PATIENT REGISTRATION FORM

First Name_____ Middle_____ Last Name_____

Address_____

City_____ State_____ Zip Code_____

Phone: Home(____)_____ Mobile (____)_____

Work(____)_____ Preferred Contact Number: H M W

E-Mail Address_____ Date of Birth _____

Social Security_____ Sex: M F Marital Status: S M D SO W

Race_____ Ethnicity_____ Preferred Language_____

Emergency Contact_____ Relationship_____

Address_____Phone_____

City_____ State_____ Zip Code_____

INSURANCE INFORMATION

Primary Insurance_____

Secondary Insurance_____

Consent to Treatment

I consent to be evaluated and treated by Marcy Galinsky, M.D. or Susan Yahia, D.O. I fully understand that I am directly responsible for all medical bills submitted for services rendered to me. I further understand that such payment is not contingent on any settlement or insurance payment.

Date_____ Signature_____

SUSAN YAHIA, D.O., F.A.C.O.I
Diplomate, American Osteopathic Board Of Internal Medicine

MEDICAL PATIENT INFORMATION

Social Security _____ Date _____

Name _____ Date of Birth _____ Age _____

Occupation _____ Birth Place _____ Religion _____ S M D W Significant other

How did you choose us for your care? _____

Reason for today's visit _____

_____

Serious or chronic Illnesses your have had or have:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past operations, injuries, hospitalizations:
1. _____
2. _____
3 _____

Medications and over-the-counter drugs currently or regularly used:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Additional:
_____
_____

Health care providers (name & specialty) seen in the past 2 years:
_____ Reason _____
_____ Reason _____
_____ Reason _____

PERSONAL CONCERNS

HAVE YOU RECENTLY NOTED:

YES	NO		YES	NO		YES	NO	
☐	☐	Severe headaches	☐	☐	Problems with sexual activity	☐	☐	Nausea/vomiting
☐	☐	Fainting	☐	☐	Problems urinating	☐	☐	Change in appetite
☐	☐	Dizziness	☐	☐	Pain in legs walking	☐	☐	Pain in abdomen
☐	☐	Weakness or Numbness of arm or leg	☐	☐	Joint pain	☐	☐	Change bowel habits
☐	☐	Ringing in ears	☐	☐	Sleep problems	☐	☐	Blood in stool
☐	☐	Double vision	☐	☐	Weight change	☐	☐	Change in mole
☐	☐	Tightness in chest	☐	☐	Hoarseness	☐	☐	Skin problems
☐	☐	Shortness of breath	☐	☐	Hernia	☐	☐	Other _____
☐	☐	Swelling						

TO BE ANSWERED BY FEMALES ONLY:

	YES	NO
Do you have regular monthly menstrual periods?	☐	☐
Do you have any problems with your periods?	☐	☐
Your last menstrual period _____		
Any possibility of being pregnant?	☐	☐
Have you ever had problems with a pregnancy?	☐	☐
Do you use contraception?	☐	☐
Have you had a discharge from a nipple?	☐	☐
Have you ever had lumps in your breast?	☐	☐

TO BE ANSWERED BY MALES ONLY:

	YES	NO
Have you ever had problems with your genitals. (private parts)?	☐	☐
Have you ever had a discharge from penis?	☐	☐
Have you ever had a hernia (rupture)	☐	☐
Have you ever had prostate trouble?	☐	☐
Do you use contraception?	☐	☐
Any history of sexually transmitted disease	☐	☐

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health Problems	Age at Death	Cause
Father				
Mother				
Brothers or Sisters				
Spouse or Significant Other				
Sons or Daughters				

HAS ANY BLOOD RELATIVE HAD:

Yes	No		Yes	No		Yes	No	
☐	☐	Alcoholism	☐	☐	Heart Disease	☐	☐	Migraine
☐	☐	Cancer	☐	☐	Thyroid Disease	☐	☐	Psychiatric Illness
☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Kidney Disease
☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐	Bleeding/Clotting Disorder
☐	☐	Arthritis/Rheumatoid	☐	☐	Ulcer	☐	☐	Other_____
☐	☐	Bowel Disease	☐	☐	Asthma			

IMMUNIZATIONS (Date)

Tetanus_____ Measles_____ Flu_____ Pneumovax _____
Hepatitis B_____ Mumps_____ Varicella (Chicken Pox) _____
Hepatitis A_____ Rubella_____ Polio_____

SCREENING TESTS (Most recent date and results)

	Date	Result		Date	Result
Mammogram	_____	_____	Colorectal Cancer Screen	_____	_____
Pap Smear	_____	_____	Prostate Exam	_____	_____
Cholesterol Level	_____	_____	EKG or Stress Test	_____	_____
TB Skin Test	_____	_____	Chest X-Ray	_____	_____
Dental Exam	_____	Dr._____	Bone Density	_____	_____
Eye Exam	_____	Dr._____			

DIET: (I am) (am not) satisfied with my weight
EXERCISE: I do_____ (Activity)_____times per Week / Month
SOCIAL HABITS: **Smoking:** I smoke / smoked_____ cigarettes / day for _____years. I quit smoking in _____.
Other tobacco products: _____.
Alcohol: I drink___ glasses / cans / shots or _____per day / week / month.
Drug use: I do / do not use recreational drugs.
HOBBIES: _____.
PETS IN MY HOME _____
I FEEL SAFE IN MY HOME: YES or NO
LIVING WILL: I know what an advance directive is. Yes ☐ No ☐ I have one. ☐ YES ☐ No

SUSAN YAHIA, D.O., F.A.C.O.I.
Diplomate, American Osteopathic Board of Internal Medicine
8700 N Kendall Drive Suite 105
Miami, Florida 33176
(305) 271-0878 Fax: (305) 271-8618

MEDICAL MALPRACTICE INSURANCE ACKNOWLEDGMENT

Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR, DR. SUSAN YAHIA HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. **This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.**

I,_____, have read and understand the above.
Patient's Name (Print)

_____ _____
Patient's Signature **Date**

_____
If minor, Parent's/Guardian's Signature

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

SUSAN YAHIA, D.O.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Susan Yahia, D.O. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Susan Yahia D.O. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Susan Yahia, D.O. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susan Yahia, D.O. at 8700 N Kendall Drive Suite 105, Miami, Florida 33176.

With this consent, Susan Yahia, D.O. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Susan Yahia, D.O. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Susan Yahia, D.O. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Susan Yahia, D.O. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Susan Yahia, D.O. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Susan Yahia, D.O. may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable

SUSAN YAHIA, D.O., F.A.C.O.I.

DIPLOMATE, AMERICAN OSTEOPATHIC BOARD OF INTERNAL MEDICINE

8700 N. KENDALL DR., SUITE 105
MIAMI, FLORIDA 33176
PHONE (305) 271-0878 FAX (305) 271-8618
SUSAN@DOCTORYAHIA.COM

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO:_____ DATE:_____

FAX/ADDRESS:_____

NAME OF PATIENT:_____ DOB:_____

ITEMS REQUESTED:_____

_____

_____

_____

Please release my medical records and information regarding my treatment, hospitalization, and/or outpatient care for my condition, including, but not limited to, psychological or psychiatric impairment, drug abuse, and or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), AIDS-related complex (ARC) and HIV antibody testing to:

SUSAN YAHIA, D.O.
8700 N KENDALL DR. SUITE 105
MIAMI, FL 33176
(305)271-0878 phone
(305)271-8618 fax
SUSAN@DOCTORYAHIA.COM

Signature_____ DATE:_____