Regal Pediatrics Patient Information

Dr. M. Elghoroury, MD

Patient Information

Name_____Birthdate_____Sex_____
Address_____City_____State____Zip_____

SSN#_____-_____-_____

How did you hear about us?_____

Preferred Contact #_____Whose # is this?_____Home/Work/Cell

Emergency Contact(s)

Name_____ Relationship_____Phone_____
Name_____ Relationship_____Phone_____

Employer Information

Are you currently employed? _____

Name of Employer:_____ Phone number _____

Employer Address

_____
_____

Insurance Information

PRIMARY INSURANCE: COMPANY NAME: _____
MEMBER ID #: _____ GROUP #: _____

SECONDARY INSURANCE: COMPANY NAME:_____
MEMBER ID #: _____ GROUP #: _____

It is our policy that you inform us of all insurance information. If you fail to inform our staff, charges may apply.

I hereby authorize Regal Pediatrics to release any information acquired in the course of my examinations or medical treatment to my insurance company. I also understand that I am personally responsible for any and all copays, deductibles, and/or non-covered services incurred by myself and not payable by insurance.

SIGNATURE: _____ DATE: _____

Regal Pediatrics Patient History Information

Medical History

1. List allergies, including allergic reactions to drugs_____
2. List any hospitalizations, surgeries and/or serious illnesses and the corresponding dates._____
_____
3. Any significant trauma (car accidents, falls etc..)_____
_____
4. List any medications you are taking and their doses_____
_____
5. Do you smoke cigarettes? If yes, how many per day?_____
6. Are you sexually active? If yes, do you think you are pregnant?_____

Family History

Has anyone in your family (parents, grandparents, sisters/brothers, aunts/uncles) had any of the following?

High/ Low blood pressure	Yes ☐ No ☐	If yes, who?_____
Diabetes	Yes ☐ No ☐	If yes, who?_____
Hearing loss	Yes ☐ No ☐	If yes, who?_____
Kidney problems	Yes ☐ No ☐	If yes, who?_____
Alcohol/Drug abuse	Yes ☐ No ☐	If yes, who?_____
Seizures	Yes ☐ No ☐	If yes, who?_____
Psychological Problems	Yes ☐ No ☐	If yes, who?_____
Exposure to TB, STI or HIV	Yes ☐ No ☐	If yes, who?_____
Heart disease	Yes ☐ No ☐	If yes, who?_____
Mental illness	Yes ☐ No ☐	If yes, who?_____
Cystic fibrosis	Yes ☐ No ☐	If yes, who?_____
Cerebral palsy	Yes ☐ No ☐	If yes, who?_____
Speech problems	Yes ☐ No ☐	If yes, who?_____
Birth defects	Yes ☐ No ☐	If yes, who?_____
Asthma	Yes ☐ No ☐	If yes, who?_____
Learning problems/ attention deficit disorder	Yes ☐ No ☐	If yes, who?_____
Family violence	Yes ☐ No ☐	If yes, who?_____

Is there any other family history not listed above that you would like Dr. Elghoroury to be aware of?

_____

HIPAA Authorization & Consent Form

Regal Pediatrics has taken measures to protect all of our patient's medical information. We will not release any information to anyone unless you have provided the requested information below. These would include people other than what is allowed through HIPAA. **The Health Insurance Privacy & Accountability Act** does allow us to release information to outside entities on your behalf. These would include: your insurance company, your pharmacy, and another medical office when making appointments or hospitals.

Please see medical staff at the front desk with any questions prior to signing this authorization form.

I, _____, authorize the person(s) listed below to obtain medical information about myself. I understand that Regal Pediatrics is not responsible for the information provided as long as it was given to the authorized person(s) listed below.

I fully understand the HIPAA policy and its contents.

1. Name: _____D.O.B:_____ Relationship:_____
2. Name: _____D.O.B:_____ Relationship:_____
3. Name: _____D.O.B:_____ Relationship:_____
4. Name: _____D.O.B:_____ Relationship:_____

Patient's signature: _____Date:_____

I, _____, **do not** authorize Regal Pediatrics to release any of my protected medical information to anyone other than the entities protected by **HIPAA**.

I fully understand the HIPAA policy and its contents.

Patient's signature: _____Date:_____

You have the right to obtain copies of your medical information for an applied fee based on the circumstances (accept in the case of an emergency) please allow our office staff to retrieve all information within 5-7 business days.