OSAMA ELSHAZLY, MD
REGISTRATION FORM

Today's Date____________ (PLEASE PRINT)

PATIENT INFORMATION

Name ________________________________ Birth date __________________ Age ________

Address ________________________________ City, State, Zip __________________________

Home Phone # ________________ Cell # __________________ Work # __________________

Email ____________________________ **SSN** __________________

▯ Male ▯ Female Status: ▯ Single ▯ Married ▯ Divorced ▯ Widowed ▯ Separated

Employer __________________________________ Occupation ________________________

Work Address ________________________________ City, State, Zip______________________

Emergency Contact ______________________ Relationship ___________ Phone __________

PRIMARY INSURANCE

Insurance Company ____________________ Policy # _________________ Effective Date _______

Name of Insured (Primary Member) _______________________________ **DOB**_________________

Insured's **SS#** ____________________________ Relationship to Patient ____________________

Insured's Address _____________________________ City, State, Zip________________________

Employer______________________________________ Occupation__________________________

Work Address ________________________________ Work phone #_______________________

SECONDARY INSURANCE

Insurance Company ___________________ Policy #_________________ Effective Date _________

Name of Insured ____ DOB_____________________

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to **Osama Elshazly, MD** all insurance benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges whether or not paid by insurance.* I hereby authorize Dr. Elshazly to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims and submissions.

______________________________	____________________	____________________
Patient or Guarantor Signature	Relationship to Insured	Date

)MPREHENSIVE MEDICAL HISTOF

GENERAL INFORMATION

NAME ____________________ DOB ______________ Today's Date ______________

Date of your last complete Physical Exam?	Date of your last Chest X-Ray?
Date of your last Cholesterol screening?	Date of your last Glucose / HgbA1C?
Date of your last Eye Exam?	Date of your last EKG?

MEDICATIONS

Please list all **prescription** or **over-the-counter medications**, **vitamins, herbs** or **nutritional supplements** that you are now taking. Please include the name, dosage amount, and how many times a day you take them. Use the back of the page if needed.

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

PHARMACY:

ALLERGIES:

PAST MEDICAL HISTORY (Circle those that apply)

AIDS or HIV	Chicken Pox	Measles	Rheumatic Fever
Cancer	Epilepsy	Mumps	Scarlet Fever
Blood or Plasma Transfusion	Infectious Mononucleosis	Polio	Whooping Cough

HOSPITAL / SURGICAL HISTORY

ILLNESS or OPERATION	DATES	ILLNESS OR OPERATION	DATES
1. ______________	______	1. ______________	______
2. ______________	______	2. ______________	______

FAMILY HISTORY (List relationship to you next to each condition)

Anemia ______________ Epilepsy ______________ High Blood Pressure______________
Asthma ______________ Glaucoma ______________Kidney Disease ______________
Obesity ______________ Leukemia ______________Thyroid Disease ______________
Cancer ______________ Depression ______________ High Blood Pressure ______________
Diabetes ______________ Heart Disease ______________Alcohol/Drug Abuse ______________
Stroke ______________ Lung Disease ______________ Bleeding problems ______________

PRESENT AGE or AGE AT DEATH: Mother _____ Father _____ Sisters (Alive) ________ Sisters (Deceased) ________
Brothers (Alive) ________ Brothers (Deceased) _______

SOCIAL HISTORY

Employed: Y N	Where?	Occupation?
Marital Status: S M D W	Exercise daily? Y N What type?	How often?
Smoker? Y N	I currently smoke: Cigarettes Cigars Pipe Other	# of years?
Former Smoker? Y N Year stopped:	Recreational Drugs:	How often?
Do you drink alcohol? Y N	How much / How often?	Do you wear a seatbelt? Y N
Do you have any risk factors for HIV infection? Y N	Have you ever been exposed to someone with TB? Y N	
Are you experiencing unusual stress? Y N	Explain:	
Are there any environmental risks involved in your job or home? Y N	Explain:	

WOMEN ONLY

Age of first period:____ Date of last period: __________ Regular: Y N Normal in flow: Y N Age at Menopause: ______ # of Pregnancies: ____ # of Children: ____ Types of Birth: # of Vaginal: ____ # of C-Section:_____ # of Premature: ______ # of Stillborn:____ # of Miscarriage:______ Describe any complications: ______________________________

____

Abnormal Breast Lumps? Y N Test Results:______________________________

PLEASE CHECK ALL THE CONDITIONS YOU *CURRENTLY* HAVE:

GENERAL
- ▯ Weight loss
- ▯ Weight gain
- ▯ Change in sleep patterns
- ▯ Constant fatigue

NEUROLOGICAL
- ▯ Anxiety
- ▯ Headaches
- ▯ Depression
- ▯ Meningitis
- ▯ Paralysis
- ▯ Seizures
- ▯ Stroke
- ▯ Tingling fingers or lips
- ▯ Tremors
- ▯ Memory Loss
- ▯ Fainting spells, dizziness
- ▯ Head injuries
- ▯ Blackouts / Near Blackouts
- ▯ Change in sensation anywhere in your body

CARDIOVASCULAR
- ▯ Angina
- ▯ Chest Pain
- ▯ Murmurs
- ▯ Cardiac Catheterization
- ▯ Congenital Heart Defects
- ▯ Heart Attacks
- ▯ Heart failure
- ▯ Irregular Heart rate
- ▯ Heart palpitations
- ▯ Purple fingers or lips
- ▯ Leg cramps
- ▯ Ankle swelling
- ▯ Cold hands or feet
- ▯ Leg pain that resolves with rest
- ▯ Waking at night, shortness of breath getting out of bed
- ▯ Dizziness when standing up
- ▯ Varicose veins
- ▯ High / Low Blood Pressure

GENITOURINARY
- ▯ Blood in urine
- ▯ Dribbling after urination
- ▯ Painful urination
- ▯ Involuntary urination
- ▯ Frequent urination
- ▯ Hesitant urination
- ▯ Excessive thirst
- ▯ Frequent bladder infections
- ▯ Kidney stones
- ▯ Kidney disease

MUSCULOSKELETAL
- ▯ Back or Neck Pain
- ▯ Joint pain or Bursitis
- ▯ Arthritis or Tendonitis
- ▯ Gout
- ▯ Joint swelling
- ▯ Muscle aches
- ▯ Morning stiffness
- ▯ Blood clots in legs / lungs
- ▯ Easy bleeding or bruising
- ▯ Anemia
- ▯ Abnormal blood clots
- ▯ Bone marrow biopsy

ENDOCRINE
- ▯ Diabetes
- ▯ Borderline Diabetes
- ▯ Sickle Cell
- ▯ Thyroid disease
- ▯ Rheumatism
- ▯ Abnormal body hair
- ▯ Increased loss of hair
- ▯ Changes in skin texture
- ▯ Cold temp intolerance
- ▯ Heat intolerance

GASTROINTESTINAL
- ▯ Diarrhea or constipation
- ▯ Black tarry stools
- ▯ Red blood after bowel movement
- ▯ Hemorrhoids
- ▯ Nausea / Vomiting
- ▯ Vomiting blood
- ▯ Abdominal pain
- ▯ Indigestion / Heartburn
- ▯ Problems swallowing
- ▯ Intestinal obstruction
- ▯ Hiatal hernia
- ▯ Ulcers
- ▯ Anal fissures
- ▯ Hepatitis A, B, C
- ▯ Liver disease

EYE / EAR / NOSE / THROAT
- ▯ Hay fever / Seasonal allergies
- ▯ Glaucoma
- ▯ Cataracts
- ▯ Double Vision
- ▯ Glasses / Contacts
- ▯ Other Eye Problems
- ▯ Ear Infections
- ▯ Hearing Loss
- ▯ Ear Discharge / Pain
- ▯ Tubes in Ears
- ▯ Ringing in Ears
- ▯ Sinus Infections
- ▯ Frequent Nosebleeds
- ▯ Swollen glands
- ▯ Polyps
- ▯ Goiter
- ▯ Hoarseness
- ▯ Sore Throat

RESPIRATORY
- ▯ Asthma / Wheezing
- ▯ Breathless when lying flat
- ▯ Shortness of breath
- ▯ Wheezing
- ▯ Pneumonia / Pleurisy
- ▯ URI / Bronchitis
- ▯ Prolonged cough
- ▯ Emphysema / COPD
- ▯ Coughing up blood

SKIN
- ▯ Acne / Boils / Abscesses
- ▯ Dry or Oily Skin
- ▯ Hives / Rashes / Psoriasis
- ▯ Shingles
- ▯ Excessive sweating/body odor
- ▯ Moles: Irregular or New
- ▯ Fungal infections

SEXUAL HEALTH
- ▯ Painful intercourse
- ▯ Loss of interest in sex
- ▯ Unprotected sex
- ▯ Groin Itching
- ▯ Sexually transmitted diseases

MEN ONLY
- ▯ Hernia
- ▯ Erection difficulties
- ▯ Bloody ejaculation
- ▯ Inability to finish intercourse
- ▯ Penile discharge
- ▯ Premature ejaculation
- ▯ Penis sores or warts
- ▯ Lump on testicle
- ▯ Testicular pain / swelling
- ▯ Prostate disease

WOMEN ONLY
- ▯ Abnormal bleeding between cycles
- ▯ Abnormal Pap Smear
- ▯ Bleeding after intercourse
- ▯ Vaginal discharge
- ▯ Vaginal dryness
- ▯ Vaginal warts
- ▯ Fibroids
- ▯ Endometriosis
- ▯ Ovarian cysts
- ▯ Pelvic inflammatory disease
- ▯ Post menopause symptoms
- ▯ Hot flashes or PMS
- ▯ Pregnancy complications
- ▯ D&C (Dilation & Curettage)
- ▯ Breast Discharge

PLEASE NOTE ANYTHING NOT LISTED THAT MAY BE HELPFUL FOR THE DOCTOR

____
____
____
____
____

________________________ ________________

Patient Signature ***Date***

NOTICE TO OUR PATIENTS

To serve you better, please be aware of our office policies. To reduce the cost to the doctor due to NO SHOWS or SAME DAY cancellations, a $25.00 fee will be applied to your account for any appointment not cancelled within a 24-hour time period after 3 of the no call/no shows. This is to be paid upon arrival at your next appointment. Along with your Co-pay or deductible fees.

We also charge a$30.00 for any paperwork without an appointment. $20.00 with an appointment. We will do our best to have it filled out and returned to you within a 72-hour time period. We will not be responsible for mailing any forms.

I, ______________________________ understand and acknowledge this policy.

Osama Elshazly, MD
2316 W. 23rd St. Ste A
Panama City, FL 32405
(850) 785-0085 office - (850) 785-0558 fax

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow among the multiple healthcare providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of this Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by
such restrictions.

Patient Name: ______________________________ DOB: ____________________
Relationship to Patient: ______________________________ Date: ____________________

OFFICE USE ONLY

Attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

____

____

Date ____________________ Auth. Initials _______

Osama Elshazly, MD
2316 W. 23rd St. Ste A
Panama City, FL 32405
(850) 785-0085 office
(850) 785-0558 fax

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: ________________________________ DOB: ____________________

ADDRESS: ____________________________________ City, State, Zip ______________

Receive Records From Previous Doctor:

____
Healthcare Provider / Facility

____
Address

____
City, State, Zip

____
Office phone # / Fax #

Release Records To:

Osama Elshazly, MD

2316 W. 23rd Street, Ste A
Address

Panama City, FL 32405
City, State, Zip

(850) 785-0085 tel / (850) 785-0558 fax
Office phone # / Fax #

Information to be released: One (1) year of Chart Notes, Medical History, Medication List, Psychiatric Care, Psychological Testing, Alcohol / Drug Abuse / Treatment; Two (2) years of Lab reports and Radiology reports.

Purpose of Disclosure:

- ☐ Further / Continuing Medical Care
- ☐ Legal
- ☐ Insurance
- ☐ Other

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Patient Rights Regarding this Disclosure:

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present to the office of Osama Elshazly, MD. I understand that revocation will not apply to information that has already been released. I understand that revocation will not apply to my insurance company when the law provides my insurer to a right to contest a claim under my policy. Unless otherwise revoked this authorization will expire one (1) year from the date signed.

____________________ ____________________ ____________________
Signature | Printed Name | Date

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Relationship to Patient (Self, Parent, Legal Guardian, etc.)