

MEDICAL INFORMATION

DATE OF LAST HEALTH CARE EXAMINATION _____

REASON _____

LAST HOSPITALIZATION _____

REASON _____

Do you have or have you ever had:

- | | | |
|--|---|--|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> JAUNDICE/HEPATITIS | <input type="checkbox"/> CANCER (TYPE) _____ |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HIATAL HERNIA (REFLUX) | <input type="checkbox"/> EPILEPSY/NEUROLOGICAL DISEASE |
| <input type="checkbox"/> ABNORMAL BLOOD PRESSURE | <input type="checkbox"/> PEPTIC ULCER (STOMACH) | <input type="checkbox"/> ARTHRITIS/JOINT PAIN |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> BOWEL DISEASE | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> ANXIETY/DEPRESSION |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> URINARY INFECTIONS | <input type="checkbox"/> SLEEP PROBLEMS |
| <input type="checkbox"/> WEIGHT LOSS/GAIN | <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> MENTAL ILLNESS |
| <input type="checkbox"/> HEADACHES DISEASE | <input type="checkbox"/> ANEMIA/BLOOD DISORDER | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> VASCULAR DISEASE | <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SKIN DISEASE | <input type="checkbox"/> HEART PALPITATIONS |

Social History:

Smoking _____ Cig./Day _____ # Years _____

Alcohol _____ oz/week _____

Coffee _____ Cups/Day _____

Street Drugs _____

Are you taking any medication, if so which ones? _____

Are you allergic to any medication, drugs, local anesthetic? _____

Are there any physical conditions we should know about? _____

Name of your physician _____ Phone _____

May we request your medical records, if needed? Yes No

Women

Are you pregnant? Yes No

Not All Services Rendered by Dr. Munasifi Are Covered By Insurance Companies.

It is the patients responsibility to secure the necessary preauthorization that his/her insurance company may require for treatment. Dr. Munasifi's staff will assist by answering inquiries received. Since insurance companies have various restrictions for medical treatment, it is the patients obligation to make sure that all requirements have been satisfied and accept the liability for any losses if this is not accomplished.

I authorize Talal A. Munasifi, M.D., P.C. to furnish any medical information necessary to process my insurance claims, including photographs. I authorize that insurance payments be made directly to Dr. Munasifi unless the services were paid in advance. I realize that my insurance carrier may not pay 100% of expenses incurred and I accept full responsibility for an balance due. I further agree to send full payment within 30 days after having received a statement.

Signed: _____ Date: _____

Relationship: _____
(If not signed by patient)