Institute of Comprehensive Health, LLC

PATIENT (Please Print)

Patient Name: _____
Last First Middle Nickname

Address _____
Apartment Number Street Address

City/State/Zip _____ Home Phone Number: (____)_____ Cell Phone Number: (____)_____

Mailing Address (if not above): _____

Employer: _____ Work Phone Number: (____)_____

Sex: ❑ Male ❑ Female Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ Oriental/Asian/Pacific Islander ❑ Native American ❑ Other

Marital Status: ❑ Never married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life Partner Date of Birth: ____/____/____

Employment Status: ❑ Employed ❑ Retired ❑ Full Time Student ❑ Part Time Student ❑ Unemployed Social Security Number ____-____-_____

Chosen Physician Within this Practice: _____

Referral From: ❑ Relative ❑ Friend ❑ Yellow Pages ❑ Physician Finder ❑ Ins. directory ❑ Employee ❑ Physician Name _____

Spouse/Partner Name: _____ Employer: _____ SSN: _____ Phone: _____

GUARANTOR

Person responsible for Payment: Name (if not above): _____ ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

Address (if not above): _____

Phone Number (if not above): Home: _____ Work _____

Emergency Contact: _____ (____)_____
Name Relationship Phone Number

PATIENT INSURANCE INFORMATION (copy of card(s) required)

Insurance Company: _____

Policyholder Name: _____ Policyholder Sex: ❑ Male ❑ Female

Policyholder Address: _____ Policyholder DOB: _____

Policyholder City/State/Zip: _____

Policyholder ID #: _____ Group Name: _____ Group #: _____

Is this your ❑ Primary Insurance ❑ Secondary Insurance or ❑ Other _____ ?

Relationship of patient to policyholder: ❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Policyholder Employer: _____ CoPay Amount: $_____/_____%

Policy Activation/Effective Date: ____/____/____ Policy Expiration/Termination Date: ____/____/____

ADDITIONAL INSURANCE INFORMATION

Insurance Company: _____

Policyholder Name: _____ Policyholder Sex: ❑ Male ❑ Female

Policyholder Address: _____ Policyholder DOB: _____

Policyholder City/State/Zip: _____

Policyholder ID# _____ Group Name: _____ Group #: _____

Is this your ❑ Primary Insurance ❑ Secondary Insurance or ❑ Other _____ ?

Relationship of patient to policyholder: ❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Policyholder Employer: _____ CoPay Amount: $_____/_____%

Policy Activation/Effective Date: ____/____/____ Policy Expiration/Termination Date: ____/____/____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby consent to such medical and other treatment deemed appropriate by my treating physician unless I specifically direct otherwise. I authorized my treating physician, Dr. Edward Gaber, MD to release any information concerning medical care, including the reproduction of any and all medical or billing records to the Social Security Administration, Health Care Financing Administration, Medicare, Medicaid (or their various intermediaries) and any applicable insure or other third party payors, when requested for payment, coverage determination, or to other healthcare providers for continuity of care. I hereby assign all benefits and rights to which I am entitled or which may otherwise be payable to me by any third party payor and authorize and direct that such payment for services be made directly to my treating physician and Metairie Institute of Comprehensive Health, LLC, for services rendered. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify my treating physician of any other party who may be responsible for payment for my treatment (Section 11288 of the Social Security Act and 31 U.S.A., 3801-3812 provides penalties for withholding this information). The undersigned hereby accepts financial responsibility for all charges and services not paid by any third party payor, or for any remaining balance due. The undersigned also agrees to pay attorneys fees of twenty-five percent (25%) of the amount due, if referred for collection.

I authorize the physician or medical staff to discuss information pertaining to my health with the following:

❑ No One ❑ List Persons: _____

_____ _____
Signature of Patient (if 18 years or older) or Legal Representative (Parent/Guardian/Power of Attorney) Date

For OFFICE USE ONLY

METAIRIE INSTITUTE OF COMPREHENSIVE HEALTH, LLC

PATIENT QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis (including treatment, payment and health care operations).

   Name:_____Relationship:_____

   Name: _____Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your condition ONLY IN AN EMERGENCY:

   Name:_____Telephone:_____

   Name:_____Telephone:_____

3. Please print the address of where you would like your postcards and/or correspondence from our office to be sent if other than your home address.
   Address:_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".
   YES_____ NO_____

5. Please print the telephone number where you want to receive calls about your appointments, lab and xray results, other health care information if other than your home telephone number: (___) _____.

6. Can confidential messages be left on your telephone answering machine?

   YES_____ NO_____

Patient/Guarantor
Signature:_____Date:_____

METAIRIE INSTITUTE OF COMPREHENSIVE HEALTH, LLC
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Metairie Institute of Comprehensive Health, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Metairie Institute of Comprehensive Health LLC. I understand that diagnosis or treatment of me by Dr. Edward Gaber may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Metairie Institute of Comprehensive Health, LLC is not required to agree to the restrictions that I may request. However, if Metairie Institute of Comprehensive Health, LLC agrees to a restriction that I request, the restriction is binding on Metairie Institute of Comprehensive Health, LLC and Dr. Edward Gaber. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Edward Gaber or Metairie Institute of Comprehensive Health, LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Metairie Institute of Comprehensive Health, LLC Notice of Privacy Practices prior to signing this document. Metairie Institute of Comprehensive Health, LLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Metairie Institute of Comprehensive Health, LLC. The Notice of Privacy Practices for Metairie Institute of Comprehensive Health, LLC is also provided in the patient registration office and each exam room. This notice also describes my rights and Metairie Institute of Comprehensive Health, LLC duties with respect to my protected health information.

Metairie Institute of Comprehensive Health, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ (Signature of patient or personal representative)

_____ (Name of patient or personal representative)

_____ (Date)

_____ (Description of Personal Representative's Authority)

_____ Patient /Guarantor Signature _____ Date

I. Please state briefly the main problem which prompted you to come and the length of time you have had it. (i.e., stomach ache for 7 days)

MY MAIN PROBLEM IS: _____

PHYSICIANS NOTES:

II. **PAST MEDICAL HISTORY:** (Illnesses you have been told you had before.)

Have you had?	No	Yes	Year		No	Yes	Year		No	Yes	Year
Measles				Stroke or Paralysis				Hives			
German Measles				Psychiatric Disorder				Food Allergy			
Mumps				Heart Disease				Skin Disorder			
Scarlet Fever				Heart Murmur				Chronic Bronchial Trouble			
Rheumatic Fever				High Blood Pressure				Peptic Ulcer			
Diphtheria				Vein Trouble				Ulcerative Colitis			
Chicken Pox				Blood Disease or Anemia				Liver Disease			
Tuberculosis or a Positive TB Skin Test				Bleeding Tendency				Jaundice or Hepatitis			
				Kidney Disease				Rectal Polyp			
Pneumonia or Pleurisy				Kidney or Bladder Infection				Hemorrhoids			
Malaria				Kidney Stone				Diabetes			
Amoebic Infection				Prostate Trouble				Goiter or Thyroid Trouble			
Intestinal Worms				Arthritis or Joint Trouble				Gallbladder Disease			
Syphilis				Back Trouble				Other			
Gonorrhea				Ruptured Disc or Sciatica							
Polio				Gout							
Cancer				Asthma							
Epilepsy				Hay Fever							

PHYSICIANS NOTES:

OPERATIONS	No	Yes	Date		No	Yes	Date
Tonsillectomy				Broken Bones			
Appendix				Major Accidents			
Hemorrhoids				Pregnancy			
Hysterectomy				Abortion			
Tubes / Ovary				Caesarean Section			
Other				Gallbladder			

III. **MEDICATIONS - PLEASE LIST ALL MEDICATIONS THAT YOU TAKE NOW REGULARLY**
(include size of pill, # of times a day taken)

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES: _____

BLOOD TRANSFUSION: _____

IMMUNIZATIONS:

1. Small Pox _____ 4. Polio _____ 7. Other _____
2. Tetanus _____ 5. Rubella _____ _____
3. Influenza _____ 6. Diphtheria _____ _____

ALCOHOL _____ OUNCES PER DAY SMOKING _____ PACKS PER DAY

COFFEE _____ CUPS PER DAY DIET _____

IV. **SOCIAL AND MARITAL HISTORY**

How many hours per week do you work?_____ Describe job _____

How often do you take a vacation? _____ Do you get regular exercise? Yes___ No___

What type of exercise?_____ How often? _____

With what pets (or farm animals) have you recently had contact?_____

Married?_____ How many years?_____ Previous marriages and duration: _____

Health of spouse _____

Children: (If adopted, state so) No. living _____ Sex, Ages, & Health _____

No. dead _____ Sex, Ages, & Causes _____

V. **FAMILY HISTORY (Blood relatives only)**

APPROXIMATE AGE / PRESENT HEALTH

Mother_____

Father _____

Brothers / Sisters

1._____
2._____
3._____
4._____
5._____

HAVE ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING? (If yes, please state relationship)

Cancer_____	Allergy _____	Bleeding Tendency_____
Heart Trouble_____	Migraines_____	Mental Disease _____
High Blood Pressure_____	Diabetes_____	Tuberculosis _____
Stroke _____	Kidney Disease_____	Thyroid_____
Glaucoma	Peptic Ulcer _____	Nervous Disease _____

VI. REVIEW OF SYSTEMS:

Please answer the following questions by checking the appropriate box. If you do not understand the question, or if you are uncertain as to how it should be answered, leave it blank and your physician will discuss it with you. Your physician will attempt to discuss all "yes" responses with you also.

	No	Yes	Physician Notes
1. Has your weight changed more than 5 pounds in the past 6 months?			
2. Have you recently had unexplained fever, chills, or night sweats?			
3. Are you subject to unusual fatigue or lack of energy?			
4. Have headaches been a particular problem for you?			
5. Are you subject to lightheadedness, dizziness, or vertigo?			
6. Are you subject to fainting attacks?			
7. Do you think that you perspire excessively?			
8. Do you have trouble with your vision other than needing glasses?			
9. Have your eyes been checked recently?			
10. Is your hearing impaired?			
11. Do you have any other problem with your ears? (ringing or buzzing, draining, itching, or pain)			
12. Are you subject to stuffy nose, postnasal drip, or sinus attacks?			
13. Have you been troubled with nosebleeds?			
14. Have you recently been troubled with persistent or recurring hoarseness?			
15. Do you have frequent sore throats?			
16. Do you have any major trouble with your gums or teeth?			
17. Have you had a recent dental survey?			
18. Are you bothered with mouth or tongue problems? (canker sores, burning tongue, etc.)			
19. Are you subject to pain in the chest?			
20. Do you become abnormally short of breath on activity or when excited?			
21. Do you have spells of difficult or uncomfortable breathing?			
22. Are you subject to smothering spells which awaken you at night?			
23. Do you have to sleep propped up in bed?			
24. Are you bothered by wheezing or asthma?			
25. Do you have a persisting or chronic cough?			
26. Do you bring up any material (sputum, phlegm, mucus) from your chest?			
27. Have you ever coughed up blood?			
28. Are you subject to palpitation (thumping or racing of the heart)?			
29. Have you had any trouble with your heart (including murmur)?			
30. Have you had any trouble with your blood pressure?			
31. Do you have a problem with abnormal fluid retention or ankle swelling?			
32. Have you been troubled with varicose veins or phlebitis?			
33. Do your regularly get pain in the legs when you walk any distance?			
34. Do you have frequent leg cramps at night ("charley-horses")?			
35. Do your fingers become painful, numb, white, or blue when they get cold?			
36. Is your diet restricted (quantity, type of food)?			
37. Do you feel that your eating habits are unsound? (irregularity, unbalanced diet, etc.)			
38. Has there been any change in your appetite recently?			
39. Have you had any trouble swallowing food or liquids?			
40. Are you troubled with heartburn, indigestion, gas, or bloating?			
41. Is there any particular type of food that disagrees with you?			
42. Are you subject to spells of nausea or vomiting?			

	No	Yes	Physician Notes
43. Do you have a problem with pains or cramps in the abdomen?			
44. Have you ever vomited blood or material that looked like coffee grounds?			
45. Have you ever had yellow jaundice or hepatitis?			
46. Have your bowel habits changed in the past six months?			
47. Do you have trouble with constipation or diarrhea?			
48. Do you use laxatives or enemas regularly?			
49. Do you have rectal pain or pain with bowel movements?			
50. Have you ever had black or tarry stools, or bright red blood in your stools?			
51. Do you have pale or clay colored stools?			
52. Do you pass mucus in your stools?			
53. Are you troubled with hemorrhoids (piles), rectal itching, or similar problems?			
54. Pain or burning on urination?			
55. Do you regularly wake up two or more times at night to urinate?			
56. Do you have difficulty in passing your urine?			
57. Do you have difficulty in holding your urine?			
58. Have you ever had a kidney stone or colic, or passed gravel in your urine?			
Have you ever passed blood in your urine?			
60. Have you ever been treated for kidney or bladder infections?			
61. Have you ever been treated for prostate trouble?			
62. Do you have any problem related to sexual function?			
63. Are you or have you recently been under treatment for enemia?			
64. Are you subject to unusual bleeding or bruising tendencies?			
65. Do you have enlarged or painful glands?			
66. Do you have an unusual craving for sweets, salt, or other foods?			
67. Have you been aware of excessive or unexplained thirst?			
68. Has there been any recent change in your capacity to tolerate hot or cold surroundings?			
69. Do you have any skin disorders?			
70. Do you have any places on your skin that concern you?			
71. Have you noted any changes in your hair or nails that concern you?			
72. Are you subject to fits or convulsions?			
Do you tremble or shake abnormally?			
74. Have you noted any weakness or clumsiness of your arms or legs?			
75. Do you have numbness, tingling, burning, or shooting pains in your arms or legs?			
76. Do your joints swell, or hurt, or feel stiff?			
77. Do you have pain or stiffness in your neck?			
78. Have you ever had radiation (or x-ray) treatment at any time?			
79. Do you have any specific muscle weakness?			
80. Are you troubled with recurring or severe backache?			
81. Do you feel that you are a tense or high-strung person?			
82. Do you feel your home or work is unpleasant?			
83. Do you have difficulty making up your mind?			
84. Do you have periods of depression or melancholy?			
85. Are you inclined to worry excessively?			
86. Are you easily irritated or upset?			
87. Do you have persistent fears?			
88. Are your feelings easily hurt?			
89. Do you feel that nervous or emotional factors are important in your present illness?			
90. Do you have trouble sleeping?			
91. Have you ever consulted a Psychiatrist?			

(FOR WOMEN ONLY

	No	Yes	Physician Notes
92. At what age did you start to menstruate? years of age			
93. Are you still having menstrual periods?			
94. Are your periods regular?			
95. Are you troubled with bleeding between your periods?			
96. How many days does your menstrual period usually last? days			
97. Do you have problems with your periods (cramps, flooding, clots, etc.)?			
98. Do you have vaginal itching or discharge?			
99. When was your last period?			
100. How many pregnancies have you had?			
101. How many of these were miscarriages or stillborns?			
102. Was D and C done?			
103. Do you have any problems with your breasts other than at the time of your period?			

104. If there are any medical problems not covered in the previous questions that you would like to discuss, please note them in this space. Your physician will discuss them with you at your initial interview.

_____

_____

_____

_____

_____

_____

VII. DIAGNOSTIC TESTS:

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS? (If so, state approximately when)

Chest X-Ray _____

EKG _____

Diabetes Test _____

Treadmill _____

Angiograms _____

24 Hr. EKG Monitor _____

Fat Profile _____

Intestinal X-Rays _____

Proctoscope _____

Kidney X-Rays _____

Myelogram _____

Scans _____

Echogram _____

Gastroscopy _____

Reviewing Physician _____ M.D. Date _____