

**Patient Information**

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last Name First Name MI  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Preferred Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_ Marital Status:  S  M  W  D

**Demographics (Required by Centers for Medicare/Medicaid Services)**

Race:  American Indian or Alaska Native  Asian  
 Black or African American  Native Hawaiian or Other Pacific  
Ethnicity:  Decline to specify  White  
 Hispanic or Latino  Not Hispanic or Latino  Decline to specify

**Legal Guardian**

If the patient is under the age of 18, we need the name of their legal guardian:  
Name: \_\_\_\_\_ Cell: \_\_\_\_\_ DOB: \_\_\_\_\_

**Emergency Contact**

Contact Name: \_\_\_\_\_  
Last Name First Name  
Relationship to the patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Health Insurance Information**

Insurance Name: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Group # \_\_\_\_\_  
Policy # \_\_\_\_\_ Copay Amt: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_  
Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Medical History**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please list your medical problem(s) and how long they have affected you

\_\_\_\_\_

What is your main symptom?

\_\_\_\_\_

Check illness or conditions you have had:

- Cancer     Asthma     Hepatitis     Diabetes     Glaucoma     Heart Trouble     GERD  
 Vein Trouble     Emphysema     Nervous Disorder     High Blood Pressure  
 Bleeding Tendencies     Thyroid Problem     Pneumonia     Kidney Disease  
 High Cholesterol     Arthritis     Anxiety     Depression

Previous Operations with Dates:  Tonsillectomy Year: \_\_\_\_\_  Appendectomy Year: \_\_\_\_\_

Other Operations and Year: \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No Year: \_\_\_\_\_

When was your last colonoscopy? Year: \_\_\_\_\_ Who is your GI Specialist? \_\_\_\_\_

When was your last TB skin test or Chest X-ray? Year: \_\_\_\_\_

Please list any other illnesses NOT requiring operation for which you were hospitalized:

\_\_\_\_\_

Have you had serious injuries, broken bones, etc.?  Yes  No List: \_\_\_\_\_

Current Weight: \_\_\_\_\_ How long have you been at this weight? \_\_\_\_\_

Please list any medication allergies:

Medication

Reaction/symptom

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to Iodine or Latex?  Yes (CIRCLE Iodine or Latex)  No

List any other medical providers or specialists you see regularly:

\_\_\_\_\_



**Women**

For Women Only: Number of pregnancies: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

Onset date of last menstrual period: \_\_\_\_\_ Periods are:  Regular  Irregular

Have you gone through menopause?  Yes  No

Any complications in pregnancies? Please list: \_\_\_\_\_

Last Mammogram Date: \_\_\_\_\_  Normal  Abnormal

Last PAP Smear Date: \_\_\_\_\_  Normal  Abnormal

**Men**

For Men Only: When was your last Prostate Blood Test (PSA)? \_\_\_\_\_

**Immunization History**

Your Immunizations: Please check to the immunization shots you have received

Tetanus shots Year of last shot: \_\_\_\_\_

Pneumovax Year of last shot: \_\_\_\_\_

Influenza Year of last shot: \_\_\_\_\_

COVID shot(s) Year of last shot: \_\_\_\_\_

COVID booster shot Year of last shot: \_\_\_\_\_

**Pharmacy Information**

Preferred Pharmacy Name: \_\_\_\_\_

Preferred Pharmacy Address: \_\_\_\_\_

**Cultural History**

Education Level:

Elementary

Vocational College

High School

Graduate/Professional

Are there any vision or hearing problems that affect your ability to communicate well?  Yes  No

Are there any limitations to understanding or following instructions (either written or verbal)  Yes  No

Occupation: \_\_\_\_\_

Current Living Situation:

Single Family Household

Shelter

Multi-Generational Household

Skilled Nursing Facility

Homeless

Other

Are there any personal problems or concerns you would like to discuss?  Yes  No

Are there any cultural or religious concerns you have related to our delivery of care?  Yes  No

Are there any financial issues that directly impact your ability to manage your health?  Yes  No

Will you have reliable transportation for all your appointments?  Yes  No

How often do you get the social and emotional support you need?

Always  Usually  Sometimes  Rarely  Never

**Social History**

Below are questions regarding your current lifestyle:

Have you traveled outside the US?  Yes  No Where? \_\_\_\_\_

Have you ever or do you currently smoke or vape?  Yes (CIRCLE smoke or vape)  No

If yes, then:

How many packs per day? \_\_\_\_\_ How Long? \_\_\_\_\_ When did you or have you quit? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No How often? \_\_\_\_\_

Have you ever had same sex relations?  Yes  No How long ago? \_\_\_\_\_

Have you ever used, or do you currently use illicit drugs?  Yes  No



**PROMISECARE**  
*Quality Healthcare. Promised.*

**Hemchand Kolli, M.D.**

1278 E. Latham Avenue Hemet, CA 92543

(951) 925-6625

<https://drkolli.health/>

If yes, then please describe:

---

Do you currently use Cannabis products in any form?  Yes  No

If yes, then please describe:

---

Caffeine intake?  Yes  No

Type: \_\_\_\_\_ Amount: \_\_\_\_\_

Exercise routine: \_\_\_\_\_



**Family History**

Alcoholism	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Mental Illness	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Obesity	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Prostate Disease	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No
Ulcer Disease	<input type="checkbox"/> Yes	Paternal/Maternal? Who _____	<input type="checkbox"/> No

**Patient Contact Consent**

I \_\_\_\_\_, hereby give consent to **Hemchand Kolli, M.D.** and his staff to contact me regarding results, referrals, appointments, and any other health issues via:

Check all that may apply

**Do not contact anyone other than myself**

Cell phone number: \_\_\_\_\_

Answering machine

Email address: \_\_\_\_\_

Mail to listed home address

Message with spouse/ friend/ caregiver (List Below)

Other:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**HIPAA Compliance Patient Consent**

Under the Health Insurance Portability and Accountability Act of 1994 (“HIPAA”), The Family Practice of **Hemchand Kolli, M.D.** does not release confidential medical information regarding your treatment to family members or friends, except for a parent/legal guardian or other persons authorized by the patient.

If you bring another person into the exam room during a regular or emergency appointment, we will assume without objection, the person is entitled to hear or receive information regarding your medical issue and/or treatment.

**Notice of Privacy Practice**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of the information for treatment, payment, or healthcare operations.

**Advance Directive Status**

This is acknowledgment that the physician or one of their staff members, has provided and discussed Advance Health Care Directives information with me.

1. I am age 18 or older.  Yes  No

2. I understand I have the option of putting together an Advance Health Care Directive for my healthcare. My physician has provided me written information concerning these Advance Health Care Directives. I understand that it is my responsibility to provide my Physician(s) with any documents that are required to carry out my Advance Health Care Directives.

3. I am aware that Advance Health Care Directives may be any one of the following:

a. A Durable Power of Attorney for Health Care.

b. The Declaration in the A Natural Death Act – For example, A Living Will

c. I may write my wishes on paper so that my family may use the document in deciding my medical treatment in the event I am unable to do so.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**This document will be part of my medical record.**

*Note: Advance Health Care Directive information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.*

**ACKNOWLEDGEMENT**

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_



**Insurance Eligibility Guarantee Form**

I, \_\_\_\_\_, hereby certify that I am eligible for insurance coverage with \_\_\_\_\_ Health Plan as of \_\_/\_\_/\_\_. I have chosen **Hemchand Kolli, M.D.** to be my primary care physician.

I understand that if I am not eligible for coverage with my insurance, I am liable for ALL charges for services rendered. I also understand that it is my responsibility as a patient to notify the office of any changes made with my insurance coverage (co-pay changes, insurance carrier changes, etc.)

1. Private Insurance: This office will bill for all your charges. Please show your insurance card at the window. We ask you to pay any deductible that has not been met, and any co-pay or percentage at the time of your visit. If you have a co-pay or percentage, please remember that payment will be expected at check-in of each visit.
2. Medicare: This office will bill for all your charges. Please show your Medicare card at the window. We ask that you pay any Medicare deductible that has not been met yet and your 20% co-pay at the time of your visit. If you have a secondary insurance, please provide that information to the front desk, so we may bill your secondary, and you will be billed after your visit.
3. PPO/HMO: If you are covered by an insurance company that we are contracted with, please present your card at the front desk. We will bill your insurance after collecting your co-pay at the beginning of your visit.
4. Cash: If you do not have insurance, payment will be expected at the time of your visit. Charges will vary depending on length and extent of your office visit.

NOTE: You will receive a separate bill from the laboratory for all laboratory services ordered (i.e. pap smears, urinalysis, blood work, etc.). These charges are not included in our bill. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY, YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE SO THE CORRECT ORDERS CAN BE MADE.

I have read the following information and I understand my financial obligation to the office of **Hemchand Kolli, M.D.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

**Office Policies**

Financial Policies:

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Please ask if you have any questions about the financial policy.

Prescription Policies:

Allow 48-72 hours for All Controlled Medication Refills Monday thru Thursday

- No controlled medication refills will be provided Friday, Saturday or Sunday
- You must call your pharmacy to get a refill for all non-controlled medications
- DO NOT wait until you run out of your medications to contact your pharmacy
- Please call your pharmacy at least one week prior to finishing your medications

Patient Code of Conduct:

Welcome to our practice. Our providers and staff strive to make your healthcare experience the best it can be. We understand that the healthcare system can be confusing and frustrating with your own health concerns. Whether it be refilling prescriptions, specialist referrals, having lab work or x-rays done there can be many moving parts in today's healthcare environment. Please be assured that our staff will do all they can to assist you or accommodate your needs. However, the physicians and staff will not tolerate any of the following:

- Physical or verbal abuse of any kind
- Repeated missed appointments (3 or more No show/canceled appointments)
- Non-compliance of any provider recommended orders including:
  - Not taking medications as prescribed
  - Not having ordered diagnostic studies done (labs, x-rays, or procedures)
  - Non-compliance of our controlled substance agreement

Any of the behaviors listed above may result in you being discharged from this practice due to breach of patient code of conduct. We feel these behaviors compromise the patient/physician relationship and the quality of care we can provide.

We thank you for understanding and welcome you as a patient.

---

Patient Signature

Date

**Appointment Policies**

Appointments:

Our hours are by appointments only, but our staff will make every effort to accommodate urgent add on requests.

Late Appointment Arrivals:

Effective March 1, 2011, the office reserves the right to reschedule your appointment if you arrive more than fifteen (or ten according to other forms) minutes late from your scheduled appointment.

I apologize for this inconvenience, but we will be implementing this new policy to provide quality care to all patients in a timely manner.

No Show:

We know that there will be times when you will not be able to keep the appointments that you scheduled. We only ask that if this occurs you call us 24 hours in advance so that we can provide your appointment slot to another patient. If you fail to notify us and fail to keep your appointment, you will be charged a “no show” fee of \$25.00. Our practice will be implementing this “No Show” policy to all patients.

I acknowledge that I have read and understood these new policies:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date