

Nabil Keith M.D.

Family Medicine

6002 Highway 53 East Dawsonville GA. 30534

Phone (706) 216-4444



Patient Registration Form

Patient Information:		
Last Name:	First Name:	M.I.:
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	
Work Phone:	Email:	
Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	
Social Security #:	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
Employment:	Employer Name:	
Emergency Contact Name	Emergency Contact Phone #:	Relationship to Patient:
Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of the Person Responsible:		
City/State/Zip:	Relationship to Patient:	
Pharmacy Information		
Name:	Phone:	Fax:
Address:		
City/State/Zip:		
Primary Medical Insurance	Secondary Medical Insurance	
Ins. Co. Name:	Ins. Co. Name:	
Policy Holder Name:	Policy Holder Name:	
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:	
Policy Holder's Social Security #:	Policy Holder's Social Security #:	
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:	

Signature of Responsible Party: _____

Date: _____

Printed Name of Responsible Party: _____

Date: _____

Name: _____
Last First

Date of Birth: ____/____/____

Current Medications
 (Include all Prescriptions, Supplements, Over the Counter and Herbal Medications)

Name	Dose	Frequency	Diagnosis (asthma, depression...etc)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Allergies / Intolerances

Do you have allergies/intolerances to medications or other substance? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	1	3
	2	4

Past Medical Problems
 (Diabetes, hypertension, Thyroid... etc)

Problem	Date/Age diagnosed	Problem	Date/Age diagnosed
1		5	
2		6	
3		7	
4		8	

Past Surgeries

Surgery	Date	Surgery	Date
1		3	
2		4	

Family History (Please indicate if they have or ever had any of the following medical conditions)	
Father: <input type="checkbox"/> Alive Age or DOB _____ <input type="checkbox"/> Deceased Cause and age of death. _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Elevated Cholesterol Levels <input type="checkbox"/> Diabetes, <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 1 <input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____ <input type="checkbox"/> Stroke, Age Diagnosed _____ <input type="checkbox"/> Prostate Cancer, Age Diagnosed _____ <input type="checkbox"/> Colon Cancer, Age Diagnosed _____ <input type="checkbox"/> Other, _____
Mother: <input type="checkbox"/> Alive Age or DOB _____ <input type="checkbox"/> Deceased Cause and age of death. _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Elevated Cholesterol Levels <input type="checkbox"/> Diabetes, <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 1 <input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____ <input type="checkbox"/> Stroke, Age Diagnosed _____ <input type="checkbox"/> Colon Cancer, Age Diagnosed _____ <input type="checkbox"/> Breast Cancer, Age Diagnosed _____ <input type="checkbox"/> Ovarian Cancer, Age Diagnosed _____ <input type="checkbox"/> Other, _____
Siblings: Number of Brothers _____ Sisters _____	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Elevated Cholesterol Levels <input type="checkbox"/> Diabetes, <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 1 <input type="checkbox"/> Coronary Heart Disease, Age Diagnosed _____ <input type="checkbox"/> Stroke, Age Diagnosed _____ <input type="checkbox"/> Colon Cancer, Age Diagnosed _____ <input type="checkbox"/> Breast Cancer, Age Diagnosed _____ <input type="checkbox"/> Ovarian Cancer, Age Diagnosed _____ <input type="checkbox"/> Prostate Cancer, Age Diagnosed _____ <input type="checkbox"/> Other, _____
Children: Number of Sons _____ Daughters _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
Social History	
Smoking: Current Smoker <input type="checkbox"/> No <input type="checkbox"/> Yes Pack per Day _____ For How Many Years _____ Previous Smoker <input type="checkbox"/> No <input type="checkbox"/> Yes Pack per Day _____ For How Many Years _____ Quit Date _____	
Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Social <input type="checkbox"/> Yes How much and how often, Type _____	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Engaged	
Occupation:	

Review of Systems		
Are you currently or regularly experiencing any of the following signs and symptoms (please check all that apply)		
Constitutional	Endocrine	Genitourinary
<input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Unrefreshed feeling after sleeping <input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Diminished sexual drive	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Urinary incontinence (leakage) <i>Men only</i> <input type="checkbox"/> Difficulty with erection <input type="checkbox"/> Pain or mass in testicles <input type="checkbox"/> Weak urine stream <i>Female only</i> <input type="checkbox"/> Heavy/irregular menstrual bleeding <input type="checkbox"/> Pain during or following intercourse <input type="checkbox"/> Lumps in breast or nipple discharge <input type="checkbox"/> Hot flashes <input type="checkbox"/> Menopause, Age _____ <input type="checkbox"/> Post-menopausal vaginal bleeding
Skin	Cardiovascular	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling or redness <input type="checkbox"/> Joint stiffness
<input type="checkbox"/> New skin rashes or moles <input type="checkbox"/> Changes to existing skin lesions	<input type="checkbox"/> Chest pain or tightness (angina) <input type="checkbox"/> Skipping heart beat (palpitation) <input type="checkbox"/> Trouble breathing when lying flat <input type="checkbox"/> Leg pain/cramps when walking <input type="checkbox"/> Swelling in legs	<i>Neurological</i> <input type="checkbox"/> Tingling <input type="checkbox"/> Tremors
Eyes	Respiratory	Musculoskeletal
<input type="checkbox"/> Diminished or blurred vision <input type="checkbox"/> Wear glasses or contact lenses <input type="checkbox"/> Last Eye Exam _____	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Persistent cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing	<i>Psychiatric</i> <input type="checkbox"/> Depression/ sadness <input type="checkbox"/> Feel like hurting someone or self <input type="checkbox"/> Anxiety
Ears, Nose, Mouth and Throat	Gastrointestinal	<input type="checkbox"/> Frequently suffer from allergic symptoms (such as itchy eyes, runny nose or sneezing) <input type="checkbox"/> Animal or food allergies
<input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Feeling of food stuck in throat or chest <input type="checkbox"/> Last Dental Exam _____	<input type="checkbox"/> Heartburn or sour taste in mouth <input type="checkbox"/> Constipation <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Blood in stool	<input type="checkbox"/> Swollen glands or lymph nodes <input type="checkbox"/> Easy bruising
Allergic/ Immunologic	Hematologic/Lymphatic	<input type="checkbox"/> Swollen glands or lymph nodes <input type="checkbox"/> Easy bruising
Preventive Medicine		
Colonoscopy: Date _____ Result _____		
Women: Last: Pap smear: _____ / _____ Breast Exam: _____ / _____ Mammogram: _____ / _____		
Men: Last: Rectal/Prostate exam: _____ / _____ Testicular exam: _____ / _____ PSA: _____ / _____		
Immunization History		
Flu: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	Pneumonia: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	
Tetanus: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	Hepatitis B vaccine: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	
Gardasil: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	Zoster/Shingles: <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ / _____	

Medical Information Release Form (HIPAA Release Form)

Name: _____
Last First

Date of Birth: ____/____/____

Release of Information

I, authorize the release of information including the diagnosis, record; examination rendered to me and claims information. This information may be release to:

- Spouse: _____
- Child(ren): _____
- Other: _____
- Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call:

my home: _____ my work: _____ my cell: _____

If unable to reach me:

- you may leave a detailed message.
- please leave a message asking me to return your call.
- other: _____

The best time to reach me is (day) _____
between (time) _____.

Signature (*patient/ legal representative*): _____ Date: _____

Relationship to patient (*if applicable*): _____

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Consent Form to Release/Receive Medical Records

Authorization for Release of Information

I, _____, DOB: _____

SSN: _____ Phone: _____

Address: _____

City/State/Zip: _____

do hereby give my consent and authorize _____ to release unto:

Nabil Keith M.D. LLC, 6002 Highway 53 East, Suite 100, Dawsonville, Georgia, 30534.

Medical Information contained in the medical record for the treatment dates: _____

The following information is requested for release of information:

- | | | |
|--|--|--|
| <input type="checkbox"/> H&P | <input type="checkbox"/> Consultations | <input type="checkbox"/> Pathology reports |
| <input type="checkbox"/> Imaging/ X-rays | <input type="checkbox"/> Lab | <input type="checkbox"/> Office notes |
| <input type="checkbox"/> Entire medical record | <input type="checkbox"/> Other _____ | |

This information may include, but is not limited to, treatment related to psychiatric or psychological, drug and/or alcohol, or Acquired Immune Deficiency Syndrome/HIV.

I understand that this information is to be disclosed for the following purpose and that purpose only: continuity of care.

I understand that this consent is subject to revocation by me at any time, and unless an earlier date is specified, the consent will automatically expire in 90 days after the date below. I also understand that this information may be bound by the Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records. Re-disclosure of this information to any other party other than the one listed is prohibited without any additional written consent on my part.

Signature (patient/ legal representative): _____ Date: _____

Relationship to patient (if applicable): _____

HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

INTRODUCTION

Nabil Keith M.D. is required by law to maintain the privacy of “protected health information”. “Protected health information” includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the healthcare you received, or payment for your healthcare.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected information for the purposes of treatment, payment and healthcare operations. For each category, we will explain what we mean and give some examples. However, not every use or disclosure will be listed.

Treatment means the provision, coordination or management of your healthcare, including consultations between healthcare providers regarding your care and referrals for healthcare from one healthcare provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Therefore, the doctor may review your medical records to assess whether you have potentially complicating conditions like diabetes.

Payment means activities we undertake to obtain reimbursement for the healthcare provided to you, including determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide to your health plan information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill your health plan for services rendered to you, we can provide them with the information regarding your care if necessary to obtain payment.

Health care operations means the support functions of our practice related to treatment and payments, such as quality assurance activities, case management, receiving and responding to patient complaints, physical reviews, compliance programs, audits, business planning, development management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your health information so that others can use this de-identification information to study health care delivery without learning who you are.

Signature (patient/ legal representative): _____

Date: _____

Relationship to patient (if applicable): _____