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 & DVT Clinics

Seshadri Raju, MD
Arjun Jayaraj, MD
Taimur Saleem, MD

PATIENT REGISTRATION FORM

Title	First	M.I.	Last			
Address			City	State	Zip	
Home Phone	Work Phone		Cell Phone	SS #		
Date of Birth	Age	Sex (Circle one) M F	Race	Marital Status	Spouse's Name	
Email Address		Patient's Employer		Occupation		
Employer Address		City		State	Zip	
Referring Physician		Referring Physician's Address		Referring Physician #		
Emergency Contact		Phone		Relationship to Patient		

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

First	M.I.	Last		
Address	City		State	Zip
Home Phone	Work Phone	SS #		

INSURANCE INFORMATION

Primary Insurance Company		Phone	
Address	City	State	Zip
Insured's Name	ID #	Group #	Insured Date of Birth
Secondary Insurance Company		Phone	
Address	City	State	Zip
Insured's Name	ID #	Group #	

Is this visit a result of a work injury? Y N	Date of Injury	Industrial Claim #
Is this visit a result of a car accident? Y N	Date of Accident	Attorney Name

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS ACCURATE.

_____ _____

Date Patient or Patient Representative

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Patient Medical Information

Date	Last Name	First 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: _____

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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. _____

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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: _____

Do you have a pacemaker? ☐ Yes ☐ No

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.

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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

Family History

List any significant illnesses your immediate family members have experienced. Please include blood clots and bleeding disorders.

	Age	Illness	If deceased, cause
Father			
Mother			
Brother			
Sister			

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Authorization to Release/Disclose Medical Information

I HEREBY AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS TO:

THE RANE CENTER
971Lakeland Drive
Suite 401, East Tower
Jackson, MS 39216
601-939-4230 Office
601-664-6694 Fax

Medical Information Requested – For office use only			
Facility:		**Fax Number:**	
Patient Name:		**Patient DOB:**	
Patient Address:			
Records Requested:			

This authorization will expire in one (1) year from the signed date below. You have the right to revoke this authorization at any time by doing so in writing to the Privacy Officer of The Rane Center. (971 Lakeland Drive, Suite 401 Jackson, Mississippi 39216)

_____ _____

Signed Date Patient or Patient Representative

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Last Name	First Name	Date of Birth

Please provide the following information:

Primary Care Physician: _____

Address: _____

_____

Telephone Number: _____

Cardiologist: _____

Telephone Number: _____

Pulmonologist: _____

Telephone Number: _____

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ACKNOWLEDGEMENT AND CONSENT

Seshadri Raju, MD, PA is organized as a "team," consisting of physicians plus nurse practitioners or physician assistants. The physician members of the team are Seshadri Raju, MD, Arjun Jayaraj, MD, and Taimur Saleem, MD. The nurse practitioner and physician assistant members of the team provide patient care within the scope of their license and under parameters set by the physicians. By signing below, you consent to be seen and treated by any member of the team 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

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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, plus allied health professionals) 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, and any other members of the team, including nurse practitioners or physician assistants. 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

_____

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DATE

MEDICAL RECORDS RELEASE/CONSENT

Title	First	M.I.	Last	Date of Birth

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

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	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.

_____ _____

Date Patient or Patient Representative