ANWAR GERGES, MD

NEW PATIENT ENROLLMENT PACKET

PRIMARY DEMOGRAHICS

Patient Name:_____Allergies:_____

Date of Birth: _____ Age: _____ SSN: _____

Sex: Male / Female *(circle one)* Height: _____ Weight: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact name: _____ Phone: _____

Emergency Contact name: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone:_____

REFERRING PHYSICIAN INFORMATION

Name: _____ Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Reason for referral: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Policy & Group #: _____ Referral Required?: _____

Secondary Insurance: _____ Phone: _____

Policy & Group #: _____ Referral Required?: _____

HEALTH HISTORY

CONTAGIOUS ILLNESS: ___Measles ___Mumps ___Rubella ___Chicken Pox/Shingles

___Rheumatic Fever ___Polio Other: _____

IMMUNIZATIONS: ___Tetanus ___Pneumonia ___Hepatitis A/B ___Chicken Pox

___Influenza ___MMR Other: _____

Check if you have, or have had, any problems in the following areas:

___Skin ___Head/Neck ___Thyroid disease ___Lungs (asthma/emphysema) ___Diabetes ___Arthritis

___High blood pressure ___Chest pain ___Heart murmur ___Heart attack ___Stroke ___Cancer

___Bladder/Kidney/Urinary Infections/Stones ___Bowels/Gallbladder ___Swelling ___Positive TB test

___Exposure to tuberculosis ___Malaria ___Typhoid Other pain/discomfort_____

Have you ever received a blood transfusion? ___Yes ___No

Reason:_____

MEDICATIONS

List **ALL** drugs you are taking (prescribed, over the counter, vitamins, herbal supplements and inhalers)

Name of Drug Strength Frequency Taken

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS / CONTACT ALLERGIES / FOOD ALLERGIES

NAME OF DRUG REACTION YOU HAD

_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS (list all-include childbirth, surgeries, etc.)

Year Reason Hospital Name

_____
_____
_____
_____
_____
_____
_____

HEALTH HABITS AND PERSONAL SAFETY

ALCOHOL: Do you drink alcohol: ___Yes ___No If yes, Date of last drink:_____

What kind? _____ How many drinks per day? _____ How many years? _____

Have you ever had any black outs? ___Yes ___No Did you have any DTs? ___Yes ___No

Did you attend rehab, AA or counseling? ___Yes ___No

TOBACCO: Have you ever used tobacco? ___Yes ___No How many years? _____

Do you use tobacco now? ___Yes ___No If yes, Date of last use: _____

What type: Cigarettes packs/ day_____ Chew #/day_____ Pipe #/ day_____ Cigars #/day_____

ILLEGAL DRUGS: Have you ever used any illegal drugs? ___Yes ___No

Do you use any illegal drugs now (*not given by a doctor or pharmacist*)? ___Yes ___No

Date last used: _____ Have you ever shared needles? ___Yes ___No

MENTAL HEALTH

Have you ever been to a psychiatrist or counselor? ___Yes ___No

Have you been treated for a psychiatric disorder (depression, bipolar or schizophrenia)? ___Yes ___No

Do you have trouble sleeping? ___Yes ___No

HEALTH CARE MANAGEMENT

Do you have an advanced directive to physicians (living will)? ___Yes ___No

Do you have a durable power of attorney for healthcare? ___Yes ___No

If you answered yes to the questions above, please provide a copy for our records.

WOMEN ONLY

Number of pregnancies _____ Number of live births _____

Have you had a D&C, Hysterectomy or Cesarean Section? ___Yes ___No

Any Urinary tract, bladder or kidney infections within the last year? ___Yes ___No

Any blood in your urine? ___Yes ___No

Problems with control of urination? ___Yes ___No

Experienced any breast tenderness, lumps or nipple discharge? ___Yes ___No

Date of last Pap Smear or Rectal Exam? _____

Date of last Mammogram? _____

MEN ONLY

Do you usually get up to urinate during the night? ___Yes ___No How many times? _____

Do you feel pain or burning during urination? ___Yes ___No Blood in urine? ___Yes ___No

Have you had any kidney, bladder or prostate infections in the last year? ___Yes ___No

Do you have problems emptying your bladder completely? ___Yes ___No

Date of last prostate and rectal exam? _____

FAMILY HEALTH HISTORY

Parents:	Age	Age at death	Health problems
Father			
Mother			

Siblings:	Age	Age at death	Health problems		Age	Age at death	Health problems
M or F				M or F			
M or F				M or F			
M or F				M or F			

Children:	Age	Age at death	Health problems		Age	Age at death	Health problems
M or F				M or F			
M or F				M or F			

CONSENT FOR TREATMENT

I authorize and direct Dr. Anwar Gerges and any other health care professional he employs to perform any necessary diagnostic tests and evaluations as deemed medically indicated on myself. I understand that any testing to be done and/or treatment to be given will be explained to me prior to the exam and that I may ask questions about such testing.

Signature of policy holder _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to Dr Anwar Gerges and the surgical facility for all payment or reimbursements due from individual or group insurance benefits otherwise payable to me. I also understand that I am financially responsible for the charges not covered by medicare.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with the business office.

Signature of policy holder _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Anwar Gerges and the surgical facility to release any information requested by my insurance company or representatives.

Signature of policy holder _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. It explains how my medical information will be used and disclosed how I can get access to my medical information. I know that I may have a copy of the Notice I also know that, from time to time, the Notice of Privacy Practices and Red Flag Policy may be revised. If I want the revised policies, I must request it.

I have also read and understand the Red Flag Policy and agree to provide the requested documentation of my identity. I understand that if I do not have documentation of my identity, I may be denied services until that documentation is provided.

I agree to allow Dr. Anwar Gerges and any representatives he instructs to access my medical information for the purpose of the any research being conducted and, if eligible, I agree to be contacted.

Patient signature **Date**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____City: _____ State: _____ Zip:_____

Phone: _____

I request and consent to the release of a complete copy of my medical records

FROM:

Name: _____

Address: _____City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

TO:

Anwar Gerges, MD

19234 Stone Hue

San Antonio, TX 78258-3478

Phone: 210-481-9544

Fax: 210-481-9545

Please send my medical records no later than: _____

Please release a copy of all of my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS

Patient signature **Date**

FINANCIAL POLICY

We are committed to providing you the best available medical care. Or personnel will be pleased to discuss our fees and this policy with you at any time. Our professional relationship will be enhanced by your clear understanding of this policy. Your review and acceptance of this policy is appreciated.

- All new patients must complete our Patient Information Packet before seeing the doctor.
- Full payment is due at the time of service unless other mutually agreed upon arrangements are made with our staff.
- **INSURANCE**

You are responsible for timely payment of your account. Insurance is a contract between you and your insurance company. We are NOT a party to this contract, nor can we become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. We cannot be held responsible to know every plan and payment that will be made. There are some procedures done in our offices that are not considered surgical, but we are required by the insurance guidelines to report the procedure under an insurance code which your insurance company may classify as surgery. If these procedures go towards your deductible, you will be billed for the charges. Our involvement will be limited to supplying factual information to facilitate claim processing.

- **HMO and PPO**

Co-payments will be required to be made at the time of your visit as well as deductibles when applicable.

- **MEDICARE**

We are participating Medicare providers; therefore, we accept assignment on your claims. We are required by Medicare to file your claims for you. Medicare will pay us directly and provide you with an Explanation of Benefits detailing allowances, payments or denials.

- **THIRD PARTY (not HMO/PPO) OR SUPPLEMENTAL (secondary)**

We do not file claims to companies for which we are not Providers or with which Medicare does not coordinate benefits. We will provide you with the information you need to submit your primary or secondary claim.

I have read and agree to the Financial Policy.

_____

Signature of Responsible Party Date

MISSED, LATE AND CANCELLED PATIENT APPOINTMENT POLICY

We strive to provide our patients with exceptional medical care and make every effort to accommodate our patients' scheduling needs. Patients who do not show up for scheduled appointments, arrive late for scheduled appointments, or cancel scheduled appointments without providing **at least 24 hours advance notice** inconvenience other patients who need timely access to medical care. We would like to remind our patients of our policy regarding missed or late and cancelled appointments.

If a patient is unable to keep his/her scheduled appointment, please notify us at least **24 hours in advance** of the appointment by calling 210-481-9544. Patients who do not reach a member of our staff should leave a detailed voice message and a member of our staff will promptly return the call to assist in rescheduling.

No-Shows or Missed Appointments: A "no-show" is defined as a patient who fails to show up for a scheduled appointment and **did not contact the office 24 hours in advance.**

Late Cancellations: A patient is deemed to have cancelled late is he/she cancels their appointment with less than 24 hours advance notice.

Late Appointments: A patient is deemed to have arrived late to his/her appointment if they have not arrived by the scheduled appointment time, *regardless of whether a patient calls in advance to notify us that they may be late.*

We reserve the right to discontinue providing care to patients who miss or late cancel **two or more** appointments. There will be a $35.00 Late Cancellation fee as well as a $35.00 No-Show fee. We also reserve the right to discontinue providing care to patients who are late to **three or more** appointments.

This policy is applicable to all patients, regardless of race, religion, color, sex, age, disability, national origin, sexual orientation, genetic makeup and any other basis or protected class covered by federal, state or local law.

I have read and understand the appointment policy.

_____

Signature Date