

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. Zagher, MD, PA all Insurance benefits, if any, otherwise payable to me, for services rendered. I hereby authorize the office of Ralph M Zagher, MD, PA 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 Zagher, MD, PA for services furnished to me by the physician(s) of Ralph M Zagher, 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

Name Relationship () - _____
Phone number

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 many 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 ____/____/____