DATE: _____

PATIENT PROFILE FORM

PRINT ALL INFORMATION CLEARLY

. **I**. Patient's Last Name: First Name: D.O.B.: / /

Insured's Last Name: First Name: D.O.B.: / /

Street Address:` City: State: Zip:

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

Emergency Contact Name: Relationship: Phone: ( )

Married: Single: Student: Male: Female: E-mail:

Patient's SS:# No: Insured's SS:# No: Relationship: Self Spouse Child

II. Primary Insurance Company name: Primary Insurance ID #:

Please initial to allow us to contact you via email or text messaging : _____

III. REFERRING PROVIDER INFORMATION:

Referring Doctor : Phone: Fax:

Street Address: City:

State: Zip:

Medical Doctor (PCP): Phone: Fax:

Street Address: City: State: Zip:

IV. EMPLOYER (Current):

Occupation: Phone: Fax:

PHARMACY NAME: RX PHONE #:

PATIENTS HEALTH HISTORY

Please Answer ALL of the questions below to the best of your knowledge.

Your health is extremely important to us. In order for us to help you, we need your medical history.

PATIENT'S NAME (PRINT) _____ **TODAY'S DATE** _____

AGE _____ **DATE OF BIRTH** _____ **PATIENT SS#**_____

DATE OF LAST PHYSICAL EXAMINATION _____ **DOCTOR** _____

PATIENT'S HEIGHT_____ **PATIENT'S WEIGHT:**_____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

Please be as specific about the reason for your visit.

_____

_____

How long have you had this problem? _____

Have you had any previous treatment for this problem? _____

If YES, when and by who were you treated? Date _____

Doctor who treated you _____

HEALTH HABITS

Please check which substances you use and describe how much you use.

Do you Smoke? _____ **YES** _____ **NO** How much? _____

Do you drink Alcohol? _____ **YES** _____ **NO** How much? _____

Do you drink Coffee? _____ **YES** _____ **NO** How much? _____

Do you take Hormones?_____ **YES** _____ **NO** How much? _____

Do you take Birth Control _____ **YES** _____ **NO** What type? _____

Do you take Drugs? (Un-prescribed) _____ **YES** _____ **NO** What type? / How much? _____

Psychiatric Diagnosis _____ **YES** _____ **NO**

OCCUPATIONAL CONCERNS

What is your Occupation? _____

Please check if your work exposes you to any of the following:

Hazardous Material _____ Stress _____ Heavy Lifting _____ Other _____

Please check any of the following conditions *YOU HAVE OR HAVE HAD* in the past.

____ AIDS ____ Alcoholism ____ Anemia ____ Anorexia ____ Appendicitis ____ Arthritis ____ Asthma ____ Bleeding Disorders ____ Breast Lump ____ Bronchitis ____ Bulimia ____ ***CANCER*** ____ Cataracts	____ Chemical Dependency ____ ***CHICKEN POX*** ____ Diabetes ____ Emphysema ____ Epilepsy ____ Glaucoma ____ Goiter ____ Gonorrhea ____ Gout ____ Heart Disease ____ Hepatitis ____ Hernia ____ Herpes	____ High Cholesterol ____ HIV Positive ____ Kidney Disease ____ Liver Disease ____ ***MEASLES*** ____ Migraine Headaches ____ Miscarriage ____ Mononucleosis ____ Multiple Sclerosis ____ ***MUMPS*** ____ Pacemaker ____ Pneumonia ____ Polio	____ Prostate Problem ____ Psychiatric Care ____ Rheumatic Fever ____ ***SCARLET FEVER*** ____ Stroke ____ Suicide Attempt ____ Thyroid Problems ____ Tonsillitis ____ Tuberculosis ____ Typhoid Fever ____ Ulcers ____ Vaginal Infections ____ Venereal Disease

WHAT TYPE OF CANCER:

Please check any of the following symptoms *YOU HAVE EXPERIENCED* over the past year.

General

____ Chills
____ Depression
____ Dizziness
____ Fainting
____ Fever
____ Forgetfulness
____ Frequent Colds
____ Headaches
____ Loss of Sleep
____ Loss of Weight
____ Nervousness
____ Numbness
____ Sweats
____ Weight Gain

Muscle / Joint / Bone

Pain, Redness. Swelling, Weakness, or Numbness

____ Arms
____ Back
____ Feet
____ Hands
____ Hips
____ Legs
____ Neck
____ Shoulders

Genital - Urinary

____ Blood in Urine
____ Frequent Urination
____ Genital Sores
____ Lack of Bladder Control
____ Painful Urination
____ Urinate to little
____ Urinary Infections
____ Urinary Dribbling
____ Uncontrollable Wetting
____ Venereal Disease

Gastrointestinal

____ Abdominal Pain
____ Abnormal Stool
____ Appetite Poor
____ Bloating
____ Change in Bowel Habits
____ Constipation
____ Difficulty Belching
____ Difficulty Swallowing
____ Diarrhea
____ Excessive Belching
____ Excessive Hunger
____ Excessive Thirst
____ Gas
____ Heartburn
____ Hemorrhoids
____ Indigestion
____ Jaundice
____ Nausea
____ Rectal Bleeding
____ Spitting up Blood
____ Stomach Pain
____ Vomiting
____ Vomiting Blood

Last Colonoscopy?

_____

Cardiovascular

____ Chest Pain (any)
____ Fainting Spells
____ Heart Murmurs
____ Heaviness in Chest Area
____ High Blood Pressure
____ Irregular Heart Beat
____ Low Blood Pressure
____ Palpitations
____ Poor Circulation
____ Rapid Heart Beat
____ Swelling of Ankles/ Legs
____ Varicose Veins / Pain

Respiratory

____ Blood in sputum
____ Cough (Time of day)

_____

____ Difficulty Breathing

When?_____
____ Fever or Night Sweats
____ Pain (Where Describe)

_____

____ Respiratory Infections
____Shortness of Breath
____ Tuberculosis
____ Wheezing

Eye, Ear, Nose, Throat

____ Bleeding Gums
____ Blurred Vision
____ Crossed Eyes
____ Dentures
____ Difficulty Swallowing
____ Double Vision
____ Earaches
____ Ear Discharge
____ Hay Fever
____ Hoarseness
____ Loss of Hearing
____ Neck Stiffness
____ Nosebleeds
____ Persistent Cough
____ Ringing in Ears
____ Sinus Problems
____ Thyroid Lump / Mass
____ Vision-Flashes
____ Vision-Halos
____ Vision Problems

Skin

____ Bruise Easily
____ Change in Moles
____ Change in Pigmentation
____ Change in Nails
____ Change in Hair Growth
____ Change in Hair Loss
____ Dryness
____ Hives
____ Itching
____ Moisture
____ Rash
____ Scares
____ Sore that do not heal

MEN Only

____ Breast Lump
____ Breast Tenderness
____ Erection Difficulties
____ Lump in Testicles
____ Penis Discharge
____ Sore on Penis
____ Swelling
____ Other

_____

WOMEN Only

____ Abnormal Pap Smear
____ Bleeding Between Periods
____ Breast Lump
____ Extreme Menstrual Pain
____ Hot Flashes
____ Nipple Discharge
____ Painful Intercourse
____ Swelling
____ Tenderness in Breast
____ Vaginal Discharge
____ Other

_____

FAMILY HISTORY

This is VERY IMPORTANT!!! **Please provide us with your *Family's* health history.**

Please check if your BLOOD RELATIVES have had any of the following: ***(Kindly indicate who)***
M- Mother / **F**- Father / **S**- Sibling / **GF-GM** - Grandparent

____ Arthritis / Gout
____ Asthma /Hay Fever
____ Cancer
____ Chemical Dependency
____ Diabetes
____ Heart Disease, Stroke
____ High Blood Pressure
____ Kidney Disease
____ Tuberculosis
____ Other
_____

	Living	Deceased	State of Health	Age at Death	*CAUSE OF DEATH*
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____

CANCER HISTORY :

Did any Parent, Sibling or Grand Parent have Cancer ? **M**- Mother / **F**- Father / **S**- Sibling / **GF-GM** - Grandparent

_____THYROID _____BREAST _____COLON _____OVARIAN _____UTERINE _____PROSTATE _____ LUNG

-

HOSPITALIZATIONS

Have you ever been in the hospital ? _____ **YES** _____ **NO**

Reason for Hospitalization & Outcome **Year** **Hospital**

_____/ _____ /
_____

_____/ _____ /
_____

Have you ever had a Blood Transfusion ? _____ **YES** _____ **NO**

If **YES**, Please give approximate dates:
_____

SERIOUS ILLNESSES / INJURIES **DATE** **OUTCOME**

_____ _____
_____

_____ _____
_____

PLEASE LIST ANY *MEDICATIONS* YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____
_____
_____
_____
_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR HAVE OTHER ALLERGIES ? ____ ***YES*** ____ ***NO***

If YES, Please indicate: _____ _____

_____ _____

FEMALE PATIENTS - PERSONAL HISTORY

GYNECOLOGICAL EXAMINATIONS

When was your last **GYN EXAM**? _____

When was your last rectal exam? _____

When was your last period? _____

How old were you at the onset of your first period ?
_____

Are you presently on birth control ? ____YES ____NO

How Long ? _____

Have you ever taken drugs for fertility ? ____YES ____NO

Do you have any children ? ____YES
____NO

Your age at first pregnancy ?
_____

How many pregnancies did you have ?
_____

How many live births ?
_____

How many miscarriages ?
_____

Did you ever have an abortion ? ____YES
____NO

If YES, was it induced ? ____YES ____NO

Do you have painful intercourse ? ____YES
____NO

PAP SMEAR & MAMMOGRAPHY

Did you ever have a yeast infection? ____YES ____NO

If YES, how frequent? _____

When was your last **Ovarian Ultrasound?** _____

When was your last **Pap Smear ?** _____

When was your last **Mammogram ?** _____

When was your last breast **Ultrasound ?**
_____

How often do you have Mammo / US ?
_____

Did you have a breast check-up
after your last Mammo / US ? ___YES
___NO

Have you ever had an abnormal Finding ? ___YES
___NO

PRE / POST-MENOPAUSAL

At what age did you start menopause ?
_____

Are you experiencing
post-menopausal bleeding ? ____YES
____NO

If YES, please advise _____

MALE PATIENTS - PERSONAL HISTORY

Date of last Prostate Examination _____ ***LAST PSA LEVEL*** _____

Date of last Rectal Examination _____

Do you Self Examine your testicles ? _____ **YES** _____ **NO** How often ? _____

ALL PATIENTS MUST SIGN & DATE FORM

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____
Date_____

Reviewed By _____
Date_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Arsenous for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. If I receive payment from my insurance company, I will send the payment to Dr. Arsenous at the above listed address.

Name of Insured _____

Insured Member ID# _____ Group # _____

Medicare ID# _____ Medicaid ID # _____
(If applicable)

Insured Social Security Number _____ - _____ - _____

Insured Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Arsenous to release any medical or incidental information that may be necessary for either medical care of in processing applications for financial benefit.

ALL TYPES OF INSURANCE

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

Patient Name (PRINT) _____

If Minor,
Parent/Guardian (PRINT) _____

_____ _____
Patient or Parent/Guardian Signature Date

Disclosure Consent for Purposes of Treatment, Payment and Healthcare Operations

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I consent to the use or disclosure of my protected health information by Anna Arsenous, MD, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Anna Arsenous, MD. I understand that diagnosis or treatment of me by Anna Arsenous, MD 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 to carry out treatment, payment or healthcare operations of the practice. Anna Arsenous, MD is not required to agree to the restrictions that I may request. However, if Anna Arsenous, MD agrees to a restriction that I request, the restriction is binding on Anna Arsenous, MD. I have the right to revoke this consent, in writing, at any time, except to the extent that Anna Arsenous, MD has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Anna Arsenous, MD's Notice of Privacy Practices prior to signing this document. Anna Arsenous, MD’s. Notice of Privacy Practices has been provided for me to view and copy. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health

care operations of Anna Arsenous, MD's medical/surgical practice. The Notice of Privacy Practices for Anna Arsenous, MD is also provided in the reception/waiting room and This Notice of Privacy Practice also describes my rights and the duties of Anna Arsenous, MD's General & Cosmetic Surgery practice with respect to my protected health information.

Anna Arsenous, MD reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing by writing or calling the office and requesting a revised copy be sent in the mail. I may also ask for a copy of the revised copy at the time of my next appointment.

_____

Name of Patient or Personal Representative (PRINT)

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority