MOHAN JACOB, M.D. PATIENT REGISTRATION FORM

PATIENT INFORMATION

Title Name	First		M.I.		Last
Address	City		State		Zip
Home Phone	Work Phone		Cell Phone		SS#
Birthdate	Age	Sex (circle one) M F	Race	Marital Status	Spouse's Name
Patient Employer			Patient's Occupation		
Address	City		State		Zip

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

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

INSURANCE INFORMATION

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

Is this visit a result of a work injury? Y N	Date Injured	Industrial Claim #
Is this visit a result of a car accident? Y N	Date of Accident	Attorney Name:
How long employed at current position?		
Drug Allergies (list)		
Who can we thank for referring you to us?		
Pharmacy#	Email Address	

Mohan Jacob, M.D.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Mohan Jacob M.D.'s **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed:_____ **Date:**_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnesses by:** _____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____

By: (name and title): _____

Mohan Jacob, M.D.
18955 Memorial North, Suite 440
Humble, TX 77338
(281) 446-5555

During your course of treatment it is sometimes necessary to share your health information (examples would be lab work, test results, medications, etc.) with another physician to ensure proper coordination of care. In order to assist us, we will need a list of treating physicians that you permit us to release your information to for coordination of care. If your records need to be transferred for any other reason (for example you request a second opinion and/or are beginning care with another physician) a separate waiver will need to be signed. This release is only for coordination of care purposes. For any questions regarding this policy contact the Compliance Officer.

Please list any treating physician name(s) and phone number(s) that you permit us to release your information to for coordination of care.

I also understand that this waiver may be terminated by myself or my legal representative in writing at any time.

Signature

Printed Name and Relationship

Date

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HIPAA Privacy Patient Questionnaire

You have the right to have your personal information protected. All information, medical or social, whether written, spoken, electronic, or computer-generated, is to be held in strict confidence. However, sometimes you will need us to communicate with someone else regarding your care and/or treatment. Please fill out this questionnaire completely and in detail so that we may coordinate your care to our utmost ability.

1. Please list any person(s), if **any**, whom we may discuss your general medical condition, possible diagnoses, medications, and/or treatment plans. Please list their complete names and phone numbers.

_____

_____

_____

2. Please list any person(s), if **any**, that we may inform about your medical condition **ONLY IN CASE OF EMERGENCY**. If they are the same as listed above please just write "Same as Above". Otherwise, list their complete names and phone numbers.

_____

_____

3. Should confidential messages (including appointment reminders, procedures scheduled, critical lab levels) be left on your home machine and/or voicemail?
YES_____ NO_____

4. If you do not have voice mail at work, should messages asking you to call us about results and/or to confirm appointments be left at your place of employment?
YES _____ NO_____

Patient Name (print) _____

Signature _____

Date_____

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Humble, TX 77338

Financial Agreement

I authorize the release of my medical and/or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

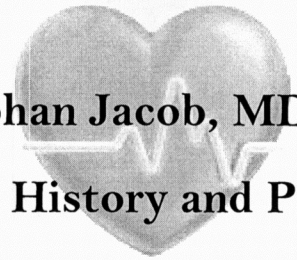
I authorize payment of medical benefits to Mohan Jacob, M.D. for services provided to me.

Signature Date

I understand that Mohan Jacob, M.D. reserves the right to collect my portion of fees at the time of service. If fees are not collected at the time of service I agree to pay such fees within 60 days of my first statement. If I cannot pay the balance in full it will be my responsibility to make payment arrangements. If my account does become delinquent and reaches 120 days, I understand that I could be reported to my insurance company for non-compliance and also sent to a collection agency without prior notice.

I also understand that it is my responsibility to contact the billing department as soon as I receive a statement if I think there is any error with my account so that the problem can be corrected as soon as possible.

Signature Date



Mohan Jacob, MD, PA

Cardiology History and Physical Form

NAME:	DOB:	DATE:
HEIGHT:	WEIGHT:	ALLERGIES:
REASON FOR YOUR VISIT:		
REFERRING PHYSICIAN:		

CARDIOVASCULAR					
1.Irregular Heart Rate	**Yes**	**No**	13. Enlarged Heart	**Yes**	**No**
2. Palpitations	**Yes**	**No**	14. Abnormal ECG	**Yes**	**No**
3.Dizziness	**Yes**	**No**	15. Abnormal Chest X-Ray	**Yes**	**No**
4. Near fainting spells	**Yes**	**No**	16. Elevated Cholesterol	**Yes**	**No**
5. Fainting spells	**Yes**	**No**	17. Elevated Triglycerides	**Yes**	**No**
6. Cardiac Arrest	**Yes**	**No**	18. High Blood Pressure	**Yes**	**No**
7. Temporary Pacemaker	**Yes**	**No**	19. Low Blood Pressure	**Yes**	**No**
8. Permanent Pacemaker	**Yes**	**No**	20. Arteriosclerosis	**Yes**	**No**
9. Chest pain	**Yes**	**No**	21.Rheumatic Fever	**Yes**	**No**
10. Easily fatigued by exercise	**Yes**	**No**	22. Congestive Heart Failure	**Yes**	**No**
11. Ankle swelling	**Yes**	**No**	23. Heart Attack	**Yes**	**No**

ALIVE (A)/DECEASED (D) AGE	**How Many?**	**How Many?**
Mother:	Bro:	Sons:
Father:	Sis:	Daughters:

Have any of your immediate family members had the following? Identify relationship below.		
1. Diabetes	**Yes No**	
2. High blood pressure	**Yes No**	
3.Heart disease (Heart attack, Clogged arteries, Cardiac Surgery)	**Yes No**	
4. Stroke	**Yes No**	
5.Depression/psychiatric illness	**Yes No**	
6. Cancer	**Yes No**	

TOBACCO USE			
Do you smoke or have you ever smoked?		How many cigarettes do you smoke a day?	
Type of Tobacco		Interested in quitting?	