IMAD E. TARABISHY, M.D., P.A.
Board Certified Orthopaedic Surgeon

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PATIENT REGISTRATION FORM

Today's Date:		
Patient's Last Name:	First:	MI:
DOB:	SS#:	
Gender (Please Circle): Male Female	(Please Circle) Single Married Divorced Separated Widowed	
Street Address:	City/St/Zip:	
Home Ph#:	Cell Ph#:	Work Ph#:
E-mail Address:		
Race:	Ethnicity:	Primary Language:

Primary Care Physician:	Ph#:
How did you hear about our office?	
Pharmacy Name:	
Pharmacy Address:	Ph#:
Emergency Contact:	Relationship to Patient:
Emergency Contact Phone#:	

Primary Insurance Name:	ID#
Secondary Insurance Name:	ID#
Employer Name:	Occupation:
Do you drink alcohol? (Please Circle): Never Occasionally Moderately Socially	
Do you use tobacco? (Please Circle): Yes No	Number of packs per day:
Number of years a smoker:	Numbers of years quit smoking:

PERSONAL MEDICAL HISTORY

Today's Date:	DOB:
Patient's Last Name: First:	MI:

Please check all that apply (past or present):

☐ AFIB	☐ Cardiovascular Disease	☐ Gout	☐ Osteoarthritis
☐ AIDS/HIV+	☐ Cataracts	☐ Hemorrhoids	☐ Osteoporosis
☐ Alcoholism	☐ Chem. Dependency	☐ Hepatitis	☐ Pneumonia
☐ Alzheimer's Disease	☐ CHF	☐ High Cholesterol	☐ Polio
☐ Anemia	☐ COPD	☐ High/Low Blood Pressure	☐ Rheumatoid Arthritis
☐ Asthma	☐ Dementia	☐ Inf. Mononucleosis	☐ Sleep Apnea
☐ Back Issues	☐ Depression	☐ Kidney Disease	☐ Stroke
☐ Bladder Infections	☐ Diabetes (Type:)	☐ Liver Disease	☐ Hyper/Hypo Thyroid
☐ Bleeding Disorders	☐ Epilepsy/Seizures	☐ Migraine Headache	☐ TB
☐ Blood Clots	☐ Fibromyalgia	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Bronchitis	☐ GERD	☐ Multiple Sclerosis	☐ Other:
☐ Cancer (Type:)	☐ Glaucoma	☐ Obesity	☐ Other:

Please check all that apply today:

Musculoskeletal	**Ear/Nose/Throat**	**Genitourinary**	**Integumentary**
☐ Joint pain/stiffness/swelling	☐ Hearing loss/ringing	☐ Frequent urination	☐ Rash
☐ Weakness of muscles/joints	☐ Earaches or drainage	☐ Burning urination	☐ Itching
☐ Muscle pain/cramps	☐ Sinus issues	☐ Blood in urine	☐ Changes in skin color
☐ Back pain	☐ Nose bleeds	☐ Incontinence/dribbling	☐ Breast pain/lump
☐ Decreased range of motion	☐ Sore/hoarse throat	**Neurological**	**Respiratory**
☐ Neck pain	**Cardiovascular**	☐ Difficulty walking	☐ Chronic/frequent cough
Constitutional Symptoms	☐ Heart trouble/disease	☐ Lightheaded/dizzy	☐ Spitting up blood
☐ Significant weight loss	☐ Chest pain/angina	☐ Numbness/tingling	☐ Shortness of breath
☐ Significant weight gain	☐ Palpitations	☐ Tremors	☐ Wheezing
☐ Fever	☐ Shortness of breath	☐ Paralysis	☐ Asthma
☐ Fatigue	**Gastrointestinal**	☐ Headache	☐ Use oxygen
☐ Loss of appetite	☐ Nausea	☐ Memory loss/confusion	**Eyes**
Psychiatric	☐ Vomiting	**Hematologic**	☐ Wear glasses/contacts
☐ Anxiety	☐ Diarrhea	☐ Bleeding/Bruising	☐ Blurred/double vision
☐ Depression	☐ Constipation	☐ Blood clots/DVT	☐ Glaucoma
☐ Insomnia	☐ Abdominal pain	☐ Anemia	☐ Cataracts

RELATION	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Father			
Mother			
Sibling			
Sibling			

HEALTH PROBLEM QUESTIONNAIRE

Today's Date:	DOB:
Patient's Last Name: First:	MI:

Height:	Weight:
Reason for Visit:	
Name of any other physician you have seen for this condition:	
Where is the pain located?	
How did the pain/injury occur?	
When did the pain/injury occur?	
Does the pain travel to other areas?	
What is your pain level from 0 -10 while at *rest*?	What is your pain level from 0 -10 with *movement*?
Describe the pain (Please Circle): Dull Throbbing Achy Sharp Stabbing Warm Red Swollen Tender	
Other associated symptoms (Please Circle): Popping Numbness Tingling Stiffness Difficulty Walking Limited Range of Motion	
What makes the problem better? (Please Circle): Rest Elevate Ice Heat Non-Weight Bearing Medication Injections	
What makes the problem worse?	
Conservative treatment you have already tried (Please Circle): Physical therapy Bracing Injections NSAIDs Weight Loss	

Please list all allergies to medications or substances: ☐ **No Known Drug Allergies**

Name of drug/substance	Reaction you had

Please list all prescribed and over-the-counter medications/vitamins:

Drug Name	Strength	Drug Name	Strength

PERSONAL MEDICAL HISTORY

Today's Date:	DOB:

Patient's Last Name: First: MI:

Please list all surgeries:

Date	Surgery Performed	Hospital/Facility

Please list all hospitalizations NOT related to the above-mentioned surgeries:

Date	Reason	Hospital/Facility

PATIENT PRIVACY QUESTIONNAIRE

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

Name	Phone #	Relationship

May we leave appointment reminders on an answering machine or voicemail? (Please Circle): Yes No

Do you consent to receiving text messages in regards to your appointments or medical care? (Please Circle): Yes No

CONSENT TO TREAT / AUTHORIZATION AND ASSIGNMENT / HIPAA ACKNOWLEDGMENT

- I, the undersigned, voluntarily give consent to Dr. Imad E. Tarabishy 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.
- I hereby authorize Dr. Tarabishy's office staff 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 Imad E. Tarabishy, MD, PA 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.
- I understand that I have a right to review the practice's Notice of Privacy Practices and the Florida Patient Bill of Rights. I have been provided with a copy or an opportunity to review and may request at any time.

Signature of Patient