# RENAMED LLC

PATIENT INFORMATION (PLEASE PRINT)

**Please read and complete the form in its entirety.**

| | |
|---|---|
| Last Name: | Date of Birth: |
| First Name: MI: | Sex: Marital Status: |
| Address Line 1: | E-mail: |
| Address Line 2: | Social Security: |
| City: | Employers Name: |
| State: Zip: | Work Number: |
| Home#: Cell#: | Primary Care Dr. |
| Race: Language of choice: | Referring Doctor: |
| Ethnicity: Hispanic / Latino ☐ Other: ☐ | Decline to report: ☐ |

**PHARMACY INFORMATION**

| | |
|---|---|
| **Preferred Pharmacy's #1** Name: | **Pharm#2** Name: |
| Pharmacy location: | Location: |

**(Statements will be addressed to the responsible party)**

| | |
|---|---|
| **Responsible Party Name:** | **Emergency Contact Name:** |
| Address: | Address: |
| Phone: | Phone: |
| Relationship: | Relationship: |

**INSURANCE INFORMATION**

| | |
|---|---|
| **PRIMARY INSURANCE:** | PHONE# |
| CLAIMS ADDRESS: | |
| POLICY# | GROUP# |
| POLICY HOLDER NAME: | BIRTHDATE: |

| | |
|---|---|
| **SECONDARY INSURANCE:** | PHONE# |
| CLAIMS ADDRESS: | |
| POLICY# | GROUP# |
| POLICY HOLDER NAME: | BIRTHDATE: |

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign payment directly to **Dr. Almakkee** I understand I am responsible for any uncovered fees. I grant permission to view my prescription history from external sources. I acknowledge receipt of notice of Dr. Almakkee's privacy practices.

Responsible Party's Signature: _____ Date_____

Please Print Name: _____

RENAMED LLC
Ammar Almakkee, MD
210 Jupiter Lakes Blvd, Bldg, 3000, Suite 201
Jupiter, FL 33458

## PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Dr. Almakkee deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature:_____ Date: _____

## HIPAA PRIVACY POLICY ACKNOWLEDGE STATEMENT

I have been informed that Dr. Almakkee has a privacy policy in place according to the health Insurance Portability and Accountability Act of 1996 (HIPPA). As a patient or parent / guardian of a patient of Dr. Almakkee understand the following:

Dr. Ammar Almakkee has a privacy policy in effect in our office.
Dr. Ammar Almakkee has made this policy readily available to me.
Dr. Ammar Almakkee has made me aware that I am entitled to a copy of this privacy policy if I desire a copy for my own personal records.

After reading the statements please sign at the bottom of this sheet, acknowledging that you have been advised of the privacy policy implemented by Dr. Almakkee and have read and understand the acknowledgment form. If you would like a copy of the privacy policy please asked for one at the front desk or print it from our website www.southtampaent.com.

☐ No, I do not want a copy of the policy, but I do acknowledge that it exists.

☐ Yes, I have requested and been given a copy of the privacy policy.

Signature:_____ Date: _____

## DESIGNATED RELATIVE

I Authorize Decision and Release of My General Medical Condition and Diagnosis (including treatment, payment and health care operations) with: ◯ Spouse ◯ Children ◯ Other_____
Please list the family members if any, We May Inform about Your Medical Condition, and/or in Case of an Emergency.

Name:_____ Relationship: _____ Phone Number: _____
Name:_____ Relationship: _____ Phone Number: _____

Messages May Be Left on My Answering Machine Regarding My Health & Appointments Made: ☐ Yes ☐ No

Print Name: _____ Signature:_____ Date: _____

RENAMED LLC

# CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____Date of Birth_____

Address:_____

Phone Number:_____Treatment dates from:_____to_____

I authorize: (enter your current physician's information)

_____

_____

_____

To release copies of my medical records to: (enter your new physician)

_____

_____

_____

I authorize release of information of the following portions of my medical record:

_____Mental Health _____HIV/AIDS

_____Substance Abuse _____Communicable Disease

_____All _____Only the following:_____

I understand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release RENAMED LLC from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (or legal representative)_____Date:_____

Relationship to Patient:_____Witness:_____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of thezzerson to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.

**RENAMED LLC**

# Patient Declaration of Communication Preferences

Patient Name: _____
Birthdate: _____ SS # _____

Our communications with you may include telephone calls made to your home phone, messages left on your answering machine or with the person answering your phone, and written correspondence (i.e., appointment reminders, statements) mailed to your home. We will only discuss information regarding your care with the individuals indicated below.

☐ I consent to the above methods for **RENAMED LLC**, to contact / communicate with me.

**-OR-**

☐ I have the following preferences (check all that apply)

- ☐ Call me at the following number ( do not call me at my home number).
- ☐ Do not leave a message on my answering machine.
- ☐ Do not leave a message with anyone answering my phone.
- ☐ Please send all mail to the following address, instead of my home address:
  - Street _____
  - City, State, Zip _____

**You may discuss my care only with the following people:**

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

I understand that the Physicians, Providers and Staff of **RENAMED LLC**, respect my right to privacy and will make reasonable efforts to accommodate these preferences, as outlined in the Notice of Privacy Practices that I received from **RENAMED LLC**

_____ _____ _____
Patient / Representative Date Name (if other than patient)

*This original form must remain in the patient's permanent record.*

Patient Name: _____ DOB: ___/___/_____ Date: ___/___/_____

**Briefly describe the reason for today's visit:** _____

Severity: *Mild* ☐ | *Moderate* ☐ | *Severe* ☐ Duration: _____

Male: ☐ | Female: ☐ Height: _____ weight: _____

## MEDICAL HISTORY

**Circle all that apply to you.**

| |
|---|
| Heart: High BP, Stroke, TIA |
| Pulmonary (Lung): Asthma, COPD, Emphysema |
| Hepatitis: - A, B or C |
| Thyroid Problems |
| Diabetes - Type I or Type II |
| Sleep Apnea |
| HIV / AIDS |
| Reflux (GERD) |
| Cancer (Indicate site and type) |
| |
| Other not listed |
| |

☐ **Check here if NO items above apply to you**

## SURGICAL HISTORY

**Circle all that apply to you**

| |
|---|
| Ear Surgery |
| Tonsils |
| Adenoid |
| Deviated Nasal Septum |
| Sinus Surgery |
| Thyroid Surgery |
| Vocal Cord Surgery |
| Tracheotomy |
| Heart: Bypass, heart valve, carotid artery Pacemaker |
| |
| Other not listed |
| |
| |
| |
| |

☐ **Check here if NO items above apply to you**

## ALLERGIES

| *ALLERGIES TO MEDICATIONS:* | *REACTION:* |
|---|---|
| ☐ **I have NO allergies to medications** | |
| | |
| | |
| | |
| | |

## SOCIAL INFORMATION AND HABITS

| | |
|---|---|
| Do you currently smoke? | ◯ Yes ◯ No |
| How much per day? | How many years? |
| If you quit smoking when? | |
| How much did you smoke? | How many years? |
| Do you drink alcohol? | ◯ No ◯ Yes |
| If YES how much? | |

## FAMILY HISTORY

| Has any family member had any of the following | Which Family Member |
|---|---|
| Heart attack | |
| Heart stents | |
| High blood pressure | |
| Asthma | |
| Emphysema or COPD | |
| Thyroid problems | |
| Diabetes | |
| Sleep apnea | |
| Parkinson's; Tremor | |
| Bleeding disorder | |
| Cancer (Site and type) | |
| | |

## HAVE YOU BEEN PREVIOUSLY HOSPITALIZED

If YES please explain:

**RENAMED LLC**
**Ammar Almakkee, MD**
**210 Jupiter Lakes Blvd**
**Bldg, 3000, Suite 201**
**Jupiter, FL 33458**

# MEDICATIONS, REVIEW OF SYSTEMS

Patient Name:_____ DOB: : ____/____/_____ Date: ____/____/_____

## MEDICATIONS

**Please list ALL medications that you take, with dosage and how often you take each one. (Include non-prescription medicines.)**

☐ **I DO NOT use any medications regularly**

## REVIEW OF SYSTEMS

| Do YOU currently **HAVE** any problems with: | Have you **HAD** any problems with: |
|---|---|
| ☐ Weight gain or loss? | ☐ Depression? |
| ☐ Sleep problems? | ☐ Anxiety |
| ☐ Hearing loss or other ear problems? | ☐ Vision or eye system? |
| ☐ Nasal congestion or discharge? | ☐ Abdominal pain, indigestion, changes in bowel habits, jaundice or other abdominal symptoms? |
| ☐ Mouth pain, ulcers, or sore throat? | |
| ☐ Hoarseness? | ☐ Immune system or swollen nodes? |
| ☐ Heartburn or acid taste in mouth or throat? | ☐ Fainting spells, weakness of arms or legs, seizures or other neurological symptoms? |
| ☐ Swallowing problems? | |
| ☐ Persistent cough? | |
| ☐ Wheezing? | |
| ☐ Shortness of breath? | |
| ☐ Chest pains or palpitations? | |
| ☐ Anemia or bleeding problems? | |
| ☐ If female, pregnant? | |

**If YES to any items in either column, please describe:**

**RENAMED LLC**
**Ammar Almakkee, MD**
**210 Jupiter Lakes Blvd**
**Bldg, 3000, Suite 201**
**Jupiter, FL 33458**

Signature:_____