PATIENT REGISTRATION INFORMATION

PHYSICIAN (Please circle): **Dr. Josiah Onyenekwe III** **Dr. Ahmed Ali**

REFERRING PHYSICIAN: _____

PERSONAL INFORMATION

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

Name: _____
LAST NAME FIRST NAME MIDDLE INT

Social Security # _____-_____-_____ Date of Birth :_____/_____/_____

Cell Phone: (____) _____ Home Phone: (____) _____

Email Address: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

PHARMACY INFORMATION

Name: _____ City: _____

EMERGENCY CONTACT

Name: _____ Phone: (____)_____

Relationship: _____

MARKETING

How did you hear about us? _____

EMPLOYER:

Name: _____ Number: _____

ADVANCE DIRECTIVE (Please Circle One):

Self Do not intubate Do not resuscitate
Non-Surrogate Decision Maker Surrogate Decision Maker

Assignment of Benefits/Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Noydeen Medical Group and any physician for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Signature: _____ Date: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize Noydeen Medical Group to RELEASE / DISCLOSE my health information to the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

I authorize Noydeen Medical Group to OBTAIN my health information to the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

Description/Dates of information that may be USED/DISCLOSED:

Entire Record? Yes or No

Specified Dates: _____

Information will be used/disclosed for the following purpose: _____

_____

- I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations. The information described above may be re-disclosed and no longer protected by these regulations.
- I understand that Noydeen Medical Group will be paid for the costs of copying the information to be released.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information USED/DISCLOSED under this authorization.
- I understand that I may revoke this authorization in writing at any time by delivering a copy of the revocation to Noydeen Medical Group.

This authorization expires ninety (90) days from the date below:

Patient Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

The signature below acknowledges a copy of the notice was RECEIVED (not necessarily read).

Patient Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

ADDENDUM: PATIENT PRIVACY

I, _____, authorize Noydeen Medical Group to share pertinent "Protected Health Information" with my immediate family members, significant others or care givers present today as noted below:

Please **PRINT** the name clearly:

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

_____ Relationship: _____ Phone: _____

I understand that I can withdraw the above at any time, with written request, I also understand that it is my responsibility to ensure that my family member, significant other or care giver, do not divulge or use the information in any way without discussing with me first.

Patient Signature: _____ Date: _____

Patient Representative: _____ Relationship: _____

This is a confidential record: Please answer the following questions as completely as you can. If you are uncertain about the question, leave it blank. Information contained here will not be released without your authorization.

Name:_____**Date:**_____

CURRENT PROBLEMS:

_____

_____

ALLERGIES: (Please Circle/List any drug allergies)

☐ **No known allergies** ☐ **Latex Allergy** ☐ **Iodine/Shell fish**

☐ **Drug/other:** **Reaction:**

_____

_____

_____

CURRENT MEDICATIONS: (prescription, over the counter, herbal supplements, etc.)

☐ **No medications** ☐ **List copied and attached**

Medication/Strength **Dose/Frequency** **Reason for Medication:**

_____

_____

_____

_____

PREVENTATIVE HEALTH HISTORY:

Influenza Vaccine: **NO** **YES** **If so, Date:**_____

Pneumonia Vaccine: **NO** **YES** **If so, Date:**_____

Colonoscopy Screening: **NO** **YES** **If so, Date:**_____

Mammogram Screening: **NO** **YES** **If so, Date:**_____

SPECIALTY PHYSICIANS: (Please list all other physicians you currently use)

Physician **Specialty** **Phone number**

_____

_____

_____

PAST MEDICAL HISTORY: (Please check all that apply to you)

- **Arthritis**
- **Arrhythmia**
- **Bladder Problems**
- **Blood Clots in legs or lungs? Require blood thinners? NO YES**
- **Blood transfusion**
- **Bleeding disorder**
- **Cancer? What type or where_____ Did you receive Chemo? Radiation?**
- **High Cholesterol or lipids**
- **Diabetes: diet controlled on oral medication on insulin**
- **High blood pressure**
- **Liver problems: Cirrhosis Hepatitis, Type:_____**
- **Lung Problems: COPD Tuberculosis emphysema asthma sleep apnea shortness of breath lung cancer other:**
- **Mammogram:_____ Date:_____ Results:_____**
- **Mental health problems: Anxiety Depression Bipolar Dementia Other:**
- **Nerve or neuro problems: Seizures Migraines**
- **Stroke/TIA Any residual deficits?_____**
- **Thyroid Problems:_____ on medication?_____**
- **Coronary Artery Disease Heart Attack Congestive Heart Failure**
- **Peripheral Vascular Disease**
- **Pap Smear:_____ Date:_____ Results?_____**
- **Skin Disorders Psoriasis skin cancer: Basal Squamous Melanoma**
- **Any other past medical history not listed above:_____**

PAST SURGICAL HISTORY: ☐ **No Prior surgeries**

Procedure **Date if known**

- **Appendectomy_____**
- **Back surgery_____ Lower Neck**
- **Breast biopsy_____ Left Right**
- **Breast augmentation_____**
- **Colon surgery_____**
- **Colonoscopy/EGD_____ Polyps Results: Normal Abnormal**
- **Gallbladder_____**
- **Heart_____ Pacemaker Bypass Stents**
- **Hernia_____ Lt Groin Rt Groin Umbilical Incisional Epigastric**
- **Hemorrhoidectomy_____**
- **Hysterectomy_____ Partial Complete**
- **Thyroid_____**
- **Tonsillectomy_____**
- **Other surgery: _____**
  _____
  _____

PAST HOSPITALIZATIONS: ☐ No Prior Hospitalization

Where? **Date if known** **Reason?**

_____

_____

_____

FAMILY HISTORY:

Do any of your blood relatives (parents, brothers/sisters, grandparents, aunts/uncles/cousins) have or ever had any of the following diseases? ☐ **NONE** ☐ **Unknown Family History**

	Relationship	Age:	Age at Death:
○ **Cancer, what type:**	_____	_____	_____
○ **Diabetes type 1 or 2:**	_____	_____	_____
○ **Heart Disease/Problems:**	_____	_____	_____
○ **High Blood Pressure:**	_____	_____	_____
○ **Lung Disease:**	_____	_____	_____
○ **Stroke:**	_____	_____	_____
○ **Kidney Disease:**	_____	_____	_____
○ **Blood Disease:**	_____	_____	_____
○ **Other:**	_____	_____	_____

OCCUPATIONAL/SOCIAL HISTORY:

Employment: ☐ **Employed** ☐ **Unemployed** ☐ **Retired** ☐ **Disabled** ☐ **Student**

Employer:_____**Occupation:**_____

Marital status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Sexual History:

Are you sexually active? NO YES Sexual problems? NO YES _____

Have you ever had an STD? NO YES If so, what type:_____

Is there any history of sexual abuse? NO YES

Are you willing to accept Blood or Blood Products in an emergency? NO YES

Do you smoke? NO YES _____**Packs per day for**_____**years.**

Previous Smoker? NO YES _____ **Packs per day for**_____**years. Quit date:**_____

Do you use smokeless tobacco products? NO YES What and how much? _____

Do you use any form of illegal substances? NO Yes: What and how often?_____

Do you currently consume any alcohol? NO YES How Often? ☐ **Daily** ☐ **Weekly** ☐ **Socially**