PATIENT REGISTRATION

Michael Kazim M.D.

Medware# Hospital MRN #_____

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Age:_____ **Circle One:** Male or Female **Circle One:** Married Div Sep Widowed Single

Mother's First Name:_____ Father's First Name:_____ Spouse Name:_____

Address:_____Apt#_____

City:_____ State:_____ Zip Code:_____ Country_____

Home Telephone_____Work_____

E-Mail Address:_____Cell_____

Employer:_____ Address & Tele_____

Occupation:_____

Referred By_____ Address & Tele_____

Internist / Pediatrician:_____ Address &Tele_____

Treating Doctor_____ Address & Tele_____

Allergies to Medication_____

Reason you are seeing Doctor Today_____

GAURANTOR INFORMATION:

Gaurantor_____Relationship to Patient_____

Guarantor Date of Birth_____ Last 4 Social Security #_____

Guarantor Address_____

Employer_____ Address Tele_____

Primary Ins Co_____ Second Ins Co_____

ID#_____Group#_____ ID#_____Group#_____

I authorize Michael Kazim M.D. to send my medical records on my behalf to treating physicians and my insurance company. I understand I am responsible for all charges incurred and are payable the day of my visit unless advised otherwise by this office. I authorize insurance benefits be made on my behalf to Dr. Kazim. I further affirm that all the information provided to Dr. Kazim to be true and accurate.

Patient/Parent Signature_____**Date**_____

NAME:_____ AGE_____DATE_____

REVIEW OF SYMPTOMS:
DO YOU HAVE OR HAVE YOU HAD ANY PROBLE IN THE FOLLOWING AREAS?

	YES	NO	EXPLANATION OF PROBLEM
GENERAL			
FEVERS	___	___	_____
WEIGHT LOSS/GAIN	___	___	_____
FATIGUE	___	___	_____
HIGH BLOOD PRESSURE	___	___	_____
EYES			
LAZY EYE (AMBLYOPIA)	___	___	_____
CROSSED EYES (STRABISMUS)	___	___	_____
GLAUCOMA	___	___	_____
CATARACTS	___	___	_____
EYE SURGERY	___	___	_____
EAR, NOSE, & THROAT			
SINUSITIS	___	___	_____
NASAL ALLERGIES	___	___	_____
HEARING LOSS	___	___	_____
DRY MOUTH	___	___	_____
HEART/CIRCULATION			
SLOW HEARTBEAT	___	___	_____
IRREGULAR HEARTBEAT	___	___	_____
HEART MURMUR	___	___	_____
MITRAL VALVE PROLAPSE	___	___	_____
HEART FAILURE	___	___	_____
SHORTNESS OF BREATH	___	___	_____
ANKLE SWELLING	___	___	_____
RHEUMATIC FEVER	___	___	_____
CHEST PAIN (ANGINA)	___	___	_____
HEART ATTACH	___	___	_____
HEART SURGERY	___	___	_____
LUNGS / BREATHING			
ASTHMA	___	___	_____
BRONCHITIS	___	___	_____
EMPHYSEMA	___	___	_____
TUBERCULOSIS	___	___	_____
KIDNEY / BLADDER			
KIDNEY STONES	___	___	_____
BLOOD / LYMPH NODES			
BLEEDING TENDENCY OR EASY BRUSING	___	___	_____
SICKLE CELL ANEMIA	___	___	_____
SKIN			
ECZEMA	___	___	_____
PSORIASIS	___	___	_____
DRY SKIN	___	___	_____
SKIN CANCER	___	___	_____
DIGESTIVE SYSTEM			
PEPTIC ULCER	___	___	_____
HIATAL HERNIA	___	___	_____
STOMACH UPSET FROM MEDICATIONS	___	___	_____
NAUSEA / VOMITING			

	YES	NO	EXPLANATION OF PROBLEM
AUTOIMMUNE DISEASE			
Lupus	___	___	_____
Rheumatoid Arthritis	___	___	_____
Vasculitis			
Inflammatory Bowel Disease	___	___	_____
Multiple Sclerosis	___	___	_____
ENDOCRINE / REPRODUCTIVE			
THYROID	___	___	_____
DIABETES	___	___	_____
SYSTEMIC DISEASE	___	___	_____
ARE YOU PREGNANT?	___	___	_____

DATE LAST MENSTRUAL PERIOD_____

ALLERGIES:_____

_____

DO YOU SMOKE:	___	___	_____

OF CIGARETES PER DAY_____ HOW MANY YEARS SMOKED_____YEAR STOPPED_____

INJURIES:_____

SURGERIES:_____

FAMILY HISTORY:			
THYROID DISEASE	___	___	_____
DIABETES	___	___	_____
GLAUCOMA	___	___	_____
MACULAR DEGENERATION	___	___	_____
HIGH BLOOD PRESSURE	___	___	_____
SYSTEMIC DISEASE	___	___	_____

PATIENT **SIGNATURE**:_____DATE:_____

PHYSICIAN SIGNATURE:_____**DATE:**_____

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided and right to request confidential communication or that a communication of PHI be made by alternative measn, such as sending correspondence to the individuals office instead of the individuals home.

I_____ **wish to be contacted in the follow manner (check all that apply):**
NAME

Home Telephone:_____

____ O.K. to leave message with detailed information
____ Leave message with a call back number only

Work Telephone:_____

____ O.K. to leave message with detailed information
____ Leave message with a call back number only

Written communication
____ O.K. to mail to my home address
____ O.K. to mail to my work / office address
____ O.K. to fax to _____

OTHER: List **NAME AND ADDRESS OF PHYSICIANS AND OR INDIVIDUALS (I.E. PHYSICIANS, FAMILY MEMBERS, NURSE, OR THYERAPIST)** you wish a report or medical information disclosed to on your behalf.

_____
_____
_____
_____
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_____
_____

_____ _____
Patient / Guardian Signature Date

PATIENT'S MEDICARE AUTHORIZATION

Patient Name:_____

Patient Medicare Number: _____

I request payment of authorized Medicare benefits be made either to me or on my behalf to:

Michael Kazim, M.D.

For any service furnished me by that physician / supplier. I authorize any holder of medical information about me to release to the Health Care financing Administration 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. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians 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.

_____ _____

Patient Signature **Date**

New York-Presbyterian

The University Hospital of Columbia and Cornell

Consent

DATE:_____

LOCATION:_____

The undersigned hereby DOES_____, DOES NOT_____ give permission to Dr. Michael Kazim of Columbia Presbyterian Center of New York Presbyterian Hospital and those persons authorized by it to take and use the name, pictures and / or voice of

_____

In any publication, film, telecast, exhibition or other form for educational, scientific, public relations or any other purpose they wish, which may also be accompanied by a description of diagnosis and treatment of other medical information and the undersigned hereby releases Dr. Michael Kazim, M.D., the New York – Presbyterian Hospital, its employees, agents, physicians and other parties from any claim, liability or responsibility whatsoever in connection therewith, including payment or royalties or other compensation.

_____

SIGNATURE

_____

Relationship to Patient

_____

Address

_____

Phone Number

_____

Medical Record Number (MRN)

Witness:_____