

OSAMA ELSHAZLY, MD REGISTRATION FORM

Today's Date _____

(PLEASE PRINT)

PATIENT INFORMATION

Name _____ Birth date _____ Age _____

Address _____ City, State, Zip _____

Home Phone # _____ Cell # _____ Work # _____

Email _____ SSN _____

⇒ Male ⇒ Female Status: ⇒ Single ⇒ Married ⇒ Divorced ⇒ Widowed ⇒ Separated

Employer _____ Occupation _____

Work Address _____ City, State, Zip _____

Emergency Contact _____ Relationship _____ Phone _____

PRIMARY INSURANCE

Insurance Company _____ Policy # _____ Effective Date _____

Name of Insured (Primary Member) _____ DOB _____

Insured's SS# _____ Relationship to Patient _____

Insured's Address _____ City, State, Zip _____

Employer _____ Occupation _____

Work Address _____ Work phone # _____

SECONDARY INSURANCE

Insurance Company _____ Policy # _____ Effective Date _____

Name of Insured _____ DOB _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to **Osama Elshazly, MD** all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I hereby authorize Dr. Elshazly to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims and submissions.

Patient or Guarantor Signature

Relationship to Insured

Date

COMPREHENSIVE MEDICAL HISTORY

GENERAL INFORMATION

NAME _____ DOB _____ Today's Date _____

Date of your last complete Physical Exam?	Date of your last EKG?
Date of your last bloodwork?	Date of your last Glucose / HgbA1C?

MEDICATIONS

Please list all **prescription or over-the-counter medications, vitamins, herbs or nutritional supplements** that you are now taking. Please include the name, dosage amount, and how many times a day you take them. Use the back of the page if needed.

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

PHARMACY: _____ ALLERGIES: _____

PAST MEDICAL HISTORY (Circle those that apply)

AIDS or HIV	Chicken Pox	Measles	Rheumatic Fever
Cancer	Epilepsy	Mumps	Scarlet Fever
Blood or Plasma Transfusion	Infectious Mononucleosis	Polio	Whooping Cough

HOSPITAL / SURGICAL HISTORY

ILLNESS or OPERATION	DATES	ILLNESS OR OPERATION	DATES
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____

FAMILY HISTORY (List their relationship to you next to each condition)

Anemia _____	Epilepsy _____	High Blood Pressure _____
Asthma _____	Glaucoma _____	Kidney Disease _____
Obesity _____	Leukemia _____	Thyroid Disease _____
Cancer _____	Depression _____	High Blood Pressure _____
Diabetes _____	Heart Disease _____	Alcohol/Drug Abuse _____
Stroke _____	Lung Disease _____	Bleeding problems _____

PRESENT AGE or AGE AT DEATH: Mother ____ (A/D) Father ____ (A/D) Sisters (Alive) ____ Sisters (Deceased) ____
 Brothers (Alive) ____ Brothers (Deceased) ____

SOCIAL HISTORY

Employed: Y N	Where? _____	Occupation? _____
Marital Status: S M D W	Smoker? Y N Former Smoker? Year Quit _____	# of yrs smoked: _____
Smoker? Y N	I currently smoke: Cigarettes Cigars Pipe Other _____	# of years? _____
Recreational Drugs: Y N	What are/were they: _____	How long? _____
Do you drink alcohol? Y N	How much / How often? _____	Do you wear a seatbelt? Y N
Do you have any risk factors for HIV infection? Y N	Have you ever been exposed to someone with TB? Y N	_____
Are there any environmental risks involved in your job or home? Y N	Explain: _____	_____

WOMEN ONLY

Age of first period: ____ Date of last period: _____ Regular: Y N Normal in flow: Y N Age at Menopause: ____
 # of Pregnancies: ____ # of Children: ____ Types of Birth: # of Vaginal: ____ # of C-Section: ____ # of Premature: ____
 # of Stillborn: ____ # of Miscarriage: ____ Describe any complications: _____

Abnormal Breast Lumps? Y N Test Results: _____

PLEASE CHECK ALL THE CONDITIONS YOU CURRENTLY HAVE:

GENERAL

- ⇒ Weight loss
- ⇒ Weight gain
- ⇒ Change in sleep patterns
- ⇒ Constant fatigue

NEUROLOGICAL

- ⇒ Anxiety
- ⇒ Headaches
- ⇒ Depression
- ⇒ Meningitis
- ⇒ Paralysis
- ⇒ Seizures
- ⇒ Stroke
- ⇒ Tingling fingers or lips
- ⇒ Tremors
- ⇒ Memory Loss
- ⇒ Fainting spells, dizziness
- ⇒ Head injuries
- ⇒ Blackouts / Near Blackouts

EYE / EAR / NOSE / THROAT

- ⇒ Hay fever / Seasonal allergies
- ⇒ Glaucoma
- ⇒ Cataracts
- ⇒ Double Vision
- ⇒ Glasses / Contacts
- ⇒ Other Eye Problems
- ⇒ Ear Infections
- ⇒ Hearing Loss
- ⇒ Ear Discharge / Pain
- ⇒ Tubes in Ears
- ⇒ Ringing in Ears
- ⇒ Sore Throat
- ⇒ Sinus Infections
- ⇒ Frequent Nosebleeds
- ⇒ Swollen glands
- ⇒ Polyps
- ⇒ Goiter
- ⇒ Hoarseness
- ⇒ Sore throat

CARDIOVASCULAR

- ⇒ Angina
- ⇒ Chest Pain
- ⇒ Murmurs
- ⇒ Cardiac Catheterization
- ⇒ Congenital Heart Defects
- ⇒ Heart Attacks
- ⇒ Heart failure
- ⇒ Irregular Heart rate
- ⇒ Heart palpitations
- ⇒ Purple fingers or lips
- ⇒ Leg cramps
- ⇒ Ankle swelling
- ⇒ Cold hands or feet
- ⇒ Leg pain that resolves with rest
- ⇒ Waking at night, shortness of breath getting out of bed
- ⇒ Dizziness when standing up
- ⇒ Varicose veins
- ⇒ High / Low Blood Pressure

RESPIRATORY

- ⇒ Asthma / Wheezing
- ⇒ Breathless when lying flat
- ⇒ Shortness of breath
- ⇒ Wheezing
- ⇒ Pneumonia / Pleurisy
- ⇒ URI / Bronchitis
- ⇒ Prolonged cough
- ⇒ Emphysema / COPD
- ⇒ Coughing up blood

SKIN

- ⇒ Acne / Boils / Abscesses
- ⇒ Dry or Oily Skin
- ⇒ Hives / Rashes / Psoriasis
- ⇒ Shingles
- ⇒ Excessive sweating
- ⇒ Body odor
- ⇒ Moles: Irregular or New
- ⇒ Fungal infections

GENITOURINARY

- ⇒ Blood in urine
- ⇒ Dribbling after urination
- ⇒ Painful urination
- ⇒ Involuntary urination
- ⇒ Frequent urination
- ⇒ Hesitant urination
- ⇒ Excessive thirst
- ⇒ Frequent bladder infections
- ⇒ Kidney stones
- ⇒ Kidney disease

ENDOCRINE

- ⇒ Diabetes
- ⇒ Borderline Diabetes
- ⇒ Sickle Cell
- ⇒ Thyroid disease
- ⇒ Rheumatism
- ⇒ Abnormal body hair
- ⇒ Increased loss of hair
- ⇒ Changes in skin texture

SEXUAL HEALTH

- ⇒ Painful intercourse
- ⇒ Unprotected sex
- ⇒ Loss of interest in sex
- ⇒ Groin Itching
- ⇒ Sexually transmitted diseases

MEN ONLY

- ⇒ Hernia
- ⇒ Erection difficulties
- ⇒ Bloody ejaculation
- ⇒ Inability to finish intercourse
- ⇒ Penile discharge
- ⇒ Premature ejaculation
- ⇒ Penis sores or warts
- ⇒ Lump on testicle
- ⇒ Testical pain / swelling
- ⇒ Prostate disease

MUSCULOSKELETAL

- ⇒ Back or Neck Pain
- ⇒ Joint pain or Bursitis
- ⇒ Arthritis or Tendonitis
- ⇒ Gout
- ⇒ Joint swelling
- ⇒ Muscle aches
- ⇒ Morning stiffness
- ⇒ Blood clots in legs / lungs
- ⇒ Easy bleeding or bruising
- ⇒ Anemia
- ⇒ Abnormal blood clots
- ⇒ Bone marrow biopsy

GASTROINTESTINAL

- ⇒ Diarrhea or constipation
- ⇒ Black tarry stools
- ⇒ Red blood after bowel movement
- ⇒ Hemorrhoids
- ⇒ Nausea / Vomiting
- ⇒ Vomiting blood
- ⇒ Abdominal pain
- ⇒ Indigestion / Heartburn
- ⇒ Problems swallowing
- ⇒ Intestinal obstruction
- ⇒ Hiatal hernia
- ⇒ Ulcers
- ⇒ Anal fissures
- ⇒ Hepatitis A, B, C
- ⇒ Liver disease

WOMEN ONLY

- ⇒ Abnormal bleeding between cycles
- ⇒ Abnormal Pap Smear
- ⇒ Bleeding after intercourse
- ⇒ Vaginal discharge
- ⇒ Vaginal dryness
- ⇒ Vaginal warts
- ⇒ Fibroids
- ⇒ Endometriosis
- ⇒ Ovarian cysts
- ⇒ Pelvic inflammatory disease
- ⇒ Post menopause symptoms
- ⇒ Hot flashes or PMS
- ⇒ Pregnancy complications

PLEASE NOTE ANYTHING NOT LISTED THAT MAY BE HELPFUL FOR THE DOCTOR

NOTICE TO OUR PATIENTS

(Please Read)

In an effort to serve you better, please be aware of Dr. Elshazly's office policies.

To reduce costs to the doctor due to "No Shows" or last-minute cancellations, a **\$25.00 fee** will be applied to your account for any appointment not kept or cancelled with **at least a 24 hour notice**. This is to be paid upon arrival *at your next office visit*, along with your normal co-pay or deductible fees.

**After 2 "No Shows" in a row,
a letter of Discharge will be sent to you.**

We also charge a **\$30.00 fee** for the completion of parking permits and **\$40.00** for all other extraneous paperwork. This includes **insurance forms, dictated letters, or any other forms** that require filling out and the doctor's signature.

Note: We will not mail any forms from this office.

I, the undersigned, acknowledge this policy.

Patient Signature

Patient's Printed Name

Date

Osama Elshazly, MD
2103 Jenks aVE
Panama City, FL 32405
(850) 785-0085 office - (850) 785-0558 fax

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI).

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow among the multiple healthcare providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of this Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____ DOB: _____
Relationship to Patient: _____ Date: _____

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date _____ Auth. Initials _____

Osama Elshazly, MD
2103 Jenks Ave.
Panama City, FL 32405
(850) 785-0085 office
(850) 785-0558 fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ City, State, Zip _____

Receive Records From Previous Doctor:

Release Records To:

Healthcare Provider / Facility

Osama Elshazly, MD

Address

2316 W. 23rd Street, Ste A

Address

City, State, Zip

Panama City, FL 32405

City, State, Zip

Office phone # / Fax #

(850) 785-0085 tel / (850) 785-0558 fax

Phone # / Fax #

Information to be released: One (1) year of Chart Notes, Medical History, Medication List, Psychiatric Care, Psychological Testing, Alcohol / Drug Abuse / Treatment; Two (2) years of Lab reports and Radiology reports.

Purpose of Disclosure:

Further / Continuing Medical Care

Legal

Insurance

Other

Patient Rights Regarding this Disclosure:

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present to the office of Osama Elshazly, MD. I understand that revocation will not apply to information that has already been released. I understand that revocation will not apply to my insurance company when the law provides my insurer to a right to contest a claim under my policy. Unless otherwise revoked this authorization will expire one (1) year from the date signed.

Signature

Date

Relationship to Patient (Self, Parent, Legal Guardian, etc.)