DORIS HAMAWY, M.D, PA
FAMILY PRACTICE
10230 W. SAMPLE ROAD
CORAL SPRINGS, FL 33065
(TEL) 954 340-9117

PATIENT INFORMATION

DATE _____

NAME _____ SS# _____

COMPLETE STREET ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE# _____ CELL PHONE#_____

BIRTHDATE_____ AGE _____ E-Mail _____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

OCCUPATION _____ WORK # _____

EMPLOYER _____

MARITAL STATUS S___M___D___W___

SPOUSE NAME (PARENT IF PATIENT IS A MINOR) _____

EMERGENCY CONTACT _____ RELATIONSHIP_____

TEL# _____

PRIMARY INSURANCE _____ POLICY/ID # _____

PHONE # _____ GROUP # _____

PRIMARY NAME ON INSURANCE POLICY _____

PRIMARY SS# _____ PRIMARY BIRTHDATE _____

CLAIMS ADDRESS _____

PARTICIPATING LAB _____
(If you do not know, please call the customer service number located on your card.)

PHARMACY TELEPHONE NUMBER _____

PATIENT SIGNATURE _____

Doris Hamawy, M.D., P.A.

Patient Name_____

Today's Date_____Age_____Date of Birth_____
Information about your health is needed by your doctor to understand your medical problems and to get to know you a little better as a person. This information will remain confidential (private) and will be available to your doctor only.

Hospitalizations and Surgeries
List the year, name of the hospital, and the location by city and state, where you were hospitalized or had any surgical procedures done.

Year	Hospital/City and State	Reason for hospitalization or type of surgery performed
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Medications
List any medicines that you now use. Under dosage, list how much you are taking in either milligrams (mg) or number of pills per dose. Under how often, list how many times a day you take the medicine., Be sure to include codeine, diet pills, vitamins, medicines like tylenol, aspirin, antacids, laxatives, sleeping pills, cold medicines, antibiotics (penicillin, sulfa, etc.), codeine, diet pills, vitamins, sedatives (nerve pills), and birth control pills.

Medication	Dosage	How often
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Allergies
List any medicine, food, plants, animals, or other products that you are allergic to:

_____ _____

_____ _____

Past Medical History (please check(√) the box next to any illnesses or problems that apply to you)

1. General
- ☐change in weight (recent)
- ☐change in appetite (recent)
- ☐weakness or fatigue(recent)
- ☐bad nerves or tension
- ☐crying for no reason
- ☐depression
- ☐poor memory
- ☐suicidal thoughts
- ☐difficulty sleeping

Lungs
- ☐asthma
- ☐emphysema
- ☐pneumonia
- ☐tuberculosis (TB)
- ☐pleurisy
- ☐bronchitis
- ☐hay fever
- ☐nagging cough
- ☐coughing up blood

Abdomen
- ☐ulcer or stomach bleeds
- ☐hepatitis(yellow jaundice)
- ☐cirrhosis
- ☐pancreatitis
- ☐gallstones
- ☐gallbladder infection
- ☐polyps in colon
- ☐hemorrhoids
- ☐hernias
- ☐diverticulosis

Glands
☐thyroid disease
☐goiter
☐sugar diabetes
☐over weight

Ears
☐deafness or trouble hearing
☐ringing in ears
☐chronic infections

☐trouble swallowing
☐constipation
☐black, tarry, or bloody stools

Past Medical History *(continued)*

Skin
☐eczema
☐hives/rashes
☐acne
☐skin cancer
☐change in mole size

Eyes
☐change in eyesight
☐glaucoma
☐cataracts
☐blindness

Blood Vessels
☐varicose veins
☐blood clots in leg (phlebitis)

Bones and Joints
☐arthritis or rheumatism
☐gout
☐broken bones (which ones?)
_____
☐scoliosis

Head and Nervous System
☐migraine or severe headaches
☐stroke
☐seizures/epilepsy/convulsions
☐polio
☐nervous or emotional problems
☐concussion
☐meningitis
☐loss of consciousness or blackouts

Kidney
☐kidney stones
☐kidney or bladder infection
☐other kidney disease
☐unable to control urination
☐frequent urination

Infections
☐chicken pox
☐mononucleosis

Heart
☐angina(heart pains)
☐high blood pressure
☐heart attack
☐hear failure (enlarged heart)
☐rheumatic fever
☐chest pain
☐racing heart or palpitations
☐shortness of breath with work or exertion

Blood
☐high cholesterol
☐anemia
☐bleeding problems
☐blood transfusion
☐sickle cell disease or trait

Other
☐cancer-type_____
☐hoarseness(recent)
☐other diseases
_____
_____

II. For Males Only
☐enlarged prostate
☐difficulty starting or stopping urine flow
☐infection in prostate
☐ painful or lumpy testicles
☐ premature ejaculation
☐venereal disease (VD)
☐unable to obtain erection
☐decreased interest in sex
Do you perform testes self-examination? ☐ Yes ☐ No

III. For Females Only (please check√) appropriate box or fill in blank)
How old were you when periods first started? ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18
How often are the periods? approximately every ☐3 weeks ☐4 weeks ☐5 weeks ☐other_____
How many days do the periods last ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐more than 7_____
Have you had menopause (Change of life)? ☐Yes ☐No If Yes, what year?_____
Do you use contraception? ☐ Yes ☐ No If yes, what type?_____
Do you perform breast self-examination? ☐ Yes ☐ No
Date of last menstrual period _____
Have you had venereal or pelvic infections? ☐ Yes ☐ No
Last PAP smear: Date_____ Doctor's name_____Results_____
Number of pregnancies_____ Number of living children_____
Number of abortions_____ Number of miscarriages_____
discharge from nipples ☐ pain with intercourse ☐ lumps in breast
☐ unexpected vaginal bleeding ☐ decreased interest in sex ☐ bleeding after intercourse

Have you had any X-Rays or Lab Tests recently? ☐ Yes ☐ No
If yes, list them . _____

Have you had any of the following Immunizations?	Year
Tetanus vaccination	_____
Pneumococcal vaccination	_____

Immunizations (continued)	Year
Flu vaccination	_____
Rubella vaccination	_____
Hepatitis vaccination	_____
Tuberculosis skin-test	_____

Family History

Answer or check mark (√) the appropriate item listed across the top row for each respective relative. Under brothers, sisters, and grandparents list only blood relationships.

Family Member	Age	If deseased, age and cause of death	Cancer (type)	Diabetes	Kidney disease	Heart disease	Heart attack	Stroke	High blood pressure	Arthritis	Gout	Seizures/Epilepsy	Bleeding problems	Anemia	Sickle cell problems	Asthma/Allergies	Tuberculosis	Alcoholism	Nervous problems	Mental illness	Glaucoma	Migraines	Other	Other	Other	Other
Father																										
Mother																										
Brothers and Sisters																										
Other blood relatives with medical problems (grandparents, aunts, uncles, etc)																										

Social/Lifestyle History

Please answer the following questions. (where indicated, check (√) appropriate response)

1. Are you ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed
2. Who lives in your house?_____
3. Are there any members in the household who are crippled, disabled, or bedridden? ☐Yes ☐ No
   If Yes, who_____
4. Are there many stresses at home? ☐ Yes ☐ No At work? ☐ Yes ☐ No

5. **Tobacco use** (check those tobacco products that you have ever used regularly)
☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Snuff ☐ None

What is the average number of packs of cigarettes that you smoke or used to smoke per day?
☐ None ☐ less than ½ ☐ ½ - 1 ☐ 1-2 ☐ 2 or more

How many years have you smoked? ☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ more than 40

Do you still smoke? ☐ Yes ☐ No If you have permanently quit, when?_____

6. **Alcohol use**
Have you ever had a problem with drinking alcohol? ☐ Yes ☐ No

Has anyone close to you ever thought you drank too much? ☐ Yes ☐ No

Do you feel guilty about drinking? ☐ Yes ☐ No

How often do you or did your drink beer, wine, or whiskey?
☐ Never ☐ Occasionally ☐ Once a week ☐ Several times a week ☐ Daily

How many ounces of alcohol do you consume per week in ounces? _____

7. Do you sometimes use marijuana or other drugs socially? ☐ Yes ☐ No

8. How many cups of coffee, tea, or cola do you drink per day? ☐ 1-2 ☐ 3-6 ☐ 7 or more

9. Are you on a special diet? ☐ Yes ☐ No If Yes, what kind?_____

10. How often do you exercise? ☐ Never ☐ Rarely ☐ Once a week ☐ Several times a week ☐ Daily

11. How many minutes do you exercise per session ☐ less than 30 minutes ☐ more than 30 minutes

12. What kind of work do you do?_____

Are you working now? ☐ Yes ☐ No

Which of the following are you exposed to at work ☐ Excessive noise ☐ Fumes ☐ Air pollution
☐ Poisons and Chemicals ☐ Crowded conditions

13. Answering the following questions, about your sex life will help us better care for you.

A. Do you find your sexual life to be satisfactory? ☐ Yes ☐ No ☐ Sometimes

B. What is your sexual preference? ☐ Homosexual ☐ Bisexual ☐ Heterosexual (opposite sex only)

C. Do you have more than one sexual partner? ☐ Yes ☐ No

D. Did/do you use alternative health providers/treatments, such as: acupuncture, natural remedies (Chinese herbs), or homeopathy? ☐ Yes ☐ No If Yes, explain_____

_____ _____
Patient Signature Date

DORIS HAMAWY, M.D., PA
Authorization and General Consent
Family Practice

AUTHORIZATION FOR MEDICAL/SURGICAL TREATMENT AND LAB WORK

I hereby authorize the physician or physicians in charge of the named patient to administer any treatment/lab work she or they deem necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments or examination.

STATEMENT OF FINANCIAL RESPONSIBILITY

The undersigned agrees, whether he signs as Agent or as Patient, that in consideration of the Services to be rendered to the patient, he hereby individually obligates himself to pay his account in accordance with the regular rates and terms of the practice of Doris Hamawy, M.D., PA. If the amount owed is not fully satisfied by the due date, then a fee of 35% of the outstanding balance as calculated on the due date, will be added to the outstanding balance and sent to our collection agency. I further understand that my physician may order lab tests to diagnose my immediate issues and that the physician is not obligated to know what my plan does or does not cover.

INSURANCE DEPARTMENT ASSIGNMENT

In the event the undersigned is entitled to professional service benefits of any type, arising out of any policy of insurance insuring patient, said benefits are hereby assigned to the appropriate physician for application on patient's bill. It is agreed that the appropriate physician may receipt for any such payment which shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and the patient are responsible for all charges not covered by this assignment.

MEDICARE ASSIGNMENT OF BENEFITS

I request authorization of payment of Medicare/Medicaid benefits on my behalf for any services furnished me by the above physicians to be made to said physicians. I authorize any holder of medical or other information about me to release to Medicare/Medicaid and its agents, any information needed to determine these benefits for related services.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes the above physicians to release or make available for medical review or their related information to insurance companies or medical assistance programs (including their agents, representatives or assignees) through which payment of benefits in connection with hospital and/or professional services are or may be available.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ FULLY AND UNDERSTANDS THE ABOVE STATEMENTS/AUTHORIZATIONS AND EXPLANATIONS THEREIN REFERRED TO HAVE BEEN MADE; HE FURTHER CERTIFIES HE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERM.

_____

Patient Date

_____

Patient's Agent or Representative Relationship to Patient

_____

Guarantor Relationship to Patient

DORIS HAMAWY, M.D., PA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Doris Hamawy MD, PA may use and disclose protected health information (PHI) about me to carry our treatment, payment, and healthcare operations (TPO). Please refer to the above practice for their Notice of Privacy Practices for a more complete description of such uses and disclosure.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doris Hamawy MD, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the above practice's Privacy Officer or requesting it at the office.

With my consent, Doris Hamawy MD, PA may call my home or other designated locations and leave a message on a voice mail or with whomever answers my phone in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, referrals and any call pertaining to my clinical care including lab and test results.

With my consent, Doris Hamawy MD, PA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked "Confidential."

I have the right to request that Doris Hamawy MD, PA's use and disclosure of my PHI to carry out TPO. The practice is not required to agree to my requested restrictions but if it does, it is bound by this agreement.

By signing this form I am consenting to Doris Hamawy MD, Pa's use and disclosure of my PHI to carry out TPO. I may revoke my consent in waiting except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the above doctor may decline to provide treatment to me.

_____

Signature of Patient or Guardian

_____ _____

Print Name **Date**

_____

Print Name of Patient or Guardian

Doris Hamawy, M.D., P.A.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The following individuals are authorized to receive information regarding my medical records:

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship** _____

I, _____ **have received a copy of Doris Hamawy, MD.**

_____ _____

Signature of Patient Date

PATIENT RESPONSIBILITIES

Thank you for choosing us as your primary care physicians. We realize that you do have a choice and we are committed to providing you with the utmost quality of care. We ask that you become familiar with our office policies and procedures, and understand that they are in effect so that we can provide all of our patients with the best service possible.

When calling our office we have a menu of options to help expedite your call. The extensions are as follows:

Appointments	7	Referrals	6
Prescription Refills	3	Billing, Insurance	5
Lab Results	4		

APPOINTMENT CHECK-IN

Please inform the front desk personnel of any address, phone, employment or insurance changes. Co-pays, deductibles and outstanding balances will be collected prior to your visit with the doctor or lab. This will eliminate delays when checking out. We accept cash, check, Visa or MasterCard.

PRESCRIPTION REFILLS

When requesting prescription refills, please allow one week for processing, as many drugs require doctor approval. When calling the prescription line, be sure to speak slowly and clearly, leave the spelling of your name, prescription name, dosage and pharmacy phone number. Follow up with your pharmacy.

Some medications may require prior authorization from your insurance company. Obtaining approval involves extensive phone calls and paperwork, and may require a doctor's visit. This does not guarantee authorization, as that is up to your insurance company.

LAB

Please note most insurance companies require lab work to be done at a contracted drawing station. As a courtesy to our patients we will collect blood/urine here and send it to the appropriate participating lab. This eliminates the need for you to travel to another facility for this service. There is a $20 bio-hazard disposal/convenience fee for labs drawn here the day of a doctor's visit.

If you prefer, we will be happy to provide you with a prescription to take to the contracted drawing station. You will receive a call from us with the results approximately two weeks from the time your lab is drawn. We will inform you if the labs are normal. If there are any abnormal results, the doctors will require you to come in to go over the results. The nurses are not authorized to go over results with you.

REFERRALS

If your insurance requires you to obtain referrals for visits to specialists, please schedule your appointment, <u>and then</u> obtain a referral from this office. Due to varying procedures for referrals by the many insurance companies we work with, please allow 7-10 business days for the referral to be completed. You will be notified when the referral is ready to be picked up.

APPOINTMENT TIMES/CANCELLATIONS

The doctors make every effort to see all patients in need of medical treatment. For this reason, if you are late for your scheduled appointment time, you may be asked to reschedule.

If you need to cancel an appointment we ask your consideration in notifying us 12 hours prior so that another patient in need may be given the appointment. Failure to notify us will result in a $25.00 no-show-fee, which must be paid before any future appointments will be scheduled.

PAYMENT FOR NON-COVERED SERVICES

Due to the high volume of insurance companies, and their agreements with varying provider networks, we cannot be responsible to track the specifics of each patient's benefits. If your insurance company does not cover a particular lab or procedure, you will be responsible for the payment of that service.

In the event an unpaid bill is sent to collections, the patient will be responsible for all charges incurred, including collection and/or attorneys' fees.

_____

Patient Name

_____ _____

Patient Signature Date