SESHADRI RAJU, MD., PA.
971 Lakeland Drive, Suite 401
Jackson, MS 39216
Phone. 601-939-4230
Fax 601-664-6694

THE RANE CENTER
VEIN, LYMPH AND DVT CLINICS
AT ST. DOMINIC'S

Seshadri Raju, MD
Arjun Jayaraj, MD
Taimur Saleem, MD
Brandi Burr, NP
Kristen Degelman, NP
Jerad Robinson, NP
Jenna Stokes, NP

REFERRING PHYSICIAN: _____

Patient Information

First: _____ MI: ____ Last: _____DOB: _____Gender: _____

Marital Status: Married Single Divorced Separated Widowed Other

Ethnicity: African American Non-Hispanic | American Indian Alaskan Native | Hispanic | Asian Pacific Islander | Caucasian Non-Hispanic | Other

Language you speak: English, Other_____

Driver's License: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____City_____ State _____ Zip _____

Employer: _____Position: _____

Employer Address: _____Phone No. _____

If you would like portal access, please provide your Email address: _____

Emergency Contact Information

Dependent:_____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No.: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____Relationship:_____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____Insured DOB: _____Relationship to Patient:_____

Insurance Company: _____ Phone No: _____

Address:_____

Policy No: _____ Group No: _____

2nd Insurance Company: _____

Insured Party: _____Insured DOB: _____Relationship to Patient: _____

Phone No:_____ Address: _____

Policy No: _____ Group No: _____

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Is this work related? Y / N Is this related to a car accident? Y / N Date of Injury/Accident:_____

Name & phone number of Contact for Work or Car Accident injury:_____

****

I authorize the doctor to employ photographs, anesthetics, medicines, surgeries, order tests and other equipment or aids as he/she deems necessary in order toprovide the proper patient care. I understand that payment, proofofinsurance, and/or copay is due at the time ofservice.I certify that allinformation I have provided is factual and correctto the best of my knowledge.

_____ _____

Signature Date

Patient Medical Information

Date:_____

Name: _____ Date of Birth: _____

Please note: You must complete this form in full so that we may be able to provide proper care to you. Thank you!

Please list your medications below. If you do not know this information, please call your pharmacy.

Medication Name	Dose	How often taken?

What is the name of your preferred pharmacy: _____

Pharmacy address: _____

Below, please mark all boxes for any medical problems you have ever been told you have by a doctor, even if the problem is being treated now or you believe it has gone away.

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Congestive heart failure
- ☐ A-fib or atrial fibrillation
- ☐ Cancer (specify): _____
- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea CPAP ☐ Yes ☐ No
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Cellulitis
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Seizures
- ☐ Chronic pain
- ☐ Parkinson's disease
- ☐ Reynaud's disease
- ☐ Varicose veins
- ☐ Hepatitis
- ☐ HIV
- ☐ Blood clots
- ☐ Acid Reflux/Heartburn
- ☐ Migraines
- ☐ Depression
- ☐ Mental health issues
- ☐ Bladder problems
- ☐ Kidney problems
- ☐ Immune system problems

Please list any other health problems not covered above. _____

_____

_____

Please list any **surgeries** with the approximate date.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list below any **allergies** you have and tell us what happens when you have a reaction.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you smoke now? ☐ Yes ☐ No

If yes, how long have you smoked? _____

How many packs per day do you smoke? _____

Have you ever been a smoker? ☐ Yes ☐ No

If yes, how long did you smoke? _____

Do you use alcohol? ☐ Yes ☐ No

If yes, how often do you drink? _____

Are you currently employed? ☐ Yes ☐ No

What is your Occupation? _____

How many hours per day do you stand? _____

Do you have any metal in your body or do you have a pacemaker? ☐ Yes ☐ No

If yes, please tell us where the metal is or if you have a pacemaker.

The metal in my body is in: _____

☐ I have a pacemaker

Do you have any ulcers or sores on your legs? ☐ Yes ☐ No

If yes, how long have you had them? _____

Whom do you see for treatment of these ulcers? _____

Please note: If you have any ulcers, we will take pictures to include in your medical records. Thank you for your understanding.

In the space provided below, please include any additional information you feel may be helpful to us in providing care to you today. Thank you!

Additional Information

ACKNOWLEDGEMENT AND CONSENT

Seshadri Raju, MD, PA is organized as a "team". By signing below you consent to be seen and treated by anyone of the team: Seshadri Raju, MD, Arjun Jayaraj, MD, Taimur Saleem, MD, Brandi Burr, CFNP, Jerad Robinson, CFNP, Kristen Degelman, CFNP, and Jenna Stokes, CFNP according to your needs and our logistics at our sole discretion.

I understand that Dr. Raju and his associated physicians may use devices, medicines, techniques, and procedures that may not yet have gained full acceptance in the medical community at large. This includes "off label" use of certain medicines or devices for purposes not yet approved by the Food and Drug Administration or any other applicable governmental entity. I understand that "off label" use of medicines and devices is not uncommon and that the fact that this may be done in connection with the care provided to me is because Dr. Raju and his associated physicians believe it is appropriate care for my case or condition. I also understand that Dr. Raju or his associated physicians or the other representatives will be willing to discuss this with me, and I should ask any questions I have regarding my particular care or the devices, medicines, techniques or procedures which will or may be used in my case. I hereby consent to the use of any such devices, medicines, techniques or procedures.

_____ _____

Date Patient or Patient Representative

PRIVACY PROTECTION POLICIES AND WAIVERS

PATIENT PRIVACY POLICY:I have read the **Notice of Privacy Policies** of Seshadri Raju,M.D.P.A.(Dr. Raju, Dr. Jayaraj, and Dr. Saleem) detailing how my information may be used and disclosed.

Your clinical records with identifying information ("protected information") may be disclosed to other doctors at your request or doctors we may consult at our sole discretion to help with your care. Your clinical records and identifying information will be known to our clinical staff, technical staff, research personnel and a limited number of outside technical people (eg. computer scientists) and collaborating scientists (eg. statisticians or medical doctors). By signing below, you authorize our use of your protected information as outlined and waive your privacy rights under HIPPA law to the extent described above. This waiver may be revoked in writing sent by registered letter with return receipt.

MEDICAL RECORDS POLICY: I hereby authorize the release of any medical information necessary for my health care and to process any claims. The practice requires a fee for searching, copying, and mailing medical records (if applicable). This fee is due in full prior to the release. The fee is set in accordance with local legislation.

FINANCIAL POLICY: Payment is due at the time services are rendered. I authorize the payment of any medical benefits directly to Seshadri Raju, M. D., P. A. I further consent to medical evaluation and/or treatment by Dr. Seshadri Raju, Dr. Arjun Jayaraj, Dr. Taimur Saleem, Brandi Burr, CFNP, and Jerad Robinson, CFNP, Kristen Degelman, CFNP, and Jenna Stokes, CFNP. I understand that I am responsible for the cost incurred should my account be turned over for collection. I understand that I may be responsible for all costs incurred in collection including interest, collection fees, and court costs. I also understand I am responsible for any costs incurred up to the amount allowed by the insurance company for my treatment in case the insurance company denies payment. For all services rendered to minors, the parent or guardian is responsible for payment.

CANCELLATION POLICY: *Allow 48 hours advance notice when cancelling surgery appointments.

I HAVE READ AND UNDERSTAND THE PRACTICE POLICIES. I ALSO UNDERSTAND THESE POLICIES MAY CHANGE AT THE DISCRETION OF THE PRACTICE TO BE APPLIED TO ALL EXISTING RECORDS. CURRENT POLICY MAY BE VIEWED ON OUR WEBSITE AT THERANECENTER.COM

_____

PATIENT (PLEASE PRINT)

_____

SIGNATURE

_____

DATE

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MEDICAL RECORDS RELEASE/CONSENT

DATE: _____

PATIENT: _____ DOB: _____

I HEREBY AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS TO: (FAMILY, SIGNIFCANT OTHER, ETC)

_____	_____	_____
Name	Relation to patient	contact phone number
_____	_____	_____
Name	Relation to patient	contact phone number
_____	_____	_____
Name	Relation to patient	contact phone number

I HEREBY AUTHORIZE THE ABOVE PEOPLE TO HAVE ACCESS AND SPEAK TO STAFF OF THE RANE CENTER REGARDING ANY OR ALL OF MY MEDICAL RECORDS AND ANY CHANGES TO THIS AUTHORIZATION WILL NEED TO BE DONE BY COMPLETING A NEW FORM WITH A NEW SIGNATURE AND DATE.

_____	_____
PATIENT SIGNATURE	DATE

I HEREBY AUTHORIZE _____ TO RELEASE MY RECORDS TO:

_____
_____
_____
_____
_____

Reason: _____

_____	_____
PATIENT SIGNATURE (GUARDIAN SIGNATURE IF UNDER 18)	DATE

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Patient Name: _____

Date of Birth: _____

Please provide the following information:

Primary Care Physician: _____

Phone: _____
Address: _____
_____
_____

Cardiologist: _____

Phone: _____

Pulmonologist: _____

Phone: _____