Patient Registration Form

(Please Fill Out All Sections Completely)

Date: _____

Patient Information

- **Full Name:** _____
  (Last, First, Middle Initial)
- **Date of Birth:** _____
- **Social Security #:** _____
- **Gender:** ☐ Male ☐ Female
- **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partnered (____yrs.)
- **Address:** _____
  (Street Address, City, State, Zip Code)
- **Phone:**
  - Primary: _____
  - Alternate: _____
- **Email:** _____

Insurance Information

Insurance Type	Insurance Name	Member/Subscriber ID	Group #	Policyholder (if different from patient: Name, Relationship, DOB, SSN)
Primary				
Secondary (if applicable)				

Assignment and Release

I certify that I and/or my dependent(s) have insurance coverage as detailed above and assign all insurance benefits to **Dr. Nadim Khatib**. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on insurance claims and consent to the disclosure of my health information to insurance companies for payment and benefit determination.

☐ **Medicare Patients:** I request payment of authorized Medicare benefits to be made on my behalf to **Dr. Nadim Khatib** and authorize the release of necessary medical information for Medicare benefits determination. **Signature:** _____ **Date:** _____

(Parent, Guardian, or Legal Representative if applicable)

Prescription Refill Instructions

- **Local Pharmacies:** Contact our office **3 days** before your medication runs out.
- **Mail-Order Pharmacies:** Contact our office **2 weeks** before your medication runs out.

Be ready to provide:

✓ Medication Name

✓ Dosage

✓ Pharmacy Fax Number

☑ **Prescription History Consent** is assumed to better manage your medication needs.

Cancellations & No-Shows

- Please provide **at least 24 hours' notice** for cancellations or rescheduling.
- A **$50 fee** will apply for no-shows or late cancellations.
- **Three (3) or more occurrences** may result in dismissal from the practice.
- Appointment reminder calls are a **courtesy**; however, remembering your appointment is **your responsibility**.

Payment Policy

- **Co-Pays & Deductibles** are **due at the time of service**.
- Accepted payment methods: **Cash, Credit/Debit cards**.
- **Credit card payments under $20.00** will incur a **$5.00 processing fee**.

HIPAA/Privacy Practices

Our **Notice of Privacy Practices (HIPAA)** is available upon request. If you have any questions or concerns, please ask our staff.

Patient Consent Form

The **Department of Health and Human Services** has established a **Privacy Rule** to protect personal healthcare information. This rule requires healthcare providers to obtain patient consent for the use and disclosure of health information for treatment, payment, or healthcare operations.

Our Commitment to Privacy

- We respect your privacy and take every reasonable precaution to protect it.
- We provide only the **minimum** necessary health information when required for treatment, payment, or healthcare operations.
- You have **full access** to your medical records.

Consent & Rights

- You may **refuse** to disclose your Personal Health Information (**PHI**) in writing.
- If you **refuse**, we have the right to **decline treatment**.
- If you provide consent, you may **revoke it at any time** (except for prior actions already taken based on consent).

If you have **objections** or **questions**, please ask to speak with our **HIPAA Compliance Officer**.

Emergency Contact Authorization

Please list the names of family members or friends authorized to receive information about your medical care in case of emergency:

Name	Relationship (e.g. sister, mother, etc.)	Phone

Patient Acknowledgment & Signature

I acknowledge that I have read and understand the above policies. **Print Name:** _____

Signature: _____

Date: _____

Health History

(Please Fill Out Completely)

Patient Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of last physical exam: _____

What is the reason for this visit? _____

Symptoms

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ☐ Arms ☑ Hip
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Rash
- ☐ Lack of Urination
- ☐ Painful Urination

Gastrointestinal
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Date of last colonoscopy

_____

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Flashes
- ☐ Vision Halos

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that won't heal

***Men Only**
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

***Woman Only**
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of last menstrual period

_____

Date of last Pap Smear

_____

Have you had a mammogram? Yes □ No □

Date of last mammogram_____

Are you pregnant? Yes □ No □

Number of children _____

Conditions
- ☐ AIDS
- ☐ Alcoholism
- ☐ Psychiatric Care
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ COVID
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Influenza/Flu
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Allergies/ Reactions

_____

_____

Pharmacy Name

_____

Family History: Fill in the health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relative had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations/Surgeries ***Pregnancies***

Year	Hospital	Reason for Hospitalization & Outcome	Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion: Yes □ No □

If yes, please give approximate dates _____

Serious illness/ Injuries	Date	Outcome

Health Habits

Check (✓) which you use and how much you use.

Caffeine	
Tobacco	
Street Drugs	
Other	

Occupational

Check (✓) if your work exposes you to:

Stress☐ Hazardous Substances☐

Heavy Lifting☐ Other☐

Vaccinations

Last flu shot _____ **Last pneumonia shot** _____

Patient Acknowledgment & Signature

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my health (or that of my minor child) changes.

Signature: _____Date: _____
(Patient, Parent, Guardian, or Legal Representative)

Print Name: _____
Relationship to Patient: _____

Reviewed By: _____Date: _____

Medication List

Medication	Strength	Frequency