Moazzam W Habib MD PC, Inc.

Consent for Purposes of Treatment, Payment and Healthcare Operations

By signing this document, I, ______, consent to the use or disclosure of my protected health information by Dr. Habib and his Office for the purpose of diagnosing or providing treatment to me, coordinating my care with other physicians/healthcare facilities, obtaining payment for the services rendered to me or for the basic healthcare operations of Moazzam W Habib MD PC., Inc. I understand that diagnosis and treatment of me by Dr. Habib may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed. I understand it is my responsibility to advise the office staff in writing as to whom has permission to receive my protected health information.

I have the right to revoke this consent, in writing, at any time, with the exception, that Dr. Habib has already disclosed my information due to prior consent.

My protected health information consists of health information including demographic information, collected for me and created or received by my physician or other healthcare provider, health plan, my employer or a healthcare clearinghouse. This protected healthcare information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe it may identify me.

Printed Name of Patient

Signature of Patient or Guardian

Patient Name:_____

DOB:_____

Personal History

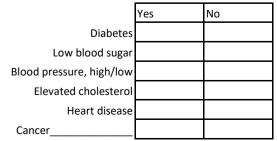
Have you ever had	Yes	No		Yes	No
Diabetes			Stroke		
Low blood sugar			cancer		
High/low blood pressure			Bone disease		
High cholesterol			High calcium		
Thyroid disease			Sexual dysfunction		
Heart disease			Adrenal disease		
			Kidney stones		
Surgeries: Y Yes N No	lf yes, pl	ease list what kind o	of surgery and when:		

Current Medications and dosage:

Medication name:		Dosage/F	requency:	Medication name	<u>e:</u>	Dosage/Frequency:
Allergies: Yes	No	lf yes, ple	ase list what you a	are allergic to:		
What kind of work do yo	u do?					
Do you smoke:	Yes	No	What kind - (Cigarettes P	lipe	Cigar
If yes, how much?			Duration?			
Do you drink alcohol?	Yes	No				
If yes, how much?			Duration?			

Family History

Please list with M-Maternal side or P-Paternal side



	Yes	No
Stroke		
Thyroid disease		
Adrenal disease		
High calcium		
Bone disease		
Kidney stones		

PATIENT REGISTRATION FORM

Patient Name:	Date of Birth:				
(Last)	(First)	(MI)			
Address:	City:	ST:	Zip Code:		
Home Phone:	Work Phone:	Cell Pho	Cell Phone:		
Social Security Number:	Marital S	Status ()Single ()Marrie	ed ()Divorced ()Widowed		
Email Address:	Name of Employer:				
Employer Address:	Phone # :				
Emergency Contact:					
Name:	Phone Number:	א <u>ַ</u>	Relationship:		
Responsible Party:					
Name:	Phone Number:	<u>م</u>	Relationship:		
Address:	City:	ST:	Zip Code:		
Primary Care Physician:					
Name:	Phone Number:				
Address:	City:	ST:	Zip Code:		
Referring Physician:					
Name:	Phone Number:				
Address:	City:	ST:	Zip Code:		
Primary Insurance Information:					
Name of Insurance Company:	A	ddress:			
ID#:GI	oup#:				
Name of Insured:	Relationship to In	nsured: ()Self ()Spouse	()Child ()Other:		
Insured's DOB:	Insured's Social Security I	Number:			
Secondary Insurance Information	n:				
Name of Insurance Company:	A	ddress:			
ID#:GI	oup#:				
Name of Insured:	Relationship to Ii	nsured: ()Self ()Spouse	()Child ()Other:		
Insured's DOB:	Insured's Social Security I	Number:			
By signing below, I acknowledge I h	ave read the Notice of Privacy P	olicy. I authorize the rele	ase of any medical informatio		

By signing below, I acknowledge I have read the Notice of Privacy Policy. I authorize the release of any medical information necessary to process my insurance claims filed on my behalf. I also authorize payment of my medical benefits for my filed claims to be made directly to Moazzam W Habib MD.

Signature of Patient or Responsible Party