Primary Care Clinic of Austin
Sukanya Burugu, MD
11615 Angus Road, Suite 108
Austin, TX 78759
(512) 372-4400 Phone (512) 372- 4402 Fax

Personal Information:

Last Name: ____________________ First Name: ____________________ Date of Birth: ______

Home Address: ____________________ City: ______________ State: _____ Zip: ______________

Home Phone: ____________________ Cell Phone: __________________ Email: ________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact: ____________________ Emergency Contact Number: ______________________

Medical Insurance Information:

Primary Insurance: ________________________ Policy #: ________________________
Name of Subscriber: ________________________ Group #: ________________________
Secondary Insurance: ________________________ Policy #: ________________________
Name of Subscriber: ________________________ Group #: ________________________

Medicaid # ________________________ **Medicare #** ________________________

Pharmacy Information:

Preferred Pharmacy: ______________________________ Phone #: ________________________

Pharmacy Address: ____

Hospitalizations and Surgeries:

Reason: ____ Date: __________

Reason: ____ Date: __________

Reason: ____ Date: __________

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned authorize payment of medical benefits to Sukanya Burugu, MD for any services furnished by the physician. I understand that I'm financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating or administering claims of benefits.

____ ____________________
Patient, Parent, or Legal Guardian. Date

By Signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Signature: ______________________________________ Date: ________________

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Substance Use:

Use of Tobacco: Type and How long? ____________________

Do you want to quit? YES or NO Have you tried to quit? YES or NO Were you successful? YES or NO

Use of Alcohol: Type and How long? ____________________

Have you ever felt the need to quit? YES or NO Have you tried to quit? YES or NO

Have friends or family members ever expressed concern? YES or NO

Use of Recreational and Non-prescription Drugs: Type and How long? ____________________

Have you ever been treated for drug or alcohol dependency? YES or NO

Additional:

Do you have or have you ever had an eating disorder?	YES	NO
Do you have any unwanted scars, moles, ages spots, or hair?	YES	NO
Are you interested in anti-aging or skin care treatment?	YES	NO

Female Patients Only:

Are you currently pregnant?	YES	NO	
Are you nursing?	YES	NO	
Are you taking birth control?	YES	NO	If so, what type? ____________
Are you on estrogen replacement?	YES	NO	

Approximate date of your last menstrual cycle? ____________

Medical History:

Reason for visit: ____________________ Date last seen by a physician: ____________

Are you currently or have you been under the care of a healthcare provider in the last 3 years? YES NO

If so, why? ____________________

Name of Healthcare provider: ____________________

Provider address: ____________________ Provider Phone #: ____________

Medications:

Current Prescription Medications:	Dosage	Frequency

Over the Counter Medications, Vitamins, or Herbal Supplements:	Dosage	Frequency

Have you EVER taken any prescription weight-loss drugs, including Fen-Phen (fenfluramine-phentermine), Redux (dexfenfluramine), and/or Pondimen (fenfluramine)? YES NO

Allergies:

Name:	Reaction (hash, hives, swelling, etc.):

Specifically, are you allergic to the following:

Latex?	YES	NO	Penicillin?	YES	NO
Erythromycin?	YES	NO	Tetracycline?	YES	NO
Codeine?	YES	NO	Hydrocodone?	YES	NO
Dental Anesthetics (Novacaine, Lidocaine, etc.)?				YES	NO

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Review of Systems: Please indicate whether you have ever had any of the following:

ALLERGY/ENT:
- ☐ HAY FEVER
- ☐ SEASONAL ALLERGIES
- ☐ SINUS PROBLEMS

CARDIOVASCULAR:
- ☐ ARTIFICIAL HEART VALVE
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HEART ATTACK OR MI
- ☐ HEART SURGERY (CABG, HEART CATHETERIZATION , ETC.)
- ☐ HIGH BLOOD PRESSURE - HYPERTENSION
- ☐ PACEMAKER
- ☐ SWOLLEN ANKLES

ENDOCRINE:
- ☐ DIABETES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ THYROID DISORDERS
- ☐ HIRSUTISM - EXCESSIVE HAIR

GASTROINTESTINAL:
- ☐ LIVER PROBLEMS
- ☐ ULCERS
- ☐ REFLUX - GERD

ONCOLOGY:
- ☐ CANCER
- ☐ CHEMOTHERAPY
- ☐ RADIATION THERAPY

SKIN:
- ☐ COLD SORES / FEVER BLISTERS
- ☐ CHANGE IN MOLES

HEMATOLOGY:
- ☐ ABNORMAL BLEEDING
- ☐ BRUISE EASILY
- ☐ ANEMIA
- ☐ BLOOD DISEASES
- ☐ BLOOD TRANSFUSIONS
- ☐ HEMOPHILIA
- ☐ SICKLE CELL DISEASE
- ☐ SPIDER OR VARICOSE VEINS

INFECTIONS:
- ☐ RHEUMATIC FEVER
- ☐ HEPATITIS A B C
- ☐ HIV POSITIVE
- ☐ AIDS
- ☐ SHINGLES

NEUROLOGICAL:
- ☐ EPILEPSY - SEIZURES
- ☐ FAINTING / DIZZY SPELLS
- ☐ FREQUENT HEADACHES
- ☐ STROKE OR TI
- ☐ OTHER NEURO DISORDERS: ______________________

OPHTHALMOLOGY:
- ☐ CATARACTS
- ☐ GLAUCOMA

PSYCHIATRIC CARE:
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ BIPOLAR DISORDER
- ☐ SCHIZOPHRENIA
- ☐ PSYCHIATRIC CARE

RENAL / UROLOGICAL:
- ☐ KIDNEY STONES
- ☐ FREQUENT URINATION
- ☐ FREQUENT BLADDER INFECTIONS
- ☐ BLOOD IN THE URINE
- ☐ PROSTATE PROBLEMS (BPH)
- ☐ KIDNEY PROBLEMS

RESPIRATORY:
- ☐ ASTHMA
- ☐ CHRONIC COUGH
- ☐ DIFFICULTY BREATHING
- ☐ EMPHYSEMA
- ☐ TUBERCULOSIS

MUSCULOSKELETAL:
- ☐ ARTHRITIS (RHEUMATOID/OSTEOARTHRITIS)
- ☐ ARTIFICIAL JOINTS
  IF SO, WHAT?______________
- ☐ CHRONIC BACK PROBLEMS
  IF SO, DID YOU HAVE SURGERY?
  YES NO
  IF SO, WHEN? ______________

GENERAL:
- ☐ UNPLANNED RECENT WEIGHT LOSS / GAIN (10lbs or More)
- ☐ VENEREAL DISEASES OR SEXUALLY TRANSMITTED DISEASES
- ☐ OTHER: ____________

Childhood Illness: ☐ MEASLES ☐ MUMPS ☐ RUBELLA ☐ CHICKENPOX ☐ RHEUMATIC FEVER ☐ POLIO
Immunizations and Dates: ☐ TETANUS ☐ HEPATITIS ☐ INFLUENZA ☐ PNEUMONIA ☐ CHICKENPOX ☐ MMR

By Signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

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PCCA

Family History:

Please check all that apply.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brothers	Sisters	Children
Alcoholism									
Alzheimer's Disease									
Anxiety									
Asthma									
Attention Deficit Disorder									
Benign Prostatic Hypertrophy									
Cancer									
Colon Cancer									
Leukemia									
Lung Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
Testicular Cancer									
Cerebrovascular Accident (Stroke)									
Cholelithiasis									
COPD									
Congestive Heart Failure									
Coronary Artery Disease									
Depression									
Diabetes									
Drug Abuse									
Hepatitis C									
HIV / AIDS									
Hyperlipidemia									
Hypertension									
Hyperthyroidism									
Migraines									
Heart Attack									
Obesity									
Osteoarthritis									
Osteoporosis									
Renal/Kidney Stones									
Rheumatoid Arthritis									
Seizure Disorder									

PATIENT SYMPTOMS UPDATE

PRIMARY CARE CLINIC OF AUSTIN

Providers: SUKANYA BURUGU, M.D

Patient Name: ______________________ Today's Date: ____________ DOB: ____________ AGE: ________

Best Daytime #: ______________ Best Evening #: ______________ e-mail: ______________________

Height: ______________ Weight: ______________ ( ) OK to leave message? Y / N

General Health Questions: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
High Blood Pressure, Low Blood Pressure, Rapid Heart Rate, Irregular Heart Rate, etc	Y / N
High Cholesterol	Y / N
Difficult Breathing (COPD, Asthma, etc)	Y / N
Digestive Disturbances (Indigestion, Constipation, Irritable Bowel Syndrome, etc)	Y / N
Endrocrine (Diabetes, Thyroid, etc)	Y / N
Chronic Pain Syndromes (Chronic Fatigue Syndrome, Fibromyalgia, etc)	Y / N
Migraines or Other Headaches	Y / N

Neurological & Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have a history of Epilepsy or Seizure activity? When: ______________	Y / N
Have you ever had abnormal involuntary muscle contractions, jerking or convulsions?	Y / N
Have you ever had a Stroke / Mini-Stroke? If yes, did you lose consciousness or have loss of awareness?	Y / N
Have you ever had a concussion? If yes, did you lose consciousness?	Y / N
Have you ever Fainted or had any unexplained loss of consciousness? Please explain: ______________	Y / N
Have you ever had unexplained episodes of Confusion or Loss of Awareness?	Y / N
Do you ever feel Disoriented, feel Brain Fog, Zone Out, lose track of time or where you are?	Y / N

Quality of Sleep: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you stop breathing, choke, or gasp for air during sleep?	Y / N
Do your legs kick at night and interfere with your sleep?	Y / N
Have you been told that you snore loudly?	Y / N
Do you have difficulty falling and staying asleep?	Y / N
How many hours of restful sleep do you get most nights?	________

How likely are you to Doze off or Fall Asleep in the following situations? (0=Never,1=Slight,2=Moderate,3=High)

Sitting and Reading	0 1 2 3	Lying Down to Rest in the Afternoon	0 1 2 3
Watching Television	0 1 2 3	While Having a Relaxed Conversation	0 1 2 3
Sitting Quietly After Lunch	0 1 2 3	In a Car While Stopped at a Traffic Signal	0 1 2 3
As a Passenger in a Car for One Hour	0 1 2 3	Sitting Inactive in a Seminar, Theater or Meeting	0 1 2 3

Bladder Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you lose urine while coughing, sneezing, laughing, lifting, jumping or running?	Y / N
Do you use protective undergarments because you cannot hold your urine?	Y / N
Do you wet your clothing because you cannot make it to the bathroom in time?	Y / N
Do you have to hurry to empty your bladder when full?	Y / N
How often do you; urinate during the day? ________ times; wake to urinate during the night? ________ times	

Balance & Fall Prevention: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have you ever Fainted, Lost Your Balance, Feel Dizzy or Unsteady?	Y / N
Does dizziness or imbalance problems interfere with your job or your household responsibilities?	Y / N
Do you feel dizzy when rising from a seated or lying position?	Y / N
Have you fallen more than once in the past year?	Y / N

Nerve and Muscle Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you experience ANY of the following (*please check those that apply*):	
( )Radiating Pain, ( )Numbness, ( )Tingling, ( )Burning, ( )Coldness, ( )Sharp Pain, ( )Dull Pain	
In The: ( ) Neck, ( ) Shoulders, ( ) Arms or ( ) Hands (ie Upper extremities)	Y / N
In The: ( ) Low Back, ( ) Hips or ( ) Legs (ie Lower Extremities)	Y / N
Have you experienced loss of motion or weakness in your neck, shoulders, arms or hands?	Y / N
Have you experienced loss of motion or weakness in your low back, hips or legs?	Y / N
Have you been told that you have Neuritis or Neuropathy?	Y / N

Cognitive Brain Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have daily problems with making judgments or decisions?	Y / N
Have daily problems with memory / Repeat the same things over and over again (questions, stories, statements) ?	Y / N
Have you been told that you may have dementia or pre-dementia?	Y / N
Have feelings of Anxiety and/or Depression?	Y / N
Have trouble handling financial affairs (paying bills) or learning how to use a tool, appliance or gadgets?	Y / N

Cognitive Behavioral Function: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Have difficulty getting organized or Avoid getting started on a challenging task?	Y / N
Have trouble completing assignments or tasks?	Y / N
Fidget or squirm with your hands or feet when you have to sit for a long time?	Y / N
Feel overly active or feel like you have to constantly do something, like you were driven by a motor?	Y / N

Allergy & Immunology: I have had these symptoms/conditions for: 0-3 months 3-6 months OVER 6 months	
Do you have Allergy and Hay Fever symptoms, such as sneezing, watery nasal drainage and nasal itching?	Y / N
Do you have persistent nasal congestion and/or post nasal drip?	Y / N
Do you have sinus problems, frequent colds, sinus headaches?	Y / N
Do your eyes itch, water, get red and/or swell?	Y / N
Do you have asthma, tight chest, and or persistent cough?	Y / N
Do you have skin problems such as eczema, hives or itching?	Y / N
Are you aware of any Food Allergies that you may have?	Y / N
My Symptoms are Worse when:	
( ) Seasons Change ( ) going from indoors to outdoors ( ) in parks and grassy areas ( ) around animals	
( ) while vacuuming or around dust ( ) in the morning and/or after waking	
Do you take medications to control your allergies? If so, describe: ______	
Do they help?	Y / N

Major Accidents/Traumas: ______

Major Surgeries: ______

Medications: ______

This Patient Symptoms Update, which will be part of your medical record, lists symptoms and other factors that may allow your physician to recommend appropriate diagnostic studies to better manage your care. *Upon review and approval*, you may be contacted by our Medical Services Scheduling Company to schedule these tests.

Patient Signature: ______ Date: ______

(rev 5-31-2017, Fax 281-310-6330)

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HIPAA PRIVACY
AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996. (P.L. 104-191), 42 U.S.C. Section 1320d. et. seq. and regulations promulgated thereunder, as amended from time to time.

This authorization affects your rights in the privacy of your healthcare information. Please read carefully before signing.

Primary Care Clinic of Austin, PCCA, will not condition treatment payment, enrollment in a health plan, or eligibility of benefits, as applicable, on your providing authorization for the requested use or disclosure.
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

- By signing this authorization you acknowledge and agree that PCCA may use or disclose ____________________ (describe information) for the purpose of ________________________ (describe intended use).
- By signing this authorization you agree that PCCA or its Business Associates may disclose your personal health care information to ____ (identify intended recipients).

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand that PCCA's HIPAA Privacy Policy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to to change the terms of the Policy's Notice, copies of the Privacy Notice, as amended are available from Covered Entity at any of its offices or by sending a written request with return address to 11615 Angus Road, Suite 108, Austin, Texas 78759.

In accordance with your rights under and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by PCCA, for as long as PHI is maintained by the designated record set. You have the right to revoke this authorization, in writing, at any time, except to the extent that PCCA has taken action in reliance on it. A revocation is effective upon receipt by PCCA of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of this authorization (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with HIPAA, (c) complete satisfaction with the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of PCCA, or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Acknowledge and agreed to by:

______________________________	______________________________	________
Patient Print	Patient Signature	Date

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(512) 372-4400 Phone (512) 372- 4402 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I, ______________________________ date of birth ______________ authorize

Facility: ______________________________ Fax # ______________________________

To release information contained in my patient records to the individual(s) and organization(s) and only under the condition below:

Sukanya Burugu, MD
11615 Angus Road, Suite 108
Austin, TX 78759
(t) 512.372.4400 (f) 512.372.4402

Specific type of information to be disclosed:

___________ Entire Records
___________ Labs
___________ Other

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise directed. This authorization is valid only for the release of medical information dated prior to and including the dates on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also included information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual or organizations. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect and obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization:

______________________________ ______________________________ __________
Patient, Parent, or Legal Guardian Printed | Signature | Date