PATIENT REGISTRATION

Important: PLEASE WRITE IN CLEAR **CAPITAL** LETTERS TO PREVENT ERROR

First Name:_____**Last** :_____**Middle**:_____

Date of Birth: _____/____/19____ □Male □Female **Social Security Number**:_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Home Telephone:_____ □I prefer this number for appt call reminders

Cell Phone:_____ □I prefer this number for appt call reminders

Does your cell get text messages? □Yes □No **Who is your cell phone provider?**:_____

E-mail (print clearly): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Ethnicity: □Non-Hispanic □Hispanic

Race: □African-American □ Asian □Caucasian/European □Hawaiian/Pacific Islander □Other Race

Marital Status: □Married - Spouse's name:_____ □Single □Widowed □Divorced □Separated

Employer:_____ **Occupation**:_____

Primary Care Physician Name:_____ **Physician Phone Number**:_____

Therapist Name:_____ **Therapist Phone Number**:_____

In Case of Emergency please notify:

_____

(Name) (Relationship) (Address) (Phone)

*****INSURANCE INFORMATION (Please complete ALL sections)*****

A) Primary Insurance:_____ Name of Policy Holder:_____

Policy #:_____ ID #:_____

B) Secondary Insurance:_____ Name of Policy Holder:_____

Policy #:_____ ID #:_____

*****NO SHOW POLICY*****

Patients will be responsible for a $50.00 fee for a no-show or cancellation of an appointment without a 24-hour notice to the office. I have read and understand the above.

Patient Signature:_____ Date:_____

Witness:_____Date:_____

MOATAZ K. GIURGIUS, M.D., INC.

LAST NAME:____________________ FIRST NAME:______________________DATE:________

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NOTICE OF PRIVACY PRACTICE

I acknowledge receipt of the Notice of Privacy Practices (subject to change) of Moataz Giurgius MD Inc. which provides information about how we may use and disclose your health information.

SIGNATURE:______________________(**CIRCLE**: patient/parent/guardian) **DATE**:_____________

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HMO/PPO PATIENTS ONLY

I, _________________ (patient name), understand that I am eligble for mental health service covered by my medical plan and/or authorized by the managed care agency and utilization review process with which my plan contracts. This eligibility waiver is to substantiate that I believe my health plan to be _________________________ (health plan name) with an effective date of _________________(date) provided through my employer_________________________(employer name).

SUBSCRIBER'S NAME:____________________ SIGNATURE:_____________ DATE:________

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MEDICARE PATIENTS ONLY

If there is coverage for this period of hospitalization/professional service, please sign this authorization, and it will be forwarded to your insurance company for payment. I hereby authorize payment to Moataz Giurgius MD, for the regular charges and fees for this period of services. I understand that I am financially responsible for any amounts that are not paid by my insurance company.

NAME OF INSURANCE COMPANY:____________________________

SIGNATURE:__________________________ (insured/authorized assignor) **DATE:______________**

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NON-DISCLOSURE OF INFORMATION:

a) I do NOT wish knowledge of my condition to be released to anyone:

SIGNATURE:_____________________ WITNESS:_____________________ DATE:___________

b) I DO wish knowledge of my condition limited to my general physical health and attendance in office appointments to be released only to the following individuals:

NAME:_______________________ RELATIONSHIP:____________ PHONE:________________

NAME:_______________________ RELATIONSHIP:____________ PHONE:________________

NAME:_______________________ RELATIONSHIP:____________ PHONE:________________

SIGNATURE:_____________________ WITNESS:_____________________ DATE:___________

MEDICAL EVALUATION

Name:_____ **Today's Date**:_____

Reason for today's visit:_____

Medical History:

Do you receive regular medical care from a physician: □No □Yes - *Physician Name*:_____

What is your current weight?_____lbs **Are you a current smoker?** □No □Yes:_____

Have you ever had any of the following?

High Blood Pressure.... □No □Yes
Diabetes.....□No □Yes
Cancer.....□No □Yes
Thyroid Disease.....□No □Yes
Alcoholism..... □No □Yes
Gonorrhea.....□No □Yes
Syphilis.....□No □Yes
Epilepsy.....□No □Yes
Migraine Headaches.....□No □Yes

Peptic Ulcer.....□No □Yes
Colitis: ….....□No □Yes
Tuberculosis:.....□No □Yes
Stoke.....□No □Yes
Rheumatic Fever ….....□No □Yes
Asthma.....□No □Yes
Other:_____
Other:_____
Other:_____

Have you ever had surgery, or have been advised to have surgery? □No □Yes
*If yes, what kind of surgery, where, and who was the surgeon?*_____

Smoking Status: □Not a current Tobacco user □Current Tobacco user

□**No Known Allergies**

Allergy/Drug Allergy:_____ What happens to you?_____
Allergy/Drug Allergy:_____ What happens to you?_____

Psychiatric History:

Have you ever been admitted to a psychiatric hospital? □No □Yes
*If yes, where?*_____ *and what was the reason?*_____
First Hospitalization:_____ Last Hospitalization:_____
Have you ever attempted suicide in the past? □No □Yes: *What year?*_____ *How?*_____
Sleep disturbance? □No □Yes:
□Insomnia □Difficulty Falling Asleep □Early Awakening □Excessive Sleeping
Hallucinations? □No □Yes: □*Auditory* □*Visual* □*Smell* □*Touch* □*Taste*
Delusions? *(i.e. false fixed beliefs):* □No □Yes
Memory Loss: □Immediate Recall □Short Term □Long Term

Family History:

A certain medical illness? □No □Yes:_____ Psychiatric illness? □No □Yes:_____

Medication:

What medication are you taking currently, dose, and start date?_____
_____
Do you think these medications are helping you? □No □Yes
Have you had any side effects? □No □Yes:_____
Do you use any street drugs or alcohol while on medication? □No □Yes
Please describe or explain any symptoms not mentioned above:_____
_____

Patient Signature: x_____ Date:_____

MOATAZ GIURGIUS M.D., INC.
Adult Psychiatry
Geropsychiatry Specialist
15651 Imperial Hwy., Suite 203
La Mirada, CA 90638
Tel. (562) 947 8832
Fax. (562) 947 8839

Service Agreement

This agreement is between Moataz K. Giurgius, M.D., Inc. (My Doctor) and me, _____.
Patient's Name (Please Print)

Electronic Communication. Electronic communication such as email and eFax are available for my convenience. However, I understand that these communications are not encrypted and are not secure. I choose to release My Doctor from any liability and to not hold him/her liable for any possible adverse consequences if I choose to communicate with him/her and his/her office via email, eFax, or any other un-secure means of electronic communication.

Duty To Warn. My Doctor has the duty to inform the Department of Child Protective Services if I reveal to him/her that I, or someone I know, is actively abusing a minor. He/she also has the duty to inform the Police Department if I reveal to him/her that I am going to physically hurt or kill someone.

Medication Consent. If My Doctor recommends psychotropic medication for my condition, he/she will explain to me the benefits, side effects, risks, and alternatives of the proposed medication regimen. If he/she is not clear with his/her explanations or recommendations, I will ask him/her until I am fully informed. As My Doctor adjusts and modifies my medication regimen, I will continue to expect that he/she will explain to me the benefits, side effects, risks, and alternatives of the proposed changes. If he/she is not clear with his/her explanations, I will ask him/her until I am fully informed. By accepting and taking the proposed medications, I acknowledge that I have been fully informed and I voluntarily give informed consent to the treatment recommendations. I will not hold My Doctor liable if I encounter any ill effects from taking the medications that he/she has recommended to me.

Pregnancy. Psychiatric medications may be detrimental to the fetus. If I am a female, I will use birth control so I will not be pregnant while I take psychiatric medication. If I want to be pregnant or if I discover that I am pregnant, I will discuss my situation with My Doctor immediately. I will not hold My Doctor liable if there are any adverse effects to my fetus due to my taking of psychiatric medications.

Suicide. I will not attempt to end my life while I am under the care of My Doctor. If I have strong urges to end my life, I will call 9-1-1 or go to the nearest Emergency Room so I can be evaluated and treated before I do anything to harm myself. My family and I will not hold My Doctor liable if I attempt to or succeed in ending my life.

Treatment Outcome. The treatment of mental disorders, relationship problems, and other mental conditions require different tools such as medications, therapy, after-session assignments, support groups, and habit changes. There is ample evidence that these tools work for some people some of the time. However, there is no guarantee that any of these tools will work for my specific condition. I am willing to accept that fact going into treatment.

Public Encounter. At times, I may encounter My Doctor in a public setting. He/she wants to protect my privacy and will not acknowledge me as his/her patient unless I am comfortable revealing that information and acknowledge that I am his/her patient first.

Termination. The doctor-patient relationship is maintained between My Doctor and me for as long as I continue to receive treatment from My Doctor. If I cancel my appointment or if I do not show up for my appointment, and I do not contact My Doctor within three months of the last appointment, he/she will assume that I no longer want to be under his/her care. At which time, he/she will no longer be responsible for my treatment. Our doctor-patient relationship will be terminated as evidenced by three months of no contact from me.

_____	_____	_____
Patient's Signature	**Date**	**Doctor's Signature**