M. Youssef, M.D
99-21 67th road, Forest Hills, NY 11375
Tel: (347)642-5315 Fax: (347)642-9859
Email: mydoctoryoussefmd@gmail.com

PATIENT REGISTRATION

Patient Name (First, MI, Last) : ____

DOB: _____/_____/____ **AGE:**________ **SEX**: Male/Female **SocialSecurity#:**________

Cell Phone #____________________ **Home Phone#**________________

Email address: ____

Address:_______________________ **APT:**_____________ **City:**______________

State:_________________ **Zip:**________ Employer:_______________

Emergency contact:______________ **Phone#:**_____________________

Relationship to emergency contact:__________________________

Primary Insurance Company Name:_____________

ID#_________________ **Name of insurance:**____________________

Relationship:___________ **DOB:**____/____/_____ **Social Security#**____________

Assignment and Release

I, the undersigned certify that I (or my dep) have insurance coverage with: ______________ (Name of Insurance Company) and assign directly to **Dr.__Youssef__** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by my insurance and am also responsible for all referrals needed for reimbursement. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.**

Responsible Party Signature: _____________ Relationship__________ Date__________

** I have received the Notice of Privacy Practices and I have been provided an opportunity to review.

Patient's Name _________________________________ DOB:___/___/______

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Patients Name : ____________ Age:_______ Gender:___________

Past medical history:

☐ ADHD/ADD	☐ Allergies
☐ Asthma	☐ Autism Spectrum
☐ Chicken Pox	☐ Diabetes
☐ Eczema	☐ Frequent Colds
☐ Heart Murmur	☐ Pneumonia
☐ Seizures	☐ Strep Throat
☐ Tonsillitis	☐ Ear Infection

Smoker: Yes/ No
Alcohol: Yes/No

Allergies

Is the patient allergic to any of the following?

Medical:

☐ Adhesive tape	☐ Sulfa
☐ Anesthetics	☐ Aspirin
☐ Iodine	☐ Penicillin
☐ Seizure Medicine	☐ Codeine
☐ Latex	☐ NSAID (Ibuprofen, Naprosyn, Advil)

Food and environmental allergies:

☐ Bee Sting	☐ Tree Pollen
☐ Cats	☐ Weed Pollen
☐ Grass Pollen	☐ Dairy
☐ Wheat	☐ Shellfish
☐ Eggs	☐ Soy
☐ Dogs	☐ Dust
☐ Nuts	☐ Other :

Hospitalization and Surgeries

1. Date:___/___/___
   Reason:_____________________

2. Date:___/___/___

   Reason:______________________

Medications

What medication is the patient currently taking?

Name:	Name:	Name:
Dosage:	Dosage:	Dosage:
Frequency	Frequency:	Frequency

Family Medical History

Has anyone in the patient's family (mother, father, siblings, grandparents, cousins) been diagnosed or treated for:

- ☐ Allergies ____________
- ☐ Cancer _________________
- ☐ Blindness_________________
- ☐ Diabetes__________________
- ☐ Heart Problem _________________
- ☐ High Blood pressure _______________
- ☐ Mental Illness (depression, anxiety)________________
- ☐ Tuberculosis___________________
- ☐ HIV/AIDS___________________
- ☐ Hearing Problem/Deafness ___________________
- ☐ Obesity____________________
- ☐ Migrains____________________
- ☐ Seizures____________________
- ☐ Other:______________________

Dear Patients,

Please be advised that according to the latest Healthcare Industry Guidelines: "If an abnormality/ies is encountered or a pre existing problem is addressed **in the process of performing your yearly preventive** (wellness) medicine evaluation and management (E&M) services, and if the problem/abnormality is significant enough to require additional work to perform the key components of problem-orientated E&M service, **then the appropriate office/outpatient code should also be reported to your insurance"**

Therefore, according to your insurance benefit coverage details, copay and deductible might apply. Our practice has a **contractual obligation** with your insurance company to collect copay at the time of service and deductible as agreed. However, you are the policyholder, and if you believe your insurance is not accurately assigning your benefits, we suggest that you contact your insurance company directly.

PATIENTS WITH INSURANCE DEDUCTIBLES

PLEASE BE ADVISED THAT DEDUCTIBLE CHARGES BY YOUR INSURANCE POLICY WOULD APPLY TO ANY OFFICE VISIT FOR ANY DIAGNOSIS OTHER THAN ANNUAL PHYSICAL.

PLEASE CONSULT WITH US IF YOU HAVE ANY QUESTIONS.

ALL PAYMENTS, COPAYMENTS AND DEDUCTIBLES MUST BE PAID PRIOR TO BE SEEN BY THE DOCTOR.

DEDUCTIBLES CHARGES FOR EACH SICK VISIT WILL BE **$100** PENDING CHARGES BY YOUR INSURANCE.

LATE APPOINTMENT CANCELATION

If you fail to cancel an appointment in less than 24 hours prior to your visit, $20 charges would be required.

HEALTH FORMS CHARGES

All health forms require a **$20** fee.

RESPONSIBLE PARTY SIGNATURE:_____________

DATE:______________

WITNESS SIGNATURE:________________________

DATE:______________

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RECORD RELEASE AUTHORIZATION

I hereby authorize and request you to release to: **M. Youssef, M.D., F.A.A.P** the complete history of records in your possession concerning the illness and/or treatment during the period from ________ to _______ for:

Patient Name: ______________

Patient DOB ____/____/____

Home Address: ______________________________-

Signature:____________

Relation to Patient: _________________

Date: ____/____/____

Comments: ____

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read if I so choose) and understood the notice. I authorized the use of this form and released all of my insurance claim submissions in order to obtain payment to me or to Dr.Youssef on my behalf.

PATIENT NAME: _________________________ DATE___/___/___

PARENT OF AUTHORIZED PROXY (if applicable): _______________________

SIGNATURE:_____________________________

PREVIOUS PCP & PHONE #: ________________________

PHARMACY ADDRESS: __________________________