New Patient Forms

DATE Received: _____
INS: () Medicare () Private HMO/PPO () CASH

- **Marwan Zoghbi** Appt Date: _____ Time: _____
- **Mirella Younes** Appt Date: _____ Time: _____

Please fill out the documents attached including the signed request for medical records from your previous physicians.

Name of Previous Provider or Specialist: _____

_____

Please provide the following information that needs to be completed **PRIOR** to your appointment.

Please allow 2 to 3 weeks for the Doctor to review, we will notify you once it has been processed. There may be a delay in scheduling if failure to provide the necessary information.

- **Drivers License**
- **Insurance Cards**
- **Prescription Card**
- **Co-pays (CASH, CHECK, Credit or Debit "$1.00 extra") are due on date of service.**
- **Bring all medications you are currently taking, including vitamins, supplements, and over-the-counter medications on the FIRST appointment.**

If you've had any labs/mammogram/x-rays or tests from your previous provider or specialist, please let us know so we may obtain them. Also, if you've been to Urgent Care or been hospitalized, or requesting for any referrals please notify the receptionist.

Once you've completed the provided information. Return the packet to the receptionist. If you have any questions, please feel free to ask for any assistance.

Zoghbi Medical
Marwan Zoghbi, MD & Mirella Younes, MD
3622 W Packwood Ave
Visalia, CA 93277
Ph:559-382-3820

Zoghbi Medical

3622 W Packwood Ave
Visalia, CA, 93277
559-382-3820 Fax: 559-224-1012

DEMOGRAPHICS

(Please Print)

PATIENT'S NAME: _____ **DATE OF BIRTH:** ____/____/____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow **Gender:** [ ] Male [ ] Female

ADDRESS: _____
(Number & Street) (City) (Zip)

Home Phone: ( )_____ **Cell Phone:** ( ) _____

PATIENT'S EMPLOYER: _____ **SSN:** ____-____-____

Patient's Occupation/Job Title: _____ **Work Phone:** ( ) _____

PHARMACY: _____
(Name) (Address) (City)

Mail Order Pharmacy Name: _____

EMERGENCY CONTACT:

Name: _____
Relationship to Patient Phone Number

Address: _____
(Number & Street) (City) (Zip)

How did you hear about us? [ ] Dr._____ [ ] Insurance [ ] Other _____

INSURANCE INFORMATION:

Primary Insurance: _____ Subscriber Name:_____ Subscriber DOB: _____

[]Self []Spouse []Parent [] Guardian Subscriber ID: _____

Secondary Insurance: _____ Subscriber Name:_____ Subscriber DOB:_____

[]Self []Spouse []Parent [] Guardian Subscriber ID: _____

All co-pays and share of costs are due at time of service. We accept CASH or CHECK ONLY

FINANCIAL AGREEEMENT AND AUTHORIZATION FOR TREATMENT:
I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection in thereof. (A Copy of this assignment is as valid as the original.)
NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.
AGREEMENT: The above information is for obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.
I hereby acknowledge receipt of a copy of this form.

Signature: _____ Date: _____

MEDICAL HISTORY

Patient Name: _____ DOB: _____ Age: _____ Today's Date: _____

Current Medication List:

NAME	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Diabetic supplies:

How many times do you test? _____/Day Name of Glucometer: _____

Name of Pen: _____

Consent for RX Hub Inquiry

I hereby provide consent for the Practice of Marwan Zoghbi, MD & Mirella Younes, MD to obtain my Rx history using the SureScripts-Rx Hub Network. I understand that this inquiry will provide my physician with any accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx has certified Rx History Capture and follows strict security protocols to align with HIPPA requirements and respect patient privacy. All queries and responses are made automatically through secure system to system communications.

Signature: _____ Date: _____

Have you ever been diagnosed with or had problems with the following:

	YES	NO		YES	NO		YES	NO
Allergies, seasonal			GERD			Pneumonia		
Anemia			Gastrointestinal Problems			Stress/Anxiety		
Asthma			Gout			Substance Use/Abuse		
Cancer			Heart Disease			Thyroid Disorder		
Celiac Disease			Heart Murmur			Tuberculosis		
Chicken pox			High Blood Pressure			Ulcer		
Corona virus/COVID-19			Kidney Disease			Urinary Tract Infections		
Crohn's Disease			Meningitis			Valley Fever		
Depression			Measles/Mumps			Varicose Veins		
Diabetes			Migraine/Headaches			Vertigo		
Epilepsy/Seizures			Neurology Issues			Vitamin Deficiency		
Fibromyalgia			Osteoporosis			Other:		

Last Colonoscopy: _____ Last Mammogram: _____ LMP: _____

Last DEXA Scan: _____ Last Pap: _____

MEDICAL HISTORY (continued)

ALLERGIES to Medication or foods: [ ] YES [ ] NO

If Yes, please list below

Name:	Reaction:	Name:	Reaction:

SURGERY:	Date: Month/Year	Hospitalized? Yes or No	Hospital Name:

Family History	Living	Health: good, fair, poor	Deceased/year	Cause
Father				
Mother				
Brother(s)				
2				
3				
Sister (s)				
2				
3				
Husband				
Wife				
Son (s)				
2				
3				
Daughter(s)				
2				
3				

Smoking: [ ] No [ ] Yes…Starting Age: _____ Packs/day:_____ Former Smoker: Quit_____ (year) Packs/day: ____

Alcohol: [ ] No [ ] Yes….. Moderate _____ Daily _____Social 2-3 times a year_____ More than 6/day_____

Zoghbi Medial

Marwan Zoghbi, MD & Mirella Younes, MD
Family Medicine

Patient Authorization of Disclosure of Protected Health Information

I hereby authorize: _____ Phone Number:_____

Fax Number: _____

To provide copies of my medical records to:

Marwan Zoghbi, MD Inc
Marwan Zoghbi, MD & Mirella Younes, MD
3622 W Packwood Ave, Visalia, CA 93277

For the purpose of: _____ Continued Medical Care (No Charge)
_____ Personal use ($30.00 charge will apply)

Health information to be disclosed:
_____Any and all health information including all test results, **except** as specifically provided below
_____Other specific information: _____

Dates of Treatment: From: _____ to: _____

Mail Records _____ Pick up records _____ Fax records **559-224-1012**

PLEASE INITIAL ALL:

_____ This authorization is effective now and will remain effective until either:
Indefinitely _____or expiration date: _____

_____ I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, or mental illness. I give my specific authorization for these records to be released.

_____ I understand that I may revoke this authorization at any time notifying this medical practice in writing. My authorization will not affect actions taken by this medical practice prior to its receipt.

_____ I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Print Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

Patient's Phone#: _____

Zoghbi Medical
Marwan Zoghbi, MD & Mirella Younes, MD
3622 W Packwood Ave
Visalia, CA, 93277

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations,
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone you to confirm appointments? [ ] Yes [ ] No

May we leave a message on your answering machine at home or on your cell phone? [ ] Yes [ ] No

May we contact your emergency contact if we cannot reach you by phone? [ ] Yes [ ] No

May we discuss your medical condition with any member of your family? [ ] Yes [ ] No

If YES, please list names and phone numbers of the members allowed:

_____

_____

This consent was signed by: _____
(PLEASE PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____