Michael Baroody, MD

Patient Name____ Home Phone ( ) ___________

E-mail Address ________________________________Cell ( ) ________________ Preferred (circle) Cell or Home

Address______________________________City/State/Zip_________________________________

Social Security # _____-____-______ Age _____ Birthdate ____/____/_____ Sex ____

Patient Employer________________________________ Work Phone ( ) _________________

Occupation ________________________ School (if student) ____________________________

Marital Status ____ Spouse's Name ___________________ Spouse's Birthdate ____/___/_______

Person Responsible for Account ________________________________ Phone ( ) ____________

Relationship to Patient _____________ Social Security # ____-____-______ Birthdate___/___/______

Address ______________________________City/State/Zip _________________________________

Employer ____ Work Phone ( ) _____________

May we send you information via e-mail or your home address? Y / N

How did you hear about us? ____

Emergency Contact ____________________Relationship_______________ Phone ( ) _____________

Primary Care Doctor ______________________________ Phone ( ) _________________

Address _______________________________City/State/Zip _______________________________

Referring Doctor __________________________________ Phone ( ) __________________

Address _______________________________City/State/Zip ________________________________

Do you authorize letter/records to be sent to above doctors? Y / N Signature ____________________

Reason for office visit? ____

INSURANCE INFORMATION – BRING YOUR INSURANCE CARDS AND REFERRALS

Primary Insurance Company _____________________________________Phone ( ) ________________

Address ____

Policy # ___________________________ Group # ________________________ Plan _______________

Subscriber's Name _________________________________ Date of Birth _____/____/_____

Relationship to Patient ______________________________ Social Security ____-___-_______

Secondary Insurance Company ____________________________________Phone ( ) _______________

Address ____

Policy # ___________________________ Group # ________________________ Plan _______________

Subscriber's Name _________________________________ Date of Birth _____/____/_____

Relationship to Patient ______________________________ Social Security ____-___-_______

I authorize release of medical information necessary to facilitate the processing of all claims submitted on behalf of myself and /or dependants. I authorize the use of this signature on all insurance submission and request payment is made directly to Michael Baroody, MD. I understand I am financially responsible for all charges whether or not they are paid by my insurance.

Signature of insured ____ **Date** ___________________

Michael Baroody, MD

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Δ PATIENT'S NAME

Please answer the following questions about your medical status and history

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?
   Yes No If yes, please explain ____

2. Have you ever had surgery? Yes No
   If yes, please explain ____

4. Do you take any prescribed or over the counter medications including supplements? Yes No
   If yes, please list____
   ____

   Birth Control Yes No

5. Do you have any drug or food allergies? Yes No
   If yes, please list____

Review of Systems

Do you currently have any of the following problems? Yes No If YES, please explain

Chronic fever, unexpected weight loss/gain, fatigue……………… ____________________

Ear/nose/throat problems (e.g., hearing loss, sinus problems)……… ____________________

Heart problems (e.g., chest pain, irregular heart beat)……………… ____________________

Respiratory problems (e.g. shortness of breath, wheezing, coughing). ____________________

Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea) ____________________

Urinary problems (e.g., pain or discomfort, blood in urine)………… ____________________

Skin problems (e.g. rashes, excessive dryness)……………………… ____________________

Musculoskeletal problems (e.g., muscle aches, joint pain)………… ____________________

Neurologic problems (e.g., numbness, weakness, headaches)…… ____________________

Psychiatric problems (e.g., depression, anxiety)……………… ____________________

Family and Social History

Do any medical diseases run in your family? (e.g., diabetes, high blood pressure, cancer)
Yes No If yes, please explain ____
____

Do you smoke? Yes No If yes, how many packs per day? _____ How many years of smoking?___
Nicotine Patch, Gum, Chewing Tobacco Yes No

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

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Δ M.D. Signature **Δ Date**