Ayham Alshaar, MD
11333 Cortez Boulevard, 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

How did you hear about us?
____
____
____
____

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Phone: 352-597-4499

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				

Last Name: ____________________ **First Name:** ______________ **MI:** __ **DOB:** ________

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

CONSENT TO TREAT

I, the undersigned voluntarily give consent to my Access Health Care Physicians, LLC medical professional 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

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Access Health Care Physicians, LLC 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 (or named physicians or 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

. . . .

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, have received/reviewed a copy of the Access Health Care Physicians, LLC 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