Patient Registration Form

(Please Fill Out 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

Patient Name: _____
Today's Date: _____
Age: _____
Date of Birth: _____
Date of Last Physical Exam: _____

What is the reason for this visit?

Symptoms Checklist *(Check all that apply.)*

General	Gastrointestinal	Eye, Ear, Nose, Throat	Men Only
☐ Chills	☐ Poor appetite	☐ Bleeding Gums	☐ Breast Lump
☐ Depression	☐ Bloating	☐ Blurred Vision	☐ Erection Difficulties
☐ Dizziness	☐ Bowel Changes	☐ Crossed Eyes	☐ Lump in Testicles
☐ Fainting	☐ Constipation	☐ Difficulty Swallowing	☐ Penis Discharge
☐ Fever	☐ Diarrhea	☐ Double Vision	☐ Sore on Penis
☐ Forgetfulness	☐ Excessive Hunger	☐ Earache	☐ Other
☐ Headache	☐ Excessive Thirst	☐ Ear Discharge	
☐ Loss of Sleep	☐ Gas	☐ Hay Fever	**Women Only**
☐ Loss of Weight	☐ Hemorrhoids	☐ Hoarseness	☐ Abnormal Pap Smear
☐ Nervousness	☐ Indigestion	☐ Loss of Hearing	☐ Bleeding Between Periods
☐ Numbness	☐ Nausea	☐ Nosebleeds	☐ Breast Lump
☐ Sweats	☐ Rectal Bleeding	☐ Persistent Cough	☐ Extreme Menstrual Pain
	☐ Stomach Pain	☐ Ringing in Ears	☐ Hot Flashes

Muscle/Joint/Bone Issues *(Check all areas of pain, weakness, or numbness.)*

☐ Arms ☐ Back ☐ Feet ☐ Hands ☐ Hip ☐ Legs ☐ Neck ☐ Shoulders

Additional Symptoms

Other Symptoms	Cardiovascular	Skin Conditions
☐ Vomiting	☐ Chest Pain	☐ Bruise Easily
☐ Vomiting Blood	☐ High Blood Pressure	☐ Hives
☐ Sinus Problems	☐ Irregular Heartbeat	☐ Change in Moles
☐ Vision Flashes	☐ Low Blood Pressure	☐ Itching
☐ Vision Halos	☐ Poor Circulation	☐ Rash

Other Symptoms	Cardiovascular	Skin Conditions
☐ Painful Intercourse	☐ Rapid Heartbeat	☐ Scars
☐ Vaginal Discharge	☐ Swelling of Ankles	☐ Sore That Won't Heal

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Genito-Urinary System

☐ Blood in Urine ☐ Frequent Urination ☐ Lack of Urination ☐ Painful Urination ☐ Rash
☐ Swelling of Ankles ☐ Varicose Veins ☐ Sore That Won't Heal

☐ **Have you had a mammogram? Yes ☐ No ☐**
Date of Last Mammogram: _____

☐ **Are you pregnant? Yes ☐ No ☐**
Number of Children: _____

☐ **Date of Last Menstrual Period: _____**
☐ **Date of Last Pap Smear: _____**

Medical Conditions

(Check all that apply.)

Infectious Diseases	Metabolic & Organ Diseases	Neurological & Mental Health	Cardiovascular & Circulatory
☐ AIDS	☐ Diabetes	☐ Epilepsy	☐ High Cholesterol
☐ Chicken Pox	☐ Kidney Disease	☐ Migraine Headaches	☐ Heart Disease
☐ COVID-19	☐ Liver Disease	☐ Multiple Sclerosis	☐ Stroke
☐ Influenza/Flu	☐ Rheumatic Fever	☐ Psychiatric Care	☐ Thyroid Problems
☐ Hepatitis	☐ Scarlet Fever	☐ Suicide Attempt	☐ Goiter
☐ Mononucleosis	☐ Anemia	☐ Suicide	☐ Poor Circulation

Respiratory & Immune	Reproductive & Urinary	Skin & Musculoskeletal	Other Conditions
☐ Asthma	☐ Breast Lump	☐ Arthritis	☐ Chemical Dependency
☐ Bronchitis	☐ Prostate Problems	☐ Gout	☐ Alcoholism
☐ Emphysema	☐ Miscarriage	☐ Glaucoma	☐ Bulimia
☐ Pneumonia	☐ Vaginal Infections	☐ Cataracts	☐ Cancer
☐ Tuberculosis	☐ Gonorrhea	☐ Hernia	☐ Ulcers
☐ Tonsillitis	☐ Venereal Disease	☐ Polio	☐ Pacemaker

Allergies & Medications

Allergies or Reactions (List all):

Pharmacy Name:

Family History

(Fill in the health information about your immediate family and check if any blood relatives had the following conditions. If so, specify how many.)

Condition	Father	Mother	Sibling(s)	Grandparent(s)
☐ Heart Disease				
☐ High Blood Pressure				
☐ Stroke				
☐ Diabetes				
☐ Cancer				
☐ Thyroid Disease				
☐ Mental Illness				

Hospitalizations & Surgeries

(List past hospitalizations or surgeries.)

Year	Hospital Name	Reason for Hospitalization & Outcome

☐ Have you ever had a blood transfusion? Yes ☐ No ☐
If yes, approximate date(s): _____

Health Habits

(Check all that apply and specify frequency.)

Habit	Check if applicable	How often?
Caffeine	☐	
Tobacco	☐	
Alcohol	☐	
Street Drugs	☐	
Other	☐	

Occupational Risks

(Check if your work exposes you to any of the following.)

☐ High-Stress Environment
☐ Heavy Lifting
☐ Hazardous Substances
☐ Other: _____

Vaccinations

(Fill in the most recent vaccination dates.)

- **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: _____