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

____

Date

Patient Name:____DOB:________________

Personal History

Have you ever had…	Yes	No
Diabetes		
Low blood sugar		
High/low blood pressure		
High cholesterol		
Thyroid disease		
Heart disease		

	Yes	No
Stroke		
cancer		
Bone disease		
High calcium		
Sexual dysfunction		
Adrenal disease		
Kidney stones		

Surgeries: Y Yes N No If yes, please list what kind of surgery and when: ______________________

____

Current Medications and dosage:

Medication name:	Dosage/Frequency:	Medication name:	Dosage/Frequency:

Allergies: Yes No If yes, please list what you are allergic to:_____________________________

____

What kind of work do you do?____

Do you smoke: Yes No **What kind** - Cigarettes Pipe 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
Diabetes		
Low blood sugar		
Blood pressure, high/low		
Elevated cholesterol		
Heart disease		
Cancer______________		

	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 Phone:____________________

Social Security Number:______________________Marital Status ( )Single ( )Married ( )Divorced ( )Widowed

Email Address: ________________________________ Name of Employer:_______________________

Employer Address:____________________________________Phone # :________________________

Emergency Contact:

Name:________________________Phone Number:_______________________Relationship:______________

Responsible Party:

Name:________________________Phone Number:_______________________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:_________________________Address:__________________________________

ID#:___________________Group#:_________________ __________________________________

Name of Insured:______________________ Relationship to Insured: ( )Self ( )Spouse ( )Child ( )Other:_________

Insured's DOB:__________________ Insured's Social Security Number:______________________

Secondary Insurance Information:

Name of Insurance Company:_________________________Address:__________________________________

ID#:___________________Group#:_________________ __________________________________

Name of Insured:______________________ Relationship to Insured: ( )Self ( )Spouse ( )Child ( )Other:_________

Insured's DOB:__________________ Insured's Social Security Number:______________________

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 Date