakkar, M.D. to access my prescription history from outside sources to help keep my medical record as complete as possible. This includes many but not necessarily all medications used in the past. I understand my prescription history from other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here.

SIGNATURE

I have read and agree to the above policies.

Patient Name:	Signature of Patient or Legal Representative	Date

Relationship to Patient: ▫ Self ▫ Spouse ▫ Parent ▫ Child ▫ Other