Nabil Keith M.D.

Family Medicine

6002 Highway 53 East Ste 100 Dawsonville GA. 30534

Phone 706.265.8002 Fax 706.429.0033

Registration Form

Patient Information

Name _____ Gender □ Male □ Female
Last First Middle

Date of Birth ____ / ____ / ____ Social Security # _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail _____

Marital Status: □ Married □ Single □ Widow □ Divorced □ Other _____

Employment □ Full Time □ Part Time □ Student □ Retired □ Other_____ Employer _____

Emergency Contact _____ Relation _____

Phone: Home _____ Work _____ Cell Phone _____

Pharmacy Information

Name _____ Phone _____ Fax _____

Address _____
Street City State Zip

Primary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Policy Holder _____ Relation to Patient _____ Date of Birth _____
Last First MI

Social Security #_____ Phone _____

Secondary Insurance Information

Insurance Company _____ Policy # _____ Group # _____

Responsible Party: If other than Patient, Please Complete

Person to bill _____ Relation to Patient _____ Social Security #_____
Last First MI

Address _____
Street City State Zip

Phone: Home _____ Work _____ Cell Phone _____

Nabil Keith M.D.

Family Medicine
6002 Highway 53 East Ste 100 Dawsonville GA. 30534
Phone 706.265.8002 Fax 706.429.0033

Name _____ Date of Birth _____ / _____ / _____
Last First

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 Medication or Other Substance □ No □ 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 □ Alive Age or DOB _____ □ Deceased Cause and age of death. _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, ⌝ Type 2 ⌐ Type 1 □ Coronary Heart Disease, Age Diagnosed _____ □ Stroke, Age Diagnosed _____ □ Prostate Cancer, Age Diagnosed _____ □ Colon Cancer, Age Diagnosed _____ □ Other, _____
Mother □ Alive Age or DOB _____ □ Deceased Cause and age of death. _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, ⌝ Type 2 □ Type 1 □ Coronary Heart Disease, Age Diagnosed _____ □ Stroke, Age Diagnosed _____ □ Colon Cancer, Age Diagnosed _____ □ Breast Cancer, Age Diagnosed _____ □ Ovarian Cancer, Age Diagnosed _____ □ Other, _____
Siblings Number of Brothers _____ Sisters _____	□ High Blood Pressure □ Elevated Cholesterol Levels □ Diabetes, ⌝ Type 2 ⌐ Type 1 □ Coronary Heart Disease, Age Diagnosed _____ □ Stroke, Age Diagnosed _____ □ Colon Cancer, Age Diagnosed _____ □ Breast Cancer, Age Diagnosed _____ □ Ovarian Cancer, Age Diagnosed _____ □ Prostate Cancer, Age Diagnosed _____ □ Other, _____
Children Number of Sons _____ Daughters _____	□ _____ □ _____ □ _____

Social History

Smoking:
Current Smoker □ No □ Yes Packs per Day _____ For How Many Years _____
Previous smoker □ No □ Yes Packs per Day _____ For How Many Years _____ Quite Date _____

Alcohol: □ No □ Social □ Yes How much and how often, Type _____

Marital Status: □Single Married Divorced Widowed Engaged

Occupation:

Review of Systems

Are you currently or regularly experience any of the following signs and symptoms (please check all that apply)

Constitutional
- □ Weight loss or gain
- □ Difficulty falling asleep
- □ Unrefreshed feeling after sleep
- □ Chronic fatigue

Skin
- □ New skin rashes or moles
- □ Changes to existing skin lesions

Eyes
- □ Diminished or blurred vision
- □ Wear glasses or contact lenses
- □ Last Eye Exam

Ears, Nose, Mouth and Throat
- □ Difficulty hearing
- □ Feeling of food stuck in throat or chest
- □ Last Dental Exam

Allergic / Immunologic
- □ Frequently suffer from allergic symptoms such as (Itchy eyes, runny nose or sneezing)
- □ Animal or food allergies

Hematologic / Lymphatic
- □ Swollen glands or lymph nodes
- □ Easy bruising

Endocrine
- □ Excessive thirst
- □ Excessive urination
- □ Heat or cold intolerance
- □ Diminished sexual drive

Cardiovascular
- □ Chest pain or tightness (angina)
- □ Skipping heart beat (palpitation)
- □ Trouble breathing when lying flat
- □ Leg pain / cramps with walking
- □ Swelling in legs

Respiratory
- □ Shortness of breath
- □ Persistent cough
- □ Coughing up blood
- □ Wheezing

Gastrointestinal
- □ Heartburn or sour taste in mouth
- □ Constipation
- □ Chronic diarrhea
- □ Changes in bowel habits
- □ Blood in stool

Genitourinary
- □ Blood in urine
- □ Urinary incontinence (leakage)

Men only
- □ Difficulty with erection
- □ Pain or mass in testicles
- □ Weak urine stream

Female only
- □ Heavy / irregular menstrual bleeding
- □ Pain during or following intercourse
- □ Lumps in breast or nipple discharge
- □ Hot flashes
- □ Menopause, Age _____
- □ Post menopausal vaginal bleeding

Musculoskeletal
- □ Joint pain
- □ Joint swelling or redness
- □ Joint stiffness

Neurological
- □ Tingling
- □ Tremors

Psychiatric
- □ Depression / sadness
- □ Feel like hurting someone or self
- □ Anxiety

Preventive Medicine

Colonoscopy: Date _____ Result _____

Women: Last: Pap smear: _____ / _____ Breast Exam: _____ / _____ Mammogram: _____ / _____

Men: Last: Rectal/Prostate exam: _____ / _____ Testicular exam: _____ / _____ PSA: _____ / _____

Immunization History

Flu: □ No □ Yes Date _____ / _____

Pneumonia: □ No □ Yes Date _____ / _____

Tetanus: □ No □ Yes Date _____ / _____

Hepatitis B vaccine: □ No □ Yes Date _____ / _____

Gardasil: □ No □ Yes Date _____ / _____

Zoster/Shingles: □ No □ Yes Date _____ / _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released 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 Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

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

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

HIPPA 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 infromation 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 infromation. 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 desclosure 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 access whether you have potentially complicating conditions like diabetes.

Payment means activities we undertake to obtain reimburesement for the healthcare provided to you, including determinations of eligibility and coverage and utilization review activites. 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 uour 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, casemangement, receiving and responding to patient complaints, physican reviews, compliance programs, audits, business planning, development management and administrative activities. For example, we may use your medical information to evaluate the performance of four staff when caring for you. We may also combine medical informationn about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In additon, we may remove information that identifies you from your health information so that others can use tuis de-identified information to study health care delivery without learining who you are.

Patient/Guardian Signature_____ **Date**_____