PATIENT INFORMATION

Today's Date: / /

Patient Name (Last, Middle, First)		
Social Security #:	Male / Female:	Date of Birth: / /
Street Address:		
City:	State:	Zip:
Email Address:		
Home Phone:	Mobile Phone:	Work Phone:

IF THE PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING

Parent/Guardian Name:		
Social Security #:	Male / Female:	Date of Birth: / /
Home Phone:	Mobile Phone:	Work Phone:
Street Address:		
City:	State:	Zip:

PRIMARY INSURANCE ***Please provide a copy of your insurance card***

Insurance Name:		Telephone:
Insured Name (Last, Middle, First)		Date of Birth: / /
ID#:	Group#:	SS#: (Last 4)
Address to mail claims:		
City:	State:	Zip:

SECONDARY INSURANCE ***Please provide a copy of your insurance card***

Insurance Name:		Telephone:
Insured Name (Last, Middle, First)		Date of Birth: / /
ID#:	Group#:	SS#: (Last 4)
Address to mail claims:		
City:	State:	Zip:

Pharmacy #: Referring Physician:

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependents) have insurance coverage, and assign directly to **Leila G. Vizirov, M.D., P.A.** 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 my insurance; I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all insurance submissions, and authorization to receive and release my records.

Signature of responsible party: Date:

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PATIENT HISTORY AND HEALTH ASSESSMENT

Date: Patient Name: Date of Birth: / /

DRUG ALLERGIES

Are you allergic to any medications? YES / NO _____

If YES, Please list:

MEDICATION	REACTION

MEDICATION

Please list all the medications you are taking (Including over the counter)

MEDICATION	DOSE

ILLNESS

Indicate if you have had any of the following by entering the approximate date of diagnosis:
Month and year, if date of diagnosis is unknown, please indicate the approximate age of onset.

ILLNESS	DATE	ILLNESS	DATE
AIDS or HIV		HEPATITIS TYPE	
ANEMIA		HIGH BLOOD PRESSURE	
ALCOHOLISM		HIGH CHOLESTEROL	
ALLERGIES (other than medications)		KIDNEY DISEASE	
ANOREXIA/BULIMIA		LIVER DISEASE	
APPENDICITIS		LUNG DISEASE	
ARTHRITIS		MEASLES	
ASTHMA		MIGRAINE HEADACHE	
CANCER		MONONUCLEOSIS	
CHEMICAL DEPENDENCY		MUMPS	
CHICKEN POX		PNEUMONIA	
DEPRESSION		PSYCHIATRIC CARE	
DIABETES		RHEUCATIC FEVER	
EMPHYSEMA		RUBELA	
EPILEPSY/CONVULSIONS		SEXUALITY TRANSMITTED DISEASE	
KIDNEY/ BLADDER INFECTION		STOMACH ULSER	
GLAUCOMA, EYE DISEASE		STROKE	
GOUT		THYROID PROBLEMS	
LUNG INFECTION		TONSILITIS	
GALLBLADDER DISEASE		TUBERCULOSIS	
HEART DISEASE		WHOOPING COUGH	

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PATIENT HISTORY AND HEALTH ASSESSMENT

Date: Patient Name: Date of Birth: / /

SURGERIES / OPERATIONS

OPERATION DESCRIPTION	DATE

OTHER ILLNESS OR INJURIES	DATE

FAMILY HISTORY

Indicate if any of your blood relatives have or have had any of the following:

ILLNESS	RELATION	ILLNESS	RELATION
AIDS or HIV		GLAUCOMA EYE DISEASE	
ARTHRITIS		HEART DISEASE	
ASTHMA		HIGH BLOOD PRESSURE	
BLEEDING DISORDER		KIDNEY DISEASE	
BOWEL DISEASE		LUNG DISEASE	
CANCER		PSYCHIATRIC CARE	
CHEMICAL DEPENDENCY		STROKE	
DEPRESSION		THYROID PROBLEMS	
DIABETES		TUBERCULOSIS	
EPILEPSY/CONVULSIONS		OTHER (PLEASE LIST)	

SOCIAL HABITS

Have you ever used any of the following?

	CIRCLE ONE	FREQUENCY	FOR HOW LONG?	DATE STOPPED
ALCOHOL	Yes No	Drinks per week:		
CAFFEINE	Yes No	Ounces per day:		
TOBACCO	Yes No	Packs per day:		
STREET DRUGS	Yes No	Frequency:		
Type:				

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CONSENT TO TREATMENT

I consent to treatment as necessary and desirable for the care of the patient named, including, but not restricted to drugs, medications, immunizations, lab test or other surgical procedures which may be used by the physician or her qualified designed.

_____

Patient name (Please Print)

_____

Parent or Guardian name (Please Print)

_____ _____

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY INFORMATION PRACTICES

SECTION A: Patient to complete the following information.

I, _____ acknowledge and agree that

I have received a copy of the Notice of Privacy Practices for **LEILA G. VIZIROV, M.M., P.A.**

_____ _____
Patient signature Date

_____ _____
Patient legal representative (If applicable) Date

_____ _____
Print name of legal representative Relationship to patient

SECTION B: LEILA G VIZIROV, M.D., A.B.F.P. to complete the following information

LEILA G VIZIROV, M.D., P.A. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were to obtain the individual's written acknowledgement, written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtain.]

Date _____

Comment _____

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CONTACT PERMISSIONS

I hereby give permission for the staff of **LEILA G. VIZIROV, M.D., P.A.** to leave messages concerning my lab work, biopsy results, medications, appointments, or other medical information related to my condition, with the following:

PLEASE CHECK ALL THAT APPLY:

_____ My home answering machine
Telephone Number _____

_____ My work/mobile voice mail or answering machine
Telephone Number _____

_____ Family member: Spouse Child Parent Other (Name) _____
Telephone Number _____

_____ Housekeeper or Nanny
Telephone Number _____

_____ Secretary
Telephone Number _____

_____ I DO **NOT** give permission to the staff or physicians of **LEILA G. VIZIROV, M.D., P.A.** to release any medical information related to my condition, unless it is to me directly.

I can be reached at the following number

_____ _____
Patient name (Please Print) Date of Birth

_____
Parent or Guardian name (Please Print)

_____ _____
Signature Date

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