Diabetes & Geriatrics Specialists
Dr. Pardeep Sharma
Phone: 931-646-0880 Fax: 866.380.6439

117 North Hickory Ave,
Suite 200
Cookeville, TN 38501
Phone: 931.646.0880
Fax: 866.834.5618

PATIENT REGISTRATION

PATIENT NAME: *Last* _____ *First* _____ *MI* _____

ADDRESS: *Street* _____ *City* _____ *ST* _____ *Zip* _____

HOME PHONE: ( ) _____ CELL PHONE: ( ) _____

May we leave a message on home phone: ☐ Yes ☐ No May we leave a message on cell phone: ☐ Yes ☐ No

PERSONAL E-MAIL*: _____

** By providing an email address you will automatically be web enabled and enrolled in our practice patient portal.*

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SEX: ☐ Male ☐ Female DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: ( ) _____

Who can we thank for referring you to our practice: _____

PATIENT EMPLOYER: _____

EMPLOYER ADDRESS: _____ PHONE NUMBER: ( ) _____

OCCUPATION: _____

EMPLOYMENT STATUS: Full-Time Part-Time Unemployeed Retired

Race**: Asian Black/African American Caucasian Hispanic Other

Ethnicity**: Hispanic/Latino Not Hispanic/Latino

Preferred Language**: English Spanish Other: _____

*** Please note these questions are asked to comply with US Government Requirements.*

PRIMARY INSURANCE: _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE: _____

PHONE NUMBER: _____ SUBSCRIBER: _____

ID NUMBER: _____ GROUP NUMBER: _____

PRIMARY DOCTOR/REFERRING PHYSICIAN: _____

Please provide Name and City/State

PHARMACY: _____

Please provide Name, Street Address, and State

REASON FOR TODAYS VISIT: ☐ Primary Care ☐ Specialist

_____

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SOCIAL HISTORY QUESTIONAIRE

Patient Name: _____ **Date of Birth :** **Date:** _____

SOCIAL HISTORY:

Educational Level: (circle) Grade School ☐ High School ☐ College ☐ Post Graduate

Birthplace: _____ **Religion:** *(optional)* _____

Pets: _____

Tobacco Use:

Ever use Tobacco? (circle) ☐ Yes ☐ No

Type of tobacco use: (circle) cigarettes ☐ cigars ☐ pipe ☐ snuff ☐ chew

Year started smoking: _____ **Year quit smoking:** _____

Number of cigarettes smoked per day: _____

Alcohol Use:

How often did you have a drink containing alcohol in the past year?

Daily: How many _____ **Weekly:** How many _____ **Monthly:** How many _____

FAMILY HISTORY:

Father's Medical Problems: _____

Still living? ☐ Yes ☐ No **Age of death:** _____ **Cause of death:** _____

Mother's Medical Problems: _____

Still living? ☐ Yes ☐ No **Age of death:** _____ **Cause of death:** _____

Siblings Medical Problems:

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Brother/Sister: _____

Do you have any blood relatives with the following medical problems?

☐ Kidney Disease	☐ Diabetes	☐ Blood Clots
☐ Bladder Problems	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Prostate Problems	☐ Stroke	☐ Emphysema/COPD
☐ High Blood Pressure	☐ Connective Tissues Disease	☐ Cancer
☐ Asthma	☐ Sleep Apnea	

OCCUPATIONAL HISTORY:

Occupation: Current: _____

Previous: _____

Have you ever had occupation exposure to any of the following?

☐ Asbestos ☐ Chemical Dust ☐ Metal Dust ☐ Gas Fumes ☐ Lead Other: _____

Describe length and type of exposure: _____

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REVIEW OF SYMPTOMS AND UPDATED PATIENT INFORMATION

KINDLY FILL OUT THIS FORM. IT WILL HELP US TO PROVIDE YOU WITH THE BEST CARE.
THIS INFORMATION IS REQUIRED BY YOUR INSURANCE COMPANY AND MEDICARE.

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

MARK ANY SYMPTOMS THAT SHOULD COME TO OUR ATTENTION

GENERAL
- ☐ FEVER
- ☐ CHILLS
- ☐ SWEATS
- ☐ WEIGHT LOSS/GAIN

GENITO-URINARY
- ☐ URINARY INFECTION
- ☐ DIFFICULTY URINATING
- ☐ EXCESSIVE URINATION
- ☐ BURNING

ENDOCRINE
- ☐ EXESSIVE THIRST
- ☐ EXCESSIVE HUNGER
- ☐ HEAT/COLD INTOLERANCE
- ☐ ABNORMAL HAIR GROWTH/LOSS

NEUROLOGIC
- ☐ WEAKNESS
- ☐ NUMBNESS
- ☐ DIFFICULTY MOVING

RESPIRATORY
- ☐ SHORTNESS OF BREATH
- ☐ PHLEGM

SKIN
- ☐ RASH
- ☐ ITCHING

GASTROINTESTINAL
- ☐ STOMACH PAIN/BURNING
- ☐ CONSTIPATION/DIARRHEA
- ☐ CHANGE IN APPETITE

HEMATOLOGIC
- ☐ FATIGUE
- ☐ EASY BRUISING

CARDIAC
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ BLACK OUT SPELLS

MUSCLE/JOINT
- ☐ ARTHRITIS
- ☐ MUSCLE PAIN
- ☐ JOINT SWELLING

ENT
- ☐ SINUS PAIN
- ☐ SORE THROAT
- ☐ HEARING PROBLEMS

EYES
- ☐ IMPAIRED VISION
- ☐ PAIN
- ☐ DOUBLE VISION

PSYCHIATRIC
- ☐ ANXIETY
- ☐ DEPRESSION

☐ **NO PROBLEMS**

☐ **SAME AS LAST VISIT**

☐ **OTHERS:**

INDICATE RECENT VISITS TO ANOTHER DOCTOR IN THE PAST SIX MONTHS:

DR: _____ DATE: _____ PROBLEM: _____

DR: _____ DATE: _____ PROBLEM: _____

DR: _____ DATE: _____ PROBLEM: _____

BEEN HOSPITALIZED: LOCATION: _____ DATES: _____

HAD BLOODWORK: LOCATION: _____ DATES: _____

HAD DIAGNOSTIC TESTING SUCH AS: MRI, ULTRASOUND, X-RAY, ECHO, STRESS TEST, COLONOSCOPY, ETC.

TEST: _____ DATE: _____ LOCATION: _____

TEST: _____ DATE: _____ LOCATION: _____

TEST: _____ DATE: _____ LOCATION: _____

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MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Date of Birth: _____

PAST MEDICAL HISTORY

Have you ever had: (Circle)

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Reflux
- ☐ Lupus
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Kidney Disease
- ☐ Stones: Location: _____
- ☐ Stroke
- ☐ Voiding Problems
- ☐ Bladder Infections
- ☐ Peripheral Vascular Disease
- ☐ Prostate Problems
- ☐ High Triglycerides
- ☐ High Cholesterol
- ☐ Colonic Polyps
- ☐ Heart Disease
- ☐ High Blood Presure
- ☐ Other: _____

PAST SURGICAL HISTORY AND PROCEDURES

Please circle and provide dates of surgery or procedure:

- ☐ Appendectomy
- ☐ Cataracts
- ☐ Gallbladder
- ☐ Coronary Stents
- ☐ Hysterectomy
- ☐ Mammography
- ☐ Colonoscopy
- ☐ Coronary Artery Bypass
- ☐ Joint Replacement
- ☐ Lithotripsy
- ☐ Prostate Surgery
- ☐ Carotid Surgery
- ☐ Other Vascular Surgery
- ☐ Other: _____

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Financial Policy

We welcome you to our practice. The following is a statement of our financial policy.
All patients must complete our Patient Information Sheets before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by **CASH, CHECK, VISA OR MASTERCARD**. We only bill insurance carriers with whom we participate (have signed an agreement with).

Regarding Managed Care Insurance with which we participate:
You are responsible to supply our staff with your primary and secondary insurance identification cards(s) at the time of your appointment. If your insurance company requires a referral from your primary doctor, you must also present this to our receptionist prior to being seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the visit in full. If your insurance requires a copay, it must be paid **at the time** of the appointment.

Regarding Non-Participating Insurances:
If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. We accept CASH, CHECK, MASTERCARD and VISA. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Return Check Fee - $30:
Our bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs.

If you are unable to keep a scheduled appointment, 24 hours notice of cancellation is required. Otherwise a $25 charge will be made for the time that was reserved to you.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. **Accounts that go to collection will be subject to a 25% charge.**

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor. We are happy to work out a payment plan.

I have read the above Diabetes and Geriatrics' Financial Policy. I understand and agree to abide by its terms.

Name: **Date:**

(Please Print)

Sign: _____

Diabetes & Geriatrics Specialists
Cumberland Kidney Specialists

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CLINIC POLICIES

- **If you are unable to come to a scheduled office visit, please call at least 24 hours ahead of time to cancel the appointment.**
  There is a $25 fee for appointments missed and not canceled. **Three (3) "no-shows" or cancellations may result in dismissal from the practice as it prevents other patients from being seen.**
- **Please let the front desk know of any changes in your address, phone number, insurance or pharmacy.**
- **Please bring a list of your medications in the bottles to every visit. This will ensure that we have the correct medication list.**
- **Please notify us immediately if your pharmacy changes.**
- **Refills should be requested at your office visit. Refill requests left on the nurses refill line will take up to 24 hours to be called in. Please do not wait until you are completely out of your medication to call.**
- **Controlled medications WILL NOT be filled without an appointment so please make your follow up appointments accordingly.**
- **Messages will be returned by the nurses *after clinic is done*.**
  Messages left after 3 pm will be returned the next business day. Often, the nurse must check with the doctor before returning your call so please understand if it takes a little while longer.
- **We will call you the day before your appointment to remind you of the time.**
  If you have had any tests done, labs drawn, or been in the hospital, please make sure you tell us before your appointment so that we can have these records ready.
- **We know that your time is valuable. We try very hard to get our patients in and out quickly. We apologize if this is sometimes difficult to do. Our doctors are very thorough and spend the time needed to cover everything with every patient.**
- **We will call you with the results of your lab tests AFTER the doctor has reviewed them.**
  Abnormal tests will require an office visit to discuss the next steps.
- **Referrals for tests and specialists can be time consuming depending on the insurance you have.**
  We work on these daily and will contact you as soon as we have all of the information completed.

SIGNATURE:._____ **Date:** _____

PATIENT NAME:_____ **(please print legibly)**

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HIPAA ACKNOWLEDGEMENT AND RELEASE OF INFORMATION

Patient Name_____ **DOB**_____

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessments and provider certification.

I have been informed by you or your Notice of Privacy Practice 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 Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry our treatment or obtain payment of health care operations. I also understand you are required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this content.

PATIENT AUTHORIZATIONS

I give Cumberland Kidney and Diabetes authorization to speak to the following individuals:

1. Name_____ Relationship_____
2. Name_____ Relationship_____
3. Name_____ Relationship_____

I give Cumberland Kidney and Diabetes authorization to leave information on voicemail: ( ) YES ( ) NO

Signature _____

Date:_____

Relationship to the patient _____

This authorization will expire one year from the signed date or may be updated by the responsible party at anytime.