PATIENT REGISTRATION INFORMATION

Dr. MOHAMED

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN(If Different): _____

PERSONAL INFORMATION

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

Name: _____

Address: _____ City, State, Zip: _____

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

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

Email Address: _____

PATIENT'S INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

PHARMACY INFORMATION

Name: _____ City: _____

Name: _____ City: _____

EMERGENCY CONTACT

Name: _____ Phone: (____)_____

Relationship: _____

MARKETING

How did you hear about us? _____

EMPLOYER:

Name: _____ Number: _____

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 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: _____

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: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

Name: _____

Address: _____

Phone: _____ Fax: _____

I authorize Noydeen Medical Group to OBTAIN/RECEIVE my health information FROM 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 Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Patient Representative: _____ Relationship: _____

CANCELLATION/NO-SHOW POLICY

CANCELLATIONS:

We value all our patients and strive to provide the best patient care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your medical needs, reserving a room and preparing your records. We kindly ask that if you must change an appointment, please give us a 24-hour notice. This courtesy makes it possible to give your reserved time to another patient who is needing to be seen. If you cannot give us a 24-hour notice, please call us as soon as possible to let us know that you cannot make it to the appointment. We know that your time is valuable and appreciate your cooperation with our policy.

NO-SHOW APPOINTMENTS:

A "NO-SHOW" is defined as missing an appointment without calling us to cancel. We understand that the occasional missed appointments can occur for a variety of reasons. When you do not come to your appointment, not only are you not being seen, but you are preventing another patient from being seen.

Our policy is as follows:

1st No-Show: We will send a letter and reach out to you by phone to get your appointment rescheduled.

2nd No-Show: We will send a letter, reach out to by phone and you will incur a $25 fee added to your chart. No discounts or refunds will be issued for these charges. Your payment will be due in addition to any copay's that you may have at your next visit.

3rd No-Show: After the 3rd no-show, we will send you a letter of dismissal from the practice. We will offer 30 days of emergent care only and will send your medical records to your new physician.

I have read and understand the above policies. Any questions that I have regarding this policy has been answered and copy provided to me.

_____ _____

Patient Signature Date Signed

_____ _____

PRINTED name of patient Date of Birth

RHEUMATOLOGY QUESTIONNAIRE

Name : _____

1. Who may we thank for referring you to us?
   _____
2. Who is your primary care physician? _____
3. Do you have a previous rheumatologic or autoimmune disorder such as, Rheumatoid Arthritis, Lupus, Sjogren's, or Fibromyalgia etc? YES NO

   If yes, please answer the following:
   - What was the diagnosis? _____
   - Who made the diagnosis? _____
   - When was the diagnosis made? _____
   - Symptoms that lead to the diagnosis: _____
     _____
   - Previous treatment: _____
   - Have you had steroid injections? YES NO
     If yes, When? _____ Where? _____
4. Do you have any pain? YES NO

   If yes, please answer the following:
   - Where is the pain? _____
   - When did it start? _____
   - Please circle all that applies: Intermittent Continuous Dull Aching Throbbing Sharp
   - Would you describe your pain as Mild, Moderate or Severe? _____
   - Do you have any swelling, numbness/tingling? YES NO
     If yes, Where? _____
   - What makes your pain worse? _____
   - Do you have morning stiffness? YES NO How long does it last? _____ min / hrs
   - Do you have a skin rash, dry mouth/eye, mouth or nasal ulcers or color changes of the fingers or toes?
     If yes, please specify: _____
   - Do you take anything to relieve the pain, such as Prednisone, Tylenol, Advil, Aleve, etc?
     Please list: _____

5. 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:	_____	_____	_____
○ Rheumatoid Arthritis:	_____	_____	_____
○ Lupus:	_____	_____	_____
○ Sjogren's Syndrome:	_____	_____	_____
○ Gout:	_____	_____	_____
○ Psoriasis:	_____	_____	_____
○ Crohn's Disease:	_____	_____	_____
○ Ulcerative Colitis:	_____	_____	_____
○ Fibromyalgia:	_____	_____	_____

- STD's: _____ _____ _____
- Recurrent Pink Eye: _____ _____ _____
- Other: _____ _____ _____

6. Have you or a family member been diagnosed with Skin Cancer/Melanoma? YES NO
   - If so, when? _____ Treatment: _____

7. Please answer the following regarding your preventative health:

Vaccines:

- Influenza Vaccine: NO YES If yes, Date:_____
- Pneumonia Vaccine: NO YES If yes, Date:_____
- Hepatitis B Vaccine: NO YES If yes, Date:_____
- Shingles (Zostavax)Vaccine: NO YES If yes, Date:_____
- Tetanus Shot: NO YES If yes, Date:_____

Screenings:

- Bone Density Scan: NO YES
  If yes, Date:_____ Results? _____
- Colonoscopy Screening: NO YES
  If yes, Date:_____ Results? Normal Abnormal
- Prostate Screening: NO YES
  If yes, Date:_____ Results? Normal Abnormal
- Mammogram Screening: NO YES
  If yes, Date:_____ Results? Normal Abnormal
  Have you had a previous biopsy? NO YES
- Pap Smear: NO YES
  If yes, Date:_____ Results? Normal Abnormal
- Hysterectomy: NO YES
  If yes, Date:_____ Results? Normal Abnormal
  What was the reason? _____
- Birth Control: NO YES
  If yes, What Kind?:_____

8. Please answer the following regarding your social history:
   - Do you smoke? NO YES
     If yes, Packs/day _____ for _____ years. Start Date? _____
   - Previous Smoker? NO YES
     If yes, Packs/day _____ for _____ years Quit Date? _____
   - Do you use smokeless tobacco products? NO YES
     If yes, What? _____How much? _____
   - Do you use any form of illegal substances? NO YES
     If yes, What? _____How often? _____
   - Do you drink alcohol? NO YES
     If yes, What? _____How often? _____

9. Did you bring any previous records with you today? NO YES

Past Medical History

Patient Name: _____ DOB: _____ Date: _____

Previous PCP: _____Reason for Leaving: _____

How did you hear about us? _____

Past Medical History: Please check if you have had the following:

Cardiovascular

□ High Blood Pressure
□ Heart Attack, Year: _____
□ High Cholesterol
□ Atrial Fib
□ Congestive Heart Failure (CHF)
□ Blood Clots
□ Peripheral Vascular Disease

Endocrinology

□ Diabetes
□ Thyroid Disease
□ Pituitary Disorder
□ Adrenal Disorder
□ Testosterone Deficiency

Pulmonary

□ COPD/Emphysema
□ Asthma
□ Sleep Apnea
□ Pulmonary Nodule

Neurology

□ Stroke, Year: _____
□ Dementia
□ Epilepsy/Seizure Disorder
□ Migraine Headaches
□ Pseudotumor Cerebri
□ Restless Legs Syndrome
□ Bell's Palsy
□ Multiple Sclerosis
□ Vertigo
□ Tinnitis

Gastroenterology

□ Acid Reflux/GERD
□ Liver Disease/Hepatitis
□ Celiac Disease
□ Ulcerative Colitis
□ IBS
□ Diverticulosis

Nephrology

□ Chronic Kidney Disease
□ Kidney Stones

Hematology/Oncology

□ Anemia
□ Sickle Cell Disease/Trait
□ Bleeding Disorder
□ Cancer
Type:_____

Psychiatry

□ Depression
□ Anxiety
□ Bipolar
□ Insomnia
□ ADD/ADHD
□ PTSD
□ Schizophrenia

Rheumatology

□ Rheumatoid Arthritis
□ Lupus
□ Fibromyalgia
□ Osteoporosis
□ Scleroderma

Infectious Disease

□ +HIV or AIDS
□ Tuberculosis
□ Herpes

Gynecology

□ PCOS
□ Endometriosis
□ Uterine Fibroids
□ Menopause

Urology

□ BPH
□ Erectile Dysfunction

Ophthalmology

□ Glaucoma
□ Cataracts

Dermatology

□ Eczema
□ Psoriasis
□ Rosacea
□ Acne

Orthopedic

□ Carpal Tunnel Syndrome
□ Chronic Pain
Where?_____

Allergy/Immunology

□ Environmental/Seasonal Allergies
□ Immunodeficiency

Other: _____

_____

Past Medical History (continued) Patient Name: _____

If you are **diabetic**, when was your last HgbA1C?_____ Result? _____

When was your last dilated eye exam?_____

What was the result? _____

Who was the ophthalmologist/optometrist? _____

When was your last diabetic foot exam?_____

Exam		**Date of Last Exam**	**Result**	**Location**	**Doctor**
Pap Smear	(ages 21-65)				
Mammogram	(ages 40-75)				
Bone Density	(over 65)				
Colonoscopy	(over 50)				
PSA	(over 50)				

Immunizations: Please indicate if you have had the following immunizations and the approximate year

	Yes	No	Year		Yes	No	Year
Pneumovax (age > 65)	Yes	No	_____	Shingrix (age>50)	Yes	No	_____
Prevnar (age > 65)	Yes	No	_____	Tetanus (every 10 yrs)	Yes	No	_____
Flu (yearly)	Yes	No	_____	HPV (age 11-26)	Yes	No	_____

Please list any specialists. (ex. Cardiology, Pulmonary, Neurology, Nephrology, Endocrinology, Gastroenterology, Rheumatology, Pain Management, OBGYN, Ophthalmology, Urology, ENT, Podiatry)

Diagnosis	**Specialist Type**	**Name**

Allergies: Please list all drug allergies and/or other allergies

Drug	**Reaction**

Medications: Please list all current medications (including over-the-counter medications), dosages, how you take them and who prescribes them

Medication	Dosage	Frequency	Prescribing Dr.

Surgeries

Date	Surgery	Reason

Hospitalizations (other than those associated with surgeries listed above)

Date	Hospital	Reason

Have you used **drugs** other than those for medical reasons in the past 12 months? Yes _____ No _____

If yes, What drug? _____ How often? _____

Have you had a drink containing **alcohol** in the past 12 months? Yes_____ No_____

If yes, How often? _____ How many at each sitting? _____

How often have you had 6 or more drink on one occasion in the past year? _____

Describe your average daily caffeine intake: _____

Describe any regular exercise: _____

Describe your living situation, including who you live with: _____

_____

What is your Martial Status? _____Partner's Name: _____

What is your **occupation**? _____

Any known exposures? _____

Family History

Members	Status (alive/deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	Stroke	Kidney Disease	Mental Illness (type)	Cancer (type)	Other
Mother										
Father										
Mom's Dad										
Mom's Mom										
Dad's Dad										
Dad's Mom										
Siblings										
Son(s)										
Daughter(s)										

How many siblings do you have? Brothers _____ Sisters_____

How many children do you have? Boys _____ Girls _____