



Fida Sawalha M.D.
Endocrinology, diabetes, and metabolism

Patient name _____ Date of birth _____

Diabetes Type: _____ Initial diagnosis date: _____

How was it first diagnosed? _____

Brand name of glucometer: _____

Please list all Diabetes medication including insulin for the exact dose and time of the day that its taken:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

If you use insulin: Do you use insulin vial or insulin pen: _____

If you use an insulin pump: Please list brand/model _____

Do you wear a medical alert bracelet? Y N

Do you have glucagon at home? Y N

To have sugar raising/supplies in the car? Y N

Do you check your feet regularly? Y N

List the date: Last eye doctor's appointment: _____

Any history of diabetic ketoacidosis? Y N If so when was the last? _____

Any history of severe hypoglycemic? _____

Any history of hospitalization for severe low or high blood sugar?

Any recent blood sugars below 80 in the last 6 weeks? _____

If you use injections: Do you rotate site of injection Y N

Have you ever of her seen a Diabetic Educator/ Nutritionist: Y N

If yes when was last time: _____

Last podiatry exam: _____

Do you have history of Neuropathy? Y N

History of foot ulcer? Y N

History of stroke? Y N

History of Coronary artery disease? Y N

History of Peripheral vascular disease? Y N

Patient Name: _____

Referring Physician: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Address: _____

Review of Systems

Constitutional			<input type="checkbox"/> No constitutional symptoms
<input type="checkbox"/> fever	<input type="checkbox"/> chills	<input type="checkbox"/> headaches	<input type="checkbox"/> Other
Eyes			<input type="checkbox"/> No eye symptoms
<input type="checkbox"/> double vision	<input type="checkbox"/> blurred vision	<input type="checkbox"/> photophobia	<input type="checkbox"/> Other
Ear, Nose, Throat			<input type="checkbox"/> No ENT symptoms
<input type="checkbox"/> nasal congestion	<input type="checkbox"/> earache	<input type="checkbox"/> sore throat	<input type="checkbox"/> Other
<input type="checkbox"/> nasal discharge	<input type="checkbox"/> tinnitus	<input type="checkbox"/> dysphagia	
Neck			<input type="checkbox"/> No neck symptoms
<input type="checkbox"/> neck pain	<input type="checkbox"/> neck stiffness	<input type="checkbox"/> swollen glands	<input type="checkbox"/> Other
<input type="checkbox"/> lump or swelling			
Breast			<input type="checkbox"/> No breast symptoms
<input type="checkbox"/> nipple discharge	<input type="checkbox"/> neck stiffness	<input type="checkbox"/> swollen glands	<input type="checkbox"/> Other
<input type="checkbox"/> lump or swelling			
Respiratory			<input type="checkbox"/> No respiratory symptoms
<input type="checkbox"/> cough	<input type="checkbox"/> wheezing	<input type="checkbox"/> coughing up sputum	<input type="checkbox"/> Asthma
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> PND	<input type="checkbox"/> Other
Cardiovascular			<input type="checkbox"/> No cardio symptoms
<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitations	<input type="checkbox"/> cold hands	<input type="checkbox"/> Other
<input type="checkbox"/> dyspnea on exertion	<input type="checkbox"/> claudication	<input type="checkbox"/> orthopnea	
GI system			<input type="checkbox"/> No respiratory symptoms
<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	<input type="checkbox"/> diarrhea	<input type="checkbox"/> Other
<input type="checkbox"/> abdominal pain	<input type="checkbox"/> melena	<input type="checkbox"/> hematochezia	
Neurological			<input type="checkbox"/> No neurological symptoms
<input type="checkbox"/> difficulty walking	<input type="checkbox"/> confusion	<input type="checkbox"/> syncope	<input type="checkbox"/> Other
<input type="checkbox"/> dizziness	<input type="checkbox"/> numbness	<input type="checkbox"/> tingling	
<input type="checkbox"/> speech difficulties	<input type="checkbox"/> paresis	<input type="checkbox"/> tremors	
Psychiatric			<input type="checkbox"/> No psychological symptoms
<input type="checkbox"/> anxiety	<input type="checkbox"/> fatigue	<input type="checkbox"/> sleep disturbances	<input type="checkbox"/> Other
<input type="checkbox"/> decreased energy	<input type="checkbox"/> depression	<input type="checkbox"/> SCREENING	
Endocrine			<input type="checkbox"/> No endocrine symptoms
<input type="checkbox"/> polyuria	<input type="checkbox"/> polydipsia	<input type="checkbox"/> temperature intolerance	<input type="checkbox"/> Other
Hematologic			<input type="checkbox"/> No hemetologic symptoms
<input type="checkbox"/> easy bleeding tendency	<input type="checkbox"/> easily bruising tendency		<input type="checkbox"/> Other

Fida Sawalha M.D

REGISTRATION FORM

(Please Print)



Pharmacy Name/Number:				PCP:					
PATIENT INFORMATION									
Patient's Last name:		First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former name):		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Apt. #		Social Security no.:			
Home phone no.: ()		Work phone no.: ()		Cell phone no.: ()		Email address			
P.O. box:		City:		State:		ZIP Code:			
Occupation:		Employer:				Employer phone no.: ()			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other				Languages Spoken :					
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other			
Other family members seen here:									

INSURANCE INFORMATION								
(Please give your insurance card to the receptionist.)								
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Employer:		Employer address:				Employer phone no.: ()		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Please indicate primary insurance		<input type="checkbox"/> Medicare	<input type="checkbox"/> BCBS	<input type="checkbox"/> Aetna	<input type="checkbox"/> UHC	<input type="checkbox"/> Cigna	<input type="checkbox"/> Lifewise	
<input type="checkbox"/> HealthNet	<input type="checkbox"/> Arizona Foundation	<input type="checkbox"/> Great West		<input type="checkbox"/> Pacificare PPO		<input type="checkbox"/> Secure Horizons	<input type="checkbox"/> Other	
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):			Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):				Relationship to patient:		Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize 4C Medical Group or insurance company to release any information required to process my claims.							
Signature:				Date:			



NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire will become part of your medical record.

Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
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Marital status: Single Partnered Married Separated Divorced Widowed

Previous or referring doctor:	Date of last physical exam:
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PERSONAL HEALTH HISTORY

Infectious illness: Measles Mumps Rubella Chickenpox Polio Valley Fever Mono. TB HIV Other:

Immunizations and dates:	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Shingles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Influenza	<input type="checkbox"/> Other

Please check any medical problems you have had in the past:

<input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Cancer, type: _____ <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic lung disease or COPD <input type="checkbox"/> Chronic pain <input type="checkbox"/> Colon polyps <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Deep vein thrombosis/ Blood Clots <input type="checkbox"/> Dementia	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Skin disorder; Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GERD (heartburn) <input type="checkbox"/> GI bleed <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart disease or pacemaker <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Insomnia <input type="checkbox"/> Kidney disease	<input type="checkbox"/> Kidney stones <input type="checkbox"/> Liver disease <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Neuropathy <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Shingles <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Stroke or TIA <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Ulcers, Type: _____ <input type="checkbox"/> Other (specify) _____ _____
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Please check any surgeries you have had:

<input type="checkbox"/> Appendectomy <input type="checkbox"/> Bariatric surgery <input type="checkbox"/> Breast surgery <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Cosmetic surgery <input type="checkbox"/> C-section	<input type="checkbox"/> Eye surgery; Type: _____ <input type="checkbox"/> Gall bladder removal <input type="checkbox"/> Heart surgery, type: _____ <input type="checkbox"/> Hernia repair, type: _____ <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Orthopedic surgery, type: _____ _____	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Spine Surgery; Type: _____ <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other (specify): _____ _____ _____
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FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandmother <i>Maternal</i>	
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandfather <i>Maternal</i>	
<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>			
<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>			

NAME:	DOB:	DATE:
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name the Drug	Dose/Type	Frequency/Method Taken
Aspirin		Daily? <input type="checkbox"/> Yes <input type="checkbox"/> No
Opioids		Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Marijuana		
Contraception		

Allergies to medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Other	How much? _____
Alcohol	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?				
	Have you ever felt you needed to cut down on your drinking?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have people annoyed you by criticizing your drinking?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt guilty about drinking?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever felt you needed a drink first thing in the morning to steady your nerves?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco or nicotine products? <input type="checkbox"/> # of years				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – #/day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
Gynecological History	# of pregnancies: _____		# of live births: _____		Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No

Printed name	Signature (patient or guardian)	Date
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FINANCIAL POLICY

Thank you for choosing 4C Medical Group PLC as your health care provider. We are committed to providing quality medical care. In an effort to avoid confusion and misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

Insurance – all patients

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. 4C Medical Group PLC does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

Non-insured patients

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We will, as a convenience to you, provide a prepared claim form to allow the patient to submit for reimbursement if desired. We offer a competitive cash fee schedule for our patients with no insurance.

Deductibles/Co-pays

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

Appointments

We strive to provide the best possible service and availability to all of our patients. Our policy is to charge for missed appointments unless cancelled at least 24 hours in advance. Our no-show/late cancellation charge is \$25. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

Paperwork Services

Any paperwork filled out by our providers such as Short-term disability, or FMLA are subject to a \$25 charge.

Medical Record Copies

Copies of medical records for personal use or for parties other than your insurance company or other physicians involved with your care are subject to a \$25 charge.

Returned Checks

All checks returned from the bank for non-payment are subject to a \$25 charge.

Collection Agency

Any account turned over to a collection agency is subject to a fee amounting to 30% of the total amount turned over.

This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

Patient Name

Date

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO 4C MEDICAL GROUP FOR ANY SERVICES FURNISHED ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES, FORMERLY KNOWN AS HCFA) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Patient Name

Date

06/01/2016



Acknowledgment of Privacy Practices and Permission to Leave Messages

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received and/or reviewed a copy of 4C Medical Group Notice of Privacy Practices

I give permission to communicate messages in the following manner:

____ You may leave a message on my answering machine located at this number _____

____ You may leave a message on my cell phone _____

____ You may leave a message with my spouse, _____ at this number _____

____ You may leave a message with another person, _____ at this number _____

I give permission to communicate messages about the following:

____ Labs, x-rays, and other test results

____ Prescriptions

____ Billing or insurance matters

Patient Name

Date



Authorization for the Release of Patient Information

FROM: Provider/ Facility: _____
Address: _____
City, State Zip: _____
Phone/ Fax #: Phone: _____ Fax: _____
RE: Patient Name: _____
DOB: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- | | |
|---|--|
| <input type="checkbox"/> Complete medical record, meaning every page in my record | <input type="checkbox"/> Labs, including but not limited to, blood chemistry, pathology, and histology |
| <input type="checkbox"/> Office notes, consult notes, operative reports, and hospital records | <input type="checkbox"/> X-rays and other imaging reports |
| | <input type="checkbox"/> Pharmacy and prescription records |
| | <input type="checkbox"/> Billing records |

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of: _____

You are authorized to release the above records to:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

I understand the following:

That I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization; that the information released in response to this authorization may be re-disclosed to other parties; and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Patient Signature or Legal Representative

Date