Dr. Ralph M Zagha: Patient Information Sheet Date:
****

Patient's Name:_________________ _______ _____________________
(First) (Middle) (Last)

Address:____ Apt #_________

City:____ State:________ Zip:_________

Primary phone #: (______) _______-______________ (home/cell/work/other)

Other phone #: (______) _______-______________ (home/cell/work/other)

E-mail:____

Race:
American Indian/Alaskan Native
Asian
Black/African American
Hispanic
Native American
Other
Other Pacific Islander
White

Ethnicity:
Hispanic/Latino
Not Hispanic/Latino
Other

Language:
English
Spanish
French/French Creole
Other

Sex: ________ Marital Status: __________________ Date of Birth: ________________

Social Security #: ______-_____-________ Emergency Contact:
Name:________________________
Phone#: ______________________
Employer:_____________________________________ Work #: (______) _____-_________

Alternate/Out of State Address:____

Alternate/Out of State Phone#: (______) _______-_____________
****
Primary Insurance Carrier:____

ID/Policy#:_____________________________ Group#:_____________________

Secondary Insurance Carrier:____

ID/Policy#:_____________________________ Group#:_____________________
****
Primary Care/Referring Physician:____

Phone#: (______) _______-______________ Fax#: (______) _______-_____________

Address:____

RALPH M. ZAGHA, M.D., P.A.

INSURANCE ASSIGNMENT AGREEMENT/PRIVACY NOTICE ACKNOWLEDGMENT

PLEASE SIGN THE RELEASE(S) BELOW THAT PERTAINS TO YOUR TYPE(S) OF INSURANCE

COMMERCIAL INSURANCE

I, the undersigned, certify that I (or my dependent) have insurance coverage through

______________________________,
(Name(s) of Insurance Company(ies))

and assign directly to Ralph M Zagha, MD, PA all Insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize SCA to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Beneficiary/Patient Signature	Relationship	Date

MEDICARE and/or MEDICAID

Lifetime Authorization. Medicare and Medicaid patient certification. Patient certification authorization to release information and payment request.

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Patient Signature	Patient Name	Date

MEDIGAP

Note: If you sign here you should also sign for Medicare above

Beneficiary Signature Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Ralph M Zagha, MD, PA for services furnished to me by the physician(s) of Ralph M Zagha, MD, PA. I authorize any holder of medical information about me to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

Beneficiary/Patient Signature	Print Beneficiary/Patient Name
HIC (Medicare Number)	Medigap Number
Name of Medigap Insurance Company	Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Signature	Patient Name	Parent or Authorized Representative (if applicable)	Date

Privacy Contact

Other contact information:
The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

Name	Relationship	Phone number
____________	____________	(____) ____-________.
____________	____________	(____) ____-________.
____________	____________	(____) ____-________.

I authorize the above persons(s) to discuss my medical information with the healthcare professionals in this practice.

Patient Signature	Patient Name	Date
____________	____________	____________

Pharmacy Information:

Name	Address or Cross Street	Phone Number
____________	____________	(___)____-________

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE____/____/_____ AGE______ PRIMARY CARE PHYSICIAN_________

LAST NAME_____________________ FIRST NAME _________________ MIDDLE ______

SOCIAL SECURITY NUMBER_______-_____-________DATE OF BIRTH____/_____/_____

PRIMARY LANGUAGE SPOKEN____

CHIEF COMPLAINT (What is the main reason for your visit today? Describe in detail)

____

____

____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?____

Does anything make the problem worse?_______________________better?________________

How long does the problem last?____

Is anything else occurring at the same time?____

Is the problem constant or variable?____

Does the problem interfere with your normal function? Explain.__________________________

____

List current medical problems.

____

____

List past surgeries or illnesses.

____

____

List current medications and dosages.

____

____

____

List any allergies to medications. Please explain allergic reactions.

____

____

List all serious illnesses in your immediate family. (Example: diabetes, breast cancer, etc.)

____

____

Are you on a special diet?   Yes   No   Explain if yes________________________________

Do you currently smoke?   Yes   No   If yes, how may packs per day.__________

Did you quit smoking?   Yes   No   If yes, what year did you start smoking?___________

What year did you quit smoking?_________   How many packs per day did you smoke?_________

Do you drink alcohol?Yes   No   If yes, how many drinks per day.__________

Did you quit drinking alcohol? Yes   No   If yes, how many drinks per day before quitting.___

Do you now or have you had any problems related to the following systems?
Circle Yes or No. Please explain any Yes answers in space provided.

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Other____________________		

Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other___________________		

Genitourinary		
Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Blood in urine	Y	N
Leakage of urine	Y	N
Urinary infection	Y	N
Urinating at night	Y	N
Number of night time voids____		
Other _____________________		

Please read carefully and sign.

I attest that the information provided above in this document is true to the best of my knowledge. I fully understand that any incorrect or missing information can lead to missed or incorrect diagnoses.

Signature______________________ Date ___/___/____