Ayham Alshaar, MD
12900 Cortez Boulevard, Suite 203
Brooksville, FL 34613 / Phone: 352-597-4499

Name: _____ ☐ Female ☐ Male Age: ____ DOB: _____

Parent/Legal Guardian Name: _____ DOB: _____Relationship to Patient: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Permanent Address (if different than mailing): _____

Social Security #: ___-___-____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Work Phone: (___) ___-____

☐ Confidential messages may be left on answering machine or voice mail: ☐ Cell Phone ☐ Home Phone

Referring Physician: _____ Phone: (___) ___-____

Primary Physician: _____ Phone: (___) ___-____

Reason for Referral: _____

Person to contact in case of an emergency:

Name_____ Relationship: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Other Phone: (___) ___-____

Person(s), if any, we may inform about your general medical condition and diagnosis (including treatment, payment and health care operations):

Name_____ Relationship: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Other Phone: (___) ___-____

Name_____ Relationship: _____

Home Phone: (___) ___-____ Cell Phone: (___) ___-____ Other Phone: (___) ___-____

Primary Insurance: _____ Group Name: _____ Group#: _____

Address: _____ Phone: (___) ___-____

Insured's Name: _____ Relationship to Subscriber: _____ DOB: _____

Secondary Insurance: _____ Group Name: _____ Group#: _____

Address: _____ Phone: (___) ___-____

Insured's Name: _____ Relationship to Subscriber: _____ DOB: _____

RELEASE AND ASSIGNMENT: The information I have given is correct to the best of my knowledge. I understand that it will be held in strictest confidence. I understand that it is my responsibility to inform the office of any changes in this patient's information or medical status. I certify that I / my child is covered by the insurance named above and assign directly to Access Health Care Physicians, LLC 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 insurance. I hereby authorize Access Health Care Physicians, LLC to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on insurance submissions whether manual or electronic. I agree to pay for charges not covered by insurance when they are billed to me. I understand collection proceedings may be initiated if I do not pay my bills on time and that I may be held responsible for fees incurred in the attempt to collect outstanding debts.

_____ _____

Please *print* Patient Name **Date**

_____

Signature of Patient or Legal Representative

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PATIENT MEDICAL HISTORY

INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated.

Last Name: _____ **First Name:** _____ **MI:** __ **DOB:** _____

BRIEFLY DESCRIBE the reason for your visit and what you hope to accomplish: _____

_____

_____

SYMPTOMS: Do you experience any of the following: (check each box that applies to you)

X	NOSE:	X	EARS:	X	SINUS:	X	SKIN:
	Stuffy		Pain		Sore Throat		Rash
	Runny		Itching		Post Nasal Drip/Drainage		Hives
	Sneezing		Popping		Itchy Throat		Itching
	Itchy		Pressure		Bad Taste/Breath		Dryness
	Colored Discharge		Ringing		Hoarseness		Swelling of:
	Mouth Breathing	X	CHEST:		Throat Clearing		Face
	Snoring		Shortness of Breath		Forehead Pressure/Pain		Tongue
X	EYES:		Tightness		Cheek Pressure/Pain		Hands
	Burning		Wheezing w/ cold		Headaches		Feet
	Itching		Wheezing w/ exercise				Lips
	Redness		Chest Tightness	X	OTHER:		Other Parts
	Swelling		Dry Cough		Fatigue	X	RESPIRATORY
	Watery		Productive Cough		Heartburn		Frequent Lung Infections
	Dark Circles	X	NEURO	X	GENITOURINARY		Shortness of Breath
	Matter		Dizziness		Burning Urination		Chest Tightness
X	CONSTITUTIONAL		Lightheadedness		Excessive Urination		Wheezing
	Weight. Loss or Gain		Headache		Incontinence of Urine		Sleeping Problems
	Fever		Lack of Coordination		Blood in Urine		Persistent Cough
	Fatigue		Balance Problems		Frequent Bladder/Kidney		Asthma
	Chills		Seizures		History of Sexually Transmitted Disease		
			Numbness				

SYMPTOMS (Continued): (check each box that applies to you)

X	EYES	X	PSYCH	X	GASTROINTESTINAL	X	CARDIOVASCULAR
	Blurry Vision		Depression		Vomiting		History of Rheumatic Fever
	Double Vision		Mood Swings		Constipation		Palpitations
	Vision Changes		Memory Problems		Diarrhea		Chest Pain
	Cataracts		Anxiety		Heartburn		Swelling Hands
	Glaucoma	X	**ENDO**		Incontinence of Bowels		Swelling Feet
X	**ENT/MOUTH**		Excessive Thirst		Blood in Stools		Irregular Heartbeat
	Sinus Problems		Heat Intolerance		Bloating		High or Low Blood Pressure
	Runny Nose		Cold Intolerance		Poor Appetite	X	**MUSC/SKELETAL**
	Tooth Pain		Hair Loss		Hemorrhoids		Difficulty Walking
	Hearing Loss		Nail Changes		Nausea		Joint Stiffness
	Ringing Ears		Night Sweats	X	**HEM/LYMPH**		Muscle Pains
	Gum Pain		Hot Flashes		Bruising		Back Pain
	Gum Bleeding	X	**SKIN**		Nosebleeds		Pain During Walking
	Swallowing Difficulties		Skin Rashes		Lack of Energy		
	Ear Pain		Bruising				
	Ear Discharge		Changes in Skin Lesions				
			Wounds				
			Ulcers				

ARE YOUR SYMPTOMS: ☐ Year Round ☐ Seasonal ☐ Both
During what months do you usually have symptoms _____

Which of the following cause or make symptoms worse? (check each box that applies to you)

	Mowing Lawn/Yard Work		Cats		Exercise
	Vacuuming/dusting		Other Animals		Cleaning Agents
	Pollen		Weather Change		Chemical Fumes
	Mold or mildew		Hot Day		Smoke
	Dogs		Cold Day		Emotions/Stress

FOOD REACTIONS: Have you ever had ***symptoms*** after ingestion of food or liquid? ☐ YES ☐ NO
If yes, specify: _____

INSECT STING REACTIONS: Have you ever had ***symptoms*** after an insect sting? ☐ YES ☐ NO
If yes, specify: _____

PAST MEDICAL HISTORY: Please list any surgeries, hospitalizations, significant birth history, and/or medical conditions below including any history of asthma/sinus infections: _____

_____

_____

_____

_____

Last Name: _____ **First Name:** _____ **MI:** __ **DOB:** _____

FAMILY MEDICAL HISTORY: Please list family members who have any allergy related disease and what type? _____

_____

_____

PREVIOUS ALLERGY EVALUATION(S):

Have you seen an allergist in the past? ☐ YES ☐ NO
Have you had allergy testing? ☐ YES ☐ NO
If yes, when? _____ Any positive reactions? ☐ YES ☐ NO
Have you received allergy injections? ☐ YES ☐ NO
If yes, when and for how long? _____

HOME ENVIRONMENT:

Length of time in Florida: _____ Previous location if less than 2 years: _____
Current Residence: ☐ House ☐ Apartment ☐ Condo ☐ Mobile Home ☐ Other
Length of Time in Home: ____ Years ____ Months **Age of Home:** _____
Air Conditioning: ☐ Central ☐ Window Unit ☐ None ☐ Other
Flooring Type: ☐ Carpet ☐ Wood ☐ Vinyl ☐ Tile ☐ Other
Mattress: Age: _____ Type: _____ **Allergy Encasing:** ☐ YES ☐ NO
Pillow: Age: _____ Type: ☐ Feather ☐ Synthetic ☐ Foam **Allergy Encasing:** ☐ YES ☐ NO
Pets: ☐ YES ☐ NO If yes, ☐ Indoor ☐ Outdoor ☐ Both
Number of pets: _____ Type of pet(s): _____

_____

_____

WORK/SCHOOL ENVIRONMENT:

Current Occupation/Studies: _____

Missed time from work/school because of symptoms? ☐ YES ☐ NO If yes, how much? _____

Are symptoms worse at work/school? ☐ YES ☐ NO If yes, explain: _____

_____

_____

_____

SOCIAL / FAMILY:

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have children? ☐ YES ☐ NO If yes, please list names, gender and ages: _____

_____

Do you drink alcohol? ☐ YES ☐ NO If yes, how often? _____

Have you ever smoked? ☐ YES ☐ NO When did you start _____

Do you presently smoke? ☐ YES ☐ NO If yes, ☐ Cigarettes ☐ Cigars ☐ Other #0 per day _____

Plans to quit? ☐ YES ☐ NO If you have quit, when did you quit? _____

Last Name: _____ _____ **First Name:** _____ **MI:** __ **DOB:** _____

CURRENT MEDICATIONS: If you already have a list, we will be happy to make a photocopy to save you time. Please include prescription and over-the-counter medication taken in the last five (5) days.

Medication Name	Strength	Directions

MEDICATION REACTIONS: List any medication allergy and/or reactions below.

Medication	Symptoms/Reaction

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient

A C C E S S
HEALTH CARE PHYSICIANS

CONSENT TO TREAT

I, the undersigned voluntarily give consent to my Access Health Care Physicians, LLC. and its affiliates to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

_____ Date: _____ DOB: _____
Patient Printed Name

_____ Relationship to Patient: _____
Signature of Patient/Legal Representative

. . . . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Access Health Care Physicians, LLC. and its affiliates, Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ Date: _____
Signature of Patient/Legal Representative

. . . . . .

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Access Health Care Physicians, LLC. and its affiliates practice location to release any medical information necessary to process any and all claims for reimbursement on my behalf. I authorize payment to be made directly to Access Health Care Physicians, LLC. and its affiliates for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to cross-over medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above-named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered as effective and valid as the original.

_____ _____ Date: _____
Signature of Patient/Legal Representative

ACCESS
HEALTH CARE PHYSICIANS®

CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) and Access Healthcare Physicians, LLC, and its Affiliates, prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care with Access Healthcare Physicians, LLC, and its Affiliates, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be storedas medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Access Healthcare Physicians, LLC, and its Affiliates, to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Patient Signature _____ Date of Birth _____

Patient Printed Name _____ Date _____