Cesar Nahas, M.D. PA

PATIENT REGISTRATION

DATE: __________________

NAME: ____DOB:_________________________

AGE: ____________SS#:________________________HOME PHONE:_________________________

ADDRESS: ____CITY:_________________________

STATE: ________________ZIP:_________________DRIVER'S LICENSE #:______________________

EMAIL ADDRESS: ____

EMERGENCY CONTACT:________________________________PHONE:______________________

ADDRESS:____

EMPLOYER: ____PHONE:_______________________

ADDRESS: ____

PRIMARY INSURANCE:______________________________________PHONE:__________________

ID#:____GROUP #:_____________________________

SECONDARY INSURANCE: ___________________________________PHONE:__________________

ID#:____GROUP #:_____________________________

DISCLOSURE OF INFORMATION

CAN WE SEND MAIL TO YOUR ADDRESS?(CIRCLE)……………………………………………………YES NO

CAN WE LEAVE A MESSAGE AT YOUR NUMBER(S)?(CIRCLE)………………………………………YES NO

CAN WE SEND MAIL TO YOUR EMERGENCY CONTACT?(CIRCLE)………………………………..YES NO

CAN WE LEAVE MESSAGES WITH THAT CONTACT?(CIRCLE)………………………………..………..YES NO

PLEASE LIST ANYONE OTHER THAN YOU REFERRING AND/OR PRIMARY PHYSICIANS THAT YOU WOULD LIKE TO AUTHORIZE THE DOCTOR TO SHARE YOUR TREATMENT INFORMATION WITH.

SPOUSE:____
CHILD(REN):____
OTHER:____

FIRST VISIT COMPREHENSIVE HISTORY

Name: ____ Age: _________ Date: _______________

REASON FOR YOUR VISIT: ____

REFERRING DOCTOR: __________________________ **FAMILY DOCTOR**: ______________________

HISTORY OF PRESENT ILLNESS: (Please specify location, quality, duration, severity, timing/how often, context, any modifying factors and associated symptoms):

____

____

____

____

PAST MEDICAL HISTORY

1. History of chronic disease (check all that apply)

___ Diabetes 250	___ High Blood Pressure 401.9	___ Bleeding Disorder 286.9
___ Low blood sugar 251.1	___ Low Blood Pressure 458.9	___ Heart Attack 412
___ Peptic Ulcer 533	___ Kidney Disease 753.10	___ Stroke 437.9
___ Arthritis V13.4	___ Anemia 280.9	___ Transfusion Prob. V58.2
___ Gout 274	___ Pacemaker V45.01	___ Chest pain 786.50
___ Asthma 493.90	___ Thyroid Problems 246.9	___ End Stage Renal Disease 585
___ Bronchitis 490	___ Epilepsy / Seizure 345.0	___ Other: _____________
___ Emphysema 492.8	___ Cancer 229.0	

____

2. **LIST ALL SURGICAL OPERATIONS** – Please be complete

Operation/Hospitalization	*Doctor*	*Date*

FAMILY HISTORY

Please list any premature deaths in your family or diseases that run in your family.

(Specifically heart attacks, high blood pressure, stroke, diabetes, kidney, or respiratory disease, bleeding disorder, cancer or arthritis)

Relationship	Disease

SOCIAL HISTORY

No Yes 1. Do you or have you ever used tobacco?

_____ Current Smoker _____ Former Smoker _____ Never Smoked

MEDICATIONS

LIST ALL ALLERGIES and the reaction you had (itching, rash, difficulty breathing, ect.)

____

____

LIST ALL MEDICATION YOU ARE TAKING, including eye drops, inhalers, ointments, spays.

NAME OF MEDICATION	**DOSAGE**	**NUMBER**	**TIME**
	(mg, gr, tsp)	of tabs per dose	of each dose
EXAMPLE: Pepcid	20 mg	1	9 am, 5 pm

The above information is accurate and complete.

____

Print Name Signature Date

Review of Systems

Please check **Yes** or **No** next to the question regarding your health condition.

		Condition
Yes	**No**	**Constitutional**
		Chills
		New onset of fatigue
		Fever
		Night Sweats
		Weight Loss not related to dieting
Yes	**No**	**Head & Neck (HE ENT)**
		Frequent or unusual headache
		Blurred or double vision (Diplopia)
		Hearing loss
		Frequent colds
		Nasal obstruction
		Hoarseness or change in voice
		Abnormal or heavy snoring
Yes	**No**	**Musculoskeletal**
		Back Pain
		Bone or Joint stiffness or pain
Yes	**No**	**Endocrine**
		Chronic overweight
		Chronic underweight
		Heat intolerance
		Cold intolerance
		Generalized weakness
		Excessive thirst (Polydipsia)
		Frequent urination (Polyuria)
Yes	**No**	**Neurologic**
		Loss of consciousness
		Muscle weakness
		Paralysis
		Seizures
		Difficulty with coordination
		Tremor
		Loss of memory
Yes	**No**	**Vascular**
		Leg pain when walking (claudication)
		Cold Extremities
		History of phlebitis (Thrombophlebitis)
		Leg ulcers
		Varicose veins

Please check **Yes** or **No** next to the question regarding your health condition.

Yes	No	Respiratory
		Chronic cough
		Shortness of breath (dyspnea)
		Coughing up blood (hemoptysis)
		Pain related to breathing (respiration)
		Wheezing
		History of exposure to tuberculosis
Yes	**No**	**Cardiovascular**
		Chest pain or distress
		Shortness of breath with exertion (dyspnea)
		Swelling of the legs or ankles (edema)
		Shortness of breath lying flat (Orthopnea)
		Heart palpitations
Yes	**No**	**Gastrointestinal**
		Abdominal Pain
		Blood in Stool
		Change in appetite
		Change in bowel habits
		Constipation
		Diarrhea
		Difficulty swallowing (Dysphagia)
		Heartburn
		Vomiting blood (Hematemesis)
		Hemorrhoids
		Nausea
		Vomiting
Yes	**No**	**Genitourinary**
		Pain or burning on urination
		Urinary urgency
		Passage or kidney stone
		Hernia
		Blood in urine
		Incontinence
Yes	**No**	**Hematological**
		Easy bleeding
		Easy Bruising
		Lymph node enlargement
		History of blood clots

Cesar Nahas, M.D. PA

AUTHORIZATION TO RELEASE INFORMATION

I have received and will review the Notice of Privacy Practices given to me on my first visit to Cesar Nahas, M.D. PA and understand additional copies are available upon request. I authorize Cesar Nahas, M.D. PA to furnish any consulting physician, physician of my request or insurance company and its representative any information or copies of all hospital, medical records, consultation, and prescription relating to specific illness or injury. A copy of this authorization shall be effective and valid.

INITIAL __________

AUTHORIZATION FOR BILLING

I authorize direct payment to Cesar Nahas, M.D. PA the insurance benefits otherwise payable to me, but not to exceed my indebtedness to said organization on the account of charges listed herein. A copy of this authorization shall be effective and valid. I understand that I am responsible for any remaining balance my insurance company does not pay. I understand my office visit co-pay is due at the time of services unless other arrangements have been made.

INITIAL __________

GENERAL CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to consultation, examination and care and to consider such medical, surgical or other services determined to be necessary under the general and specific instructions of the surgeon and his assistant or his designee as is necessary in his judgment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the results of consultation, examination and care by Cesar Nahas, M.D. PA.

INITIAL __________

MISSED APPOINTMENTS

I understand the office of Cesar Nahas, M.D. PA reserves the right to cancel my appointment if I am more than 15 minutes late, to be rescheduled to the next available appointment date/time.

INITIAL __________

Printed Name: ___________________________ **Date:** ______________________

Signature:_______________________________ **Home/Mobile Phone:** ____________________