PATIENT INFORMATION SHEET DATE_____

(PLEASE PRINT CLEARLY)

PATIENT'S FULL NAME_____
(First) (Middle) (Last)

ADDRESS_____
(No. & Street) (City) (State) (Zip)

HOME PHONE (___)_____WORK PHONE (___)_____CELL (___)_____

May we leave a detail voice mail? Home: Yes (__) No (__) Work: Yes (__) No (__) Cell: Yes (__) No (__)

E-MAIL_____May we correspond with you via E-mail? Yes (__) No (__) Text? Yes (__) No (__)

PATIENT'S SS#_____ BIRTHDATE_____/_____/_____ AGE____ SEX_____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED PARTNERED

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESSS_____
(No & Street) (City) (State) (Zip)

REFERRED BY: _____NAME OF FAMILY PHYSICIAN_____

REASON FOR TODAY'S VISIT_____

DUE TO INJURY? INJURY DATE ____/____/____ ON THE JOB?_____ AUTOMOTIVE ACCIDENT?_____

RESPONSIBLE PARTY INFORMATION

NAME OF SPOUSE (OR PARENTS, IF PATIENT IS A MINOR)_____

SS#_____ BIRTHDATE_____/_____/_____ SEX_____

EMPLOYER_____ BUSINESS PHONE (___)_____

BUSINESS ADDRESS_____

NAME OF EMERGENCY CONTACT:_____

PHONE (___)_____ RELATIONSHIP TO PATIENT_____

NOTICE OF PRIVACY PRACTICE

I have received my copy of the privacy policy. I give my permission to disclose and discuss any information related to my medical condition(s), treatments, financial issues with the following family member(s), other relatives, and/or close personal friends:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

You must inform our office, in writing, of any changes in your directive. This consent takes effect on the date below.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Fadi C. Constantine, M.D., P.A. I transfer my title of reimbursement from my insurance company to Fadi C. Constantine, M.D., P.A. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize my insurance claim to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax. 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 have read and understand the above information regarding the privacy policy and assignment of benefits.

SIGNATURE_____ DATE_____

Fadi C. Constantine, M.D.

PHARMACY INFORMATION FOR ELECTRONIC PRESCRIPTIONS

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT DATE OF BIRTH: _____

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: _____

HEALTH QUESTIONS

NAME_____HEIGHT_____WEIGHT_____

MEDICAL HISTORY: Please circle the appopriate answer if you have or have had:

YES / NO Prolonged bleeding when cut
YES / NO Diabetes
YES / NO Stomach Ulcer
YES / NO High Blood Pressure
YES / NO Heart trouble/disease
YES / NO Heart murmur
YES / NO Irregular pulse
YES / NO Cancer
If yes, what type_____

YES / NO Shortness of breath/lung problems
YES / NO Fainting
YES / NO Visual problems
YES / NO Joint pains
YES / NO Excessive scarring
YES / NO Autoimmune disorder
YES / NO Hepatitis
YES / NO Any other significant illness
If yes, what_____

FAMILY HISTORY: Is there a history of the following in your blood relatives?
(Please list the family member's relationship to the patient)

Diabetes_____ Prolonged Bleeding_____
Hepatitis_____ Cancer (type?) _____
High blood pressure _____ Heart Attack or Stroke _____

PERSONAL HISTORY:

Do you smoke?_____ If yes, how many packs per day:_____
Do you drink alcohol? _____Never _____Occasionally _____Regularly Amount per day_____

List Previous Operations	Date	Problems with Surgery or Anesthesia?

ALLERGIES: Have you had reaction to medication/drugs/local anesthesia? _____

Medication Name_____ Type of Reaction _____
Medication Name _____ Type of Reaction _____
Medication Name_____ Type of Reaction _____

MEDICATIONS TAKEN REGULARLY: (include aspirin & birth control pills)

Medication Name_____ Dosage/Frequency_____
Medication Name _____ Dosage/Frequency_____
Medication Name _____ Dosage/Frequency_____
Medication Name _____ Dosage/Frequency_____
Medication Name _____ Dosage/Frequency_____

BLEEDING/TRANSFUSIONS: Have you ever had a blood transfusion?_____
Have you taken aspirin-containing drugs in the past two weeks?_____
If female, date of your last menstrual period_____

FEES, FINANCIAL ARRANGEMENTS & INSURANCE COVERAGE

It is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary will be helpful toward that end.

Your health coverage is provided through _____.

We will contact your insurance carrier to inquire about benefits available to you and your obligation under the plan. It is suggested that you do the same in order to be aware of your coverage. You may also want to verify if you are required to obtain a referral from our primary care physician prior to this appointment. **Each individual plan is different, so please call your insurance company to be sure!**

Payment for your first visit will be expected at the time of service, which may be your office visit co-payment and applicable deductible amounts. Acceptable methods of payment are cash, check, Visa and MasterCard. If you are a patient with Medicare as your primary insurance provider, payment is not required at this time.

We use electronic filing to process insurance claims for payment directly to our office beginning with your first office visit. If your insurance carrier has not paid our claim within the allowed 45 days, we will expect you to take an active part in calling them for immediate remittance. If by mistake payment is made to you, pleased send it to us along with all the paperwork sent to you at that time.

Your health plan may refuse payment of our claim for some of the following reasons:

1. There is a pre-existing illness that is not covered by your plan.
2. You have not met your full calendar deductible.
3. The type of medical service required is not covered by your plan.
4. The health plan was not in effect at the time of service.
5. You have other insurance which must be filed first.

Financial obligation for medical services rests between you and your health plan carrier. While we are pleased to be of service by filing your medical insurance claim for you, we are not liable for any limitations in coverage that may be included in your plan. If your health plan denies payment for any reason, **it is your responsibility as a patient to pay the denied amounts in full.**

I have read and understand my obligations and I acknowledge that I am fully responsible for any services not covered by my health insurance carrier.

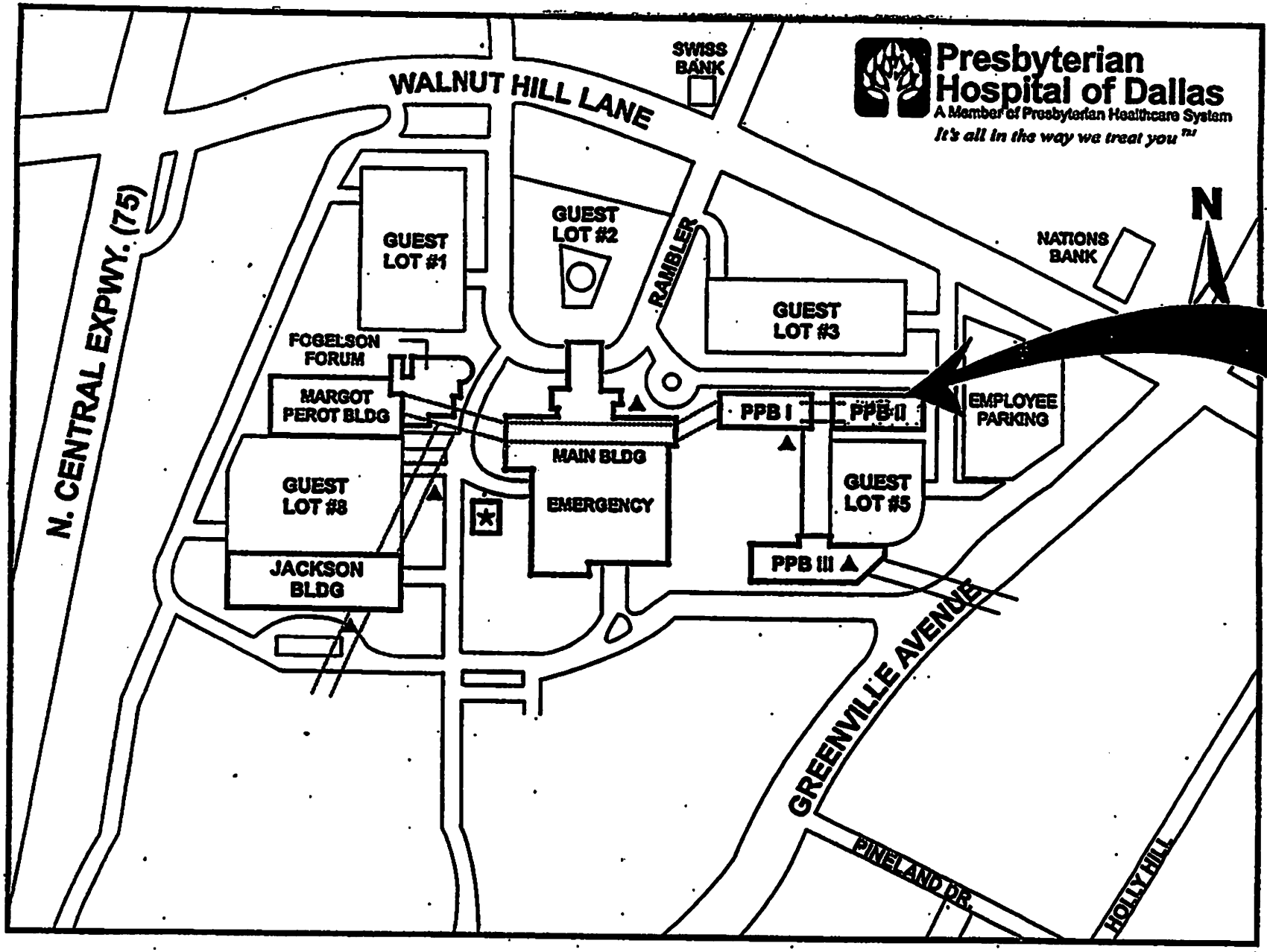
_____ _____

Patient signature Date

_____

Printed Name of Patient

We are located in Professional Building II next to Presbyterian Hospital of Dallas, which is east of 75 Central Expressway and west of Greenville Avenue. Parking is located in the front, side and rear of our building.



Fadi C. Constantine, M.D

Presbyterian
Professional Building II
8220 Walnut Hill Lane
Suite 206
Dallas, Texas 75231

(214) 739-5760
Fax (214) 739-5966

COVID-19 SCREENING TOOL

Date:

Patient Name: **Patient DOB:** **Temperature Today:**

Mom/Guardian Name: **Temperature Today:**

Dad/Guardian Name: **Temperature Today:**

Kindly respond YES or NO to the following questions by checking the appropriate box:

	YES	NO
1. Have you tested positive for COVID-19 within past 30 days?	☐	☐
If YES, did you Self-Quarantine for a minimum of 14 days?	☐	☐
2. Have you been exposed to anyone that tested positive for COVID-19 in past 30 days?	☐	☐
If YES, did you Self-Quarantine for a minimum of 14 days?	☐	☐
3. Have you had a fever of 100 degrees or higher in past 30 days?	☐	☐
4. Have you had a cough in past 30 days?	☐	☐
5. Have you had a sore throat in past 30 days?	☐	☐
6. Have you experienced body aches in past 30 days?	☐	☐
7. Have you experienced difficulty breathing or tightness in your chest in past 30 days?	☐	☐
8. Have you experienced ANY Flu like symptoms in past 30 days?	☐	☐
9. Have you traveled outside the United States in past 60 days?	☐	☐
If YES, where did you travel to?		
10. Have you traveled within the United States in past 60 days?	☐	☐
If YES, where did you travel to?		

Please note that this screening tool is not meant to diagnose or treat COVID-19.