

FIRST VISIT: 1 - 3 hours NO antihistamines 72 hour prior to appointment

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Sex: F M

Address _____ Apt.# _____ City _____ State _____ Zip _____ County _____

Race: Caucasian African American Hispanic Asian Other _____ Language: _____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____ Send copy of notes to primary care phys.

Guardian's Status: Single Married Divorced Widowed Separated Student Status: PT FT

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ Retired?

Name of Spouse/Parent/Legal Guardian _____ DOB _____ SSN _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Emergency Contact: _____ Phone #: _____

I WILL BE PAYING BY: CASH CHECK CREDIT CARD

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Fort Wayne Medical Institute's notice of privacy practice.**

Responsible Party Signature: _____**Date:** _____

Patient Name: _____ DOB: _____ Date: _____

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

Drug Allergies? Or No Known Drug Allergies

Medication	Type of Reaction	Medication	Type of Reaction

Have you ever had an allergy test? Yes No

Have you ever taken allergy shots? Yes No

If yes, are you still taking them? Yes No How much relief from shots? minimal partial significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) None

Medication	Dosage	How often taken	Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone) _____

MEDICAL / SURGICAL HISTORY: HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

No Medical / Surgical History

Cardiovascular:

- Coronary Artery Disease _____
- Elevated Cholesterol (hyperlipidemia) _____
- High Blood Pressure (hypertension) _____

Gastrointestinal:

- Hepatitis _____
- Hernia _____
- Gastroesophageal Reflux _____

Genitourinary:

- Prostate enlargement (Benign Prostate Hyperplasia) _____
- Kidney Stones (Nephrolithiasis) _____
- Renal Failure (Acute) _____

Ear / Nose / Throat: (HEENT)

- Cataracts _____
- Glaucoma _____
- Chronic Ear Infections (Otitis Media) _____
- Hearing Loss _____
- Sinus Problems (chronic sinusitis) _____
- Nasal Polyps _____
- Nasal Allergies _____
- Recurrent Tonsillitis _____
- Tinnitus _____
- Vertigo _____

Hematologic :

- Anemia _____

Immunologic:

- Allergies Type: _____
- Food Allergies Type: _____

Infectious Disease:

- Mononucleosis _____
- STD Type: _____

Metabolic/endocrine:

- Diabetes Type: _____
- Thyroid deficiency (hypothyroidism) _____
- Thyroid excess (hyperthyroidism) _____

Neoplastic:

- Cancer Type: _____

Neurologic:

- Migraine _____

Obstetric:

- Pregnancy Date(s): _____

Psychiatric:

- Adjustment Disorder - Anxiety _____
- Major Depression _____

Pulmonary:

- Asthma _____
- COPD _____
- Emphysema _____
- Sleep Apnea _____
- Tuberculosis _____

If YES to any of the above Diagnosis was surgery performed?

What _____ Where/When _____ By Who _____

FAMILY HISTORY:

- | | | | | | |
|-------------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|
| ADD/ADHD | <input type="checkbox"/> | CVA (Stroke) | <input type="checkbox"/> | Learning disability | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Mental illness | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | Developmental delay | <input type="checkbox"/> | Migraines | <input type="checkbox"/> |
| Alzheimer's Disease | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Obesity | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | Osteoarthritis | <input type="checkbox"/> |
| Blood disease | <input type="checkbox"/> | Hearing deficiency | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> |
| CAD (Coronary Artery Disease) | <input type="checkbox"/> | Hyperlipidemia | <input type="checkbox"/> | PVD | <input type="checkbox"/> |
| CAD-Premature | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Renal disease | <input type="checkbox"/> |
| Cancer Type: _____ | <input type="checkbox"/> | Irritable Bowel Syndrome | <input type="checkbox"/> | Seizure disorder | <input type="checkbox"/> |

Other Family History: _____

Tobacco Use? Yes No Former

Do you consume alcohol? Yes No Former

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? Yes No

Caffeine Consumption? Yes No **Type:** _____ **Amount per day?** _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

- Fatigue
- Fever
- Night sweats
- Weight loss
- Weight gain

Eye problems

- Double vision
- Itchy eyes
- Redness

Ear problems

- Drainage
- Hearing loss
- Infections
- Dizziness
- Itchiness
- Exposure to Excessive Noise
- Ear pain
- Ringing /noise in ears

Nose & Sinus problems

- Congestion
- Facial Pain
- Mouth Breathing
- Nose Bleeds
- Sneezing
- Runny Nose
- Post Nasal Drainage

Mouth & Throat problems

- Difficulty Swallowing
- Sleep Apnea
- Snoring
- Sore Throat
- Hoarseness
- Sores/Ulcers in Mouth

Heart or circulation problems

- Heart Murmur
- Chest pain
- Swelling of Ankles/Edema
- Blacking Out
- Irregular Heartbeat/Palpitations

Lung or respiratory problems

- Cough
- Shortness of Breath
- Wheezing

Musculoskeletal:

- Leg pain

Stomach problems

- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

Brain or Nervous system problems

- Headache
- Seizures
- Focal Weakness
- Numbness

Glands & Hormone problems

- Heat Intolerance
- Cold Intolerance
- Neck Enlargement/Goiter

Blood or Lymph nodes problems

- Easy Bleeding
- Easy Bruising

Allergy problems

- Food Allergies
- Bee Sting Allergies
- Environmental Allergies
- Urticaria / Hives

Skin

- Itchy Skin/ Pruritis
- Rash
- Contact Allergy

Patient Name: _____

DOB: _____

Responsible Party Signature: _____

Date: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) AND DRIVERS LICNESE FOR YOUR FILE.

- **APPOINTMENTS** – 24 hours notice must be provided in the event you cannot keep an appointment.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. FAILURE TO PAY THESE FEES CAN CAUSE YOUR INSURANCE TO REFUSE PAYMENT ON YOUR ACCOUNT

- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Fort Wayne Medical for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please meet with our payment staff prior to office visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Fort Wayne Medical for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Fort Wayne Medical will not be involved with separation or divorce disputes.

I agree to pay for any and all balances due for services provided. If my balance is sent to collections, I agree to pay court costs, collection costs, 18% interest and reasonable attorney fees. This agreement is to stay in place until mutually discharged by both parties and all obligations are met

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____



HASSAN N TAKI M.D.

Preferred Pharmacy and History Request

As part of our electronic medical records system, we are now able to transmit perscriptions directly to your pharmacy or online vendor.

In order to do this, we will need to know your pharmacy preferences. While addresses are helpful, we can get by with approximate location of your preferred pharmacy.

Primary Pharmacy

Pharmacy _____ Street(s) _____ City _____ State _____

Secondary Pharmacy

Pharmacy _____ Street(s) _____ City _____ State _____

Online/Mail Order Pharmacy

Pharmacy _____ Web Address _____

Permission to Obtain Medications History Accept: Decline:

Patient Signature _____ Date _____

Release of Patient Records

For Fort Wayne Medical Institute (FWMI) to release any information about your or your child's medical records to any person, we must have on file that person's name, their relationship to you, their date of birth along with your signature.

This is accordance with federal HIPAA regulations concerning your privacy.

We are unable to release information without this signed authorization.

I _____ hereby authorize FWMI to release my medical information to the people listed on this form. I may revoke or modify this list at any time but it must be done in writing.

Patient Signature: _____ Date: _____

Persons I would allow information about my medical records:

NAME:	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____