

Habib J. Khoury, M. D.
PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT REGISTRATION

Circle One:

Dr.

Mr.

Ms

Miss

DATE: _____

HOME #: _____

CELL: _____

E-Mail: _____

(Legal) Last Name

First

Middle Initial

Address

City, State

Zip

Social Security No. _____ Date of Birth: _____ Age: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____ Marital Status: _____

Please circle the source that referred you to our practice: doctor friend
newspaper ad magazine ad -----yellow pages -----Interfaith directory

Name, Social Security # and Birthdate of INSURED Person:

Name of Spouse: _____

Social Security # _____ Date of Birth: _____ Age: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Employer Phone: _____

Emergency Contact Name(person that does not live in your household):

Relationship to Patient: _____

Emergency Number: _____

MARK ANY SYMPTOMS OR ILLNESSES YOU HAVE EXPERIENCED

GENERAL:

- Fever
- Weight Loss/Gain
- Fatigue
- Depression
- Nervousness
- Trouble Sleeping
- Anxiety

ENDOCRINE:

- Thyroid Disease
- Diabetes

NECK:

- Swollen Glands
- Enlarged Thyroid

HEART:

- High Blood Pressure
- Heart Trouble/Disease
- Heart Attack
- Rheumatic Fever

URINARY:

- Difficulty Urinating
- Kidney Stones
- Kidney Disease

HEAD:

- Migrain Headaches
- Tension Headaches
- Head Injury

- Heart Murmur
- Chest Pain/Angina
- Palpitations
- Irregular Heart Beat
- Matrial Valve Prolapse

NEUROLOGICAL:

- Stroke
- Seizure
- Memory Loss
- Fainting

EYES

- Decreased Vision
- Wear Glasses/Contacts
- Pain
- Double Vision
- Dry Eyes
- Glaucoma
- Cataracts
- Frequent Irritation/Itching

LUNGS:

- Trouble Breathing
- Asthma
- Emphysema
- Pneumonia
- Tuberculoses
- Shortness of Breath

BLEEDING:

- Easy Bruising
- Excess Bleeding
- Anemia
- Blood Transfusion

LIVER:

- "Yellow" Jaundice
- Hepatitis

REPRODUCTIVE:

- Sexually Transmitted Disease
- Currently Pregnant

EARS

- Decreased Hearing
- Pain
- Drainage
- Noise/Tinnitus
- Balance Trouble/Vertigo

ARMS/LEGS:

- Pulmonary Embolism
- Arthritis
- Phlebitis
- Varicose Veins
- Raynaud's Phenomenon

SKIN:

- Dermabrasion
- Radiation Treatment
- Acne
- Chemical Peel
- Moles
- Other Skin Lesions

NOSE & THROAT

- Frequent Sore Throat
- Hoarseness
- Nasal Stuffiness
- Nasal Allergies
- Nose Bleeds
- Sinus Trouble
- Snoring

BACK:

- Back Aches/Stiffness
- Back Injury

DIGESTIVE:

- Trouble Swallowing
- Heartburn/Ulcer
- Frequent Nausea
- Frequent Vomiting
- Frequent Diarrhea
- Frequent Constipation
- Irritable Bowel

- Electrolysis
- Blotches
- Psoriasis
- Eczema

HABITS:

- Tobacco ___ pks per day
- Beer ___ Glasses per day
- Wine ___ Glasses per day
- Spirits ___ Glasses per day

PATIENT HEALTH HISTORY

NAME _____ DATE _____

WHAT IS THE PURPOSE OF THIS CONSULTATION?

PLEASE DESCRIBE YOUR CURRENT HEALTH STATUS AS:

EXCELLENT _____ GOOD _____ FAIR _____ POOR _____

ARE YOU CURRENTLY UNDER THE CARE OF A FAMILY PHYSICIAN OR INTERNIST? IF SO, PLEASE PROVIDE NAME, ADDRESS AND CONTACT PHONE NUMBER.?

PLEASE LIST AND DESCRIBE ANY SURGERIES OR SERIOUS ILLNESSES OR INJURIES, INCLUDING DATES

ANY KNOWN ALLERGIES TO MEDICATIONS INCLUDING OVER THE COUNTER DRUGS? (please list and describe reactions)

ANY KNOWN ALLERGIES TO YOUR SKIN (Adhesive tape, latex, lotions, etc.)

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING PRESCRIPTION, OVER THE COUNTER OR HERBAL/TEAS (Please do not omit anything as medications used during and after surgery may interact adversely)

MEDICATION	DOSAGE	FREQUENCY	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ARE YOU OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING:

- | | | | |
|-----------------------------------|---|--|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> LIBRIUM | <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> INDERAL |
| <input type="checkbox"/> ADVIL | <input type="checkbox"/> VALIUM | <input type="checkbox"/> KEFLEX | <input type="checkbox"/> VERAPAMI |
| <input type="checkbox"/> MOTRIN | <input type="checkbox"/> PERCOET | <input type="checkbox"/> OTHER ANTIBIOTICS | <input type="checkbox"/> OTHER 'BETA BLOCKERS' |
| <input type="checkbox"/> NUPRIN | <input type="checkbox"/> PERCODAN | <input type="checkbox"/> FEMALE HORMONES | <input type="checkbox"/> OTHER 'CALCIUM CHANNEL BLOCKERS' |
| <input type="checkbox"/> TYLENOL | <input type="checkbox"/> TRANQUILIZERS | <input type="checkbox"/> BIRTH CONTROL | <input type="checkbox"/> OTHER FISH OIL SUPPLEMENTS |
| <input type="checkbox"/> CODEINE | <input type="checkbox"/> ANTI-DEPRESSANTS | <input type="checkbox"/> DIURETICS | <input type="checkbox"/> MARINE OMEGA-3 FATTY ACIDS |
| <input type="checkbox"/> DEMEROL | <input type="checkbox"/> MORPHINE | <input type="checkbox"/> NEMBUTAL | <input type="checkbox"/> STEROIDS |
| <input type="checkbox"/> TENORMIN | <input type="checkbox"/> HERBALS/TEAS | | |

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Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE
WE ACCEPT Cash, Checks, Visa, MasterCard or American Express

Regarding Insurance:

We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. ***Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor.*** Please be aware that some, and perhaps all of the services provided may be non-covered services and not be considered reasonable and necessary under the Medicare Program and/or other medical insurance. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult Patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Surgery

Deductible, co-insurance and co-payments are due prior to surgery date, unless other arrangements have been made.

Patient Signature

Date

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IF YOU HAVE ANY INSURANCE COVERAGE, PLEASE COMPLETE THE FOLLOWING INFORMATION

Name & Birthdate of Insured Person: _____

PRIMARY INSURANCE

Name: _____
Mailing address: _____
Benefits Phone # (include area code) _____
Precertification/Authorization Phone# _____
Name of Insured: _____
Employer: _____
Employer's address: _____
Social Security # or Identification # _____ Group # _____
Relationship to Patient (please circle) self child spouse

SECONDARY INSURANCE

Name: _____
Mailing address: _____
Benefits Phone # (include area code) _____
Precertification/Authorization Phone# _____
Name of Insured: _____
Employer: _____
Employer's address: _____
Social Security # or Identification # _____ Group # _____
Relationship to Patient (please circle) self child spouse

Please sign both the authorization and the assignment:

INSURANCE AUTHORIZATION

I hereby authorize Habib Khoury, MD to furnish all necessary information including photographs to process my claim(s) for service(s) rendered from this date forward and concerning my illness and treatment to all of my insurance carriers. Also, I consent to this consultation and treatment and further consent to the release of my medical records upon request.

PATIENT SIGNATURE: _____ date _____

INSURANCE ASSIGNMENT

I hereby authorize payment of all medical benefits rendered to myself or my dependants to Habib Khoury, MD and understand that I am responsible for all remaining balances not covered by my insurance carrier. A copy of this signed authorization can be accepted as an original.

PATIENT SIGNATURE: _____ date _____

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**AUTHORIZATION TO RELEASE INFORMATION ABOUT
PATIENT'S CONDITION/TREATMENT**

Dear Patient:

In accordance with the Medical Privacy Act of Ohio, Physicians and/or staff are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care other than yourself, please complete the following authorization.

I hereby authorize Dr. Habib Khoury, MD, and/or staff to release information pertaining to my condition and/or care to only those family members and/or others involved with my care as listed below:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Patient's Signature	Date
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- If not signed by patient, please indicate relationship:**
- parent or guardian of minor patient under 12 years old
 - guardian or conservator of incompetent patient

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Ohio State Board of Medical Examiners.

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CONSENT FOR RELEASE OF PHOTOGRAPHS

I authorize Dr. Habib J Khoury and such assistants, and photographers as they may engage for this purpose, to take photographs of me as they may desire before, during and after the operation and to permit such photographs to be published in professional journals/books. This is for the purpose which they may deem fit in the interest of medical education, knowledge, or research

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of these images and/or my interview.

DATE _____

SIGNED by patient, parent, or guardian _____

NAME OF PATIENT _____

WITNESS _____

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority