3848 North Tarrant Pkwy, Suite 100 **Phone: 817-753-6917**
Fort Worth, Texas 76244 **Fax: 817-753-6921**

Patient Information Form

Name: ________________ **Age:** ____ **Sex:** Male / Female
Date of Birth:_________________ **Social Security Number:** __________________
Home Address: ____
City:__________________________ **State:** ___________ **Zip Code:**_______________
Home Phone Number:_____________________ **Cell:** ________________________
Cell phone carrier:_____________________ **E-Mail address:**________________
(May we contact you via e-mail or text)_______________.
Emergency Contact Name: __________________ **Relationship:** ____________
Phone Number: ________________________

Employer Name: ____
Employer Address: ____

Primary Care Physician: ____
Address: ____
Phone Number: ____

Referring Physician: ____
If not by physician, how were you referred?___________________________

Pharmacy Phone Number: ____
Allergies: ____

Is this illness work related: Yes / No

Insurance Company Name: ____
Insured Person's Name: _____________________ **Insured's Date of Birth:**______
Patient's Name: ____

Do you have secondary insurance coverage: Yes / No______________________

I authorize the release of any medical information necessary to process my claim and request payment directly to **Nabeel M. Shabout, MD, PLLC.** This will also serve as authorization for this office to provide insurance information regarding any claim submitted on my behalf. I authorize payment of benefits to **Nabeel M. Shabout, MD, PLLC. I understand that I am responsible for all charges incurred for services rendered by Nabeel M. Shabout, MD, PLLC.**

____ __________________
Patient or patient's Representative Signature **Date**

Authorization of Use and Disclosure of Protected Health Information

Authorization to Contact and leave messages:
Nabeel M. Shabout, MD, PLLC will contact patients by mail or phone for reminders or other communications regarding appointments or other medical information. This authorization will give us permission to contact you by mail or phone and to be able to leave messages.

Please also list the contact phone number and names of other persons we may contact to discuss your protected health information with: **Please note that information given to any other individual may not be protected by the same federal regulations and may possibly be disclosed again.**

Name	Address	Phone Number	Relationship
______________	____________________ ____________________	______________	___________
______________	____________________ ____________________	______________	___________

Telephone Communication Preference:

Location:	May we call?	May we leave message?
Home	Yes / No	Yes / No
Work	Yes / No	Yes / No
Cell	Yes / No	Yes / No

Right to Terminate or Revoke Authorization: You may revoke this authorization by submitting a written notice to:

Nabeel M. Shabout, MD, PLLC
3848 North Tarrant Pkwy, Suite 100
Fort Worth, Texas 76244

____
Patient or patient's representative Signature

____
Name of patient or patient's Representative

____
Date

Notice of Privacy Practices

PLEASE REVIEW CAREFULLY.

Uses and Disclosure

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment: Your health information may be used to seek payment from you health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services.

Healthcare operations: Your health information may be used as necessary to support day-to-day activities and management. This includes appointment reminders via mail, phone and messages.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support governmental audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any other purpose than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you have notified us of your decision.

Individual Rights:
You have certain rights under federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your Protected Health Information.
4. The right to amend or submit corrections to your Protected Health Information.
5. The right to receive an accounting of how and to whom your Protected Health Information has been disclosed.
6. The right to receive a printed copy of this notice.

Individual Physician Duties:
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: We reserve the right to amend or modify our privacy policies and practices as permitted or required by federal and state laws and regulations. The revised policies and practices will be applied to all protected health information we maintain.

NOTICE OF PRIVACY PRACTICES (continued)
Nabeel M. Shabout, MD, PLLC

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document should I request.

____
Signature of Patient or Patient's Representative

____
DATE

Name of Patient or Personal Representative__________________________________

Copy Requested and Received:__________**YES** **DATE:**_____________

Reason not Reviewed________________________ **DATE:**_____________

Date of Disclosure of Protected Information:__________________

Complaints:
If you would like to submit a comment or complaint about our privacy practices, you can do so in writing by outlining your concerns and sending it to:

Nabeel M. Shabout, MD, PLLC
3848 North Tarrant Pkwy, Suite 100
Fort Worth, Texas 76244

For additional Information regarding your rights you may visit http://www.hhs.gov/ocr/hipaa/

PLEASE NOTE

There is a $25.00 fee for ALL paperwork that needs to be completed by the Physicain and or the staff. This includes but not limited to FMLA, Short Term Disability, Aflac and any other paperwork that the employer or insurance company requests. This fee MUST be paid prior to the forms being completed and returned. The payment for this is to be paid by credit card or by cash.

Also, please take into consideration our doctors busy schedule and allow 2 weeks to have the forms completed and returned. Our office can contact you when the forms have been completed.

I have read and understand the guidelines above pertaining to ALL paperwork for the physician to complete.

Patient: ______________________ Date:____________

MEDICAL HISTORY FORM

NAME____DATE____

PCP____REFERRED BY___________________________________

DOB_________________AGE____________ALLERGIES____

Reason For Current Visit:

____

____

Medical History: (Circle all that applies)	High Blood Pressure	Heart Disease	Diabetes
	Bleeding Disorder	Clotting Disorder	Seizures
	Kidney Disease	Thyroid Disease	Stroke
	Arthritis	Heartburn	Lung disease/Asthma
	Other______________________________		

Past Surgeries: **(Please List)**	

Medication List: (list all even if can't remember dose)
1.
2.
3.
4.
5.
6.
7.

Allergies (Circle all that applies and reaction)			
None	Penicillin	Sulfa	Codeine
	Reaction:	Reaction:	Reaction:
Other: (Please list)			

Social History:	**Y/N**	**How Much?**	**Family History:**	**Y/N**	**List Condition and Who:**
Tobacco			Heart Disease		
Alcohol			Cancer		
Drugs			Other		

REVIEW OF SYSTEMS

Constitutional:
__ fever
__ chills
__ weight loss
__ weight gain

Eyes:
__ blurred vision
__ double vision
__ cataracts

Ears/nose/mouth/throat:
__ ear infection
__ nasal drainage
__ sore throat

Cardiovascular:
__ chest pains/heart attack
__ palpitations
__ sleep with head elevated
__ leg edema

Respiratory:
__ shortness of breath
__ cough (Productive: yes/ no)
__ blood in sputum

Gastrointestinal:
__ nausea/ vomiting
__ blood in stool
__ diarrhea
__ constipation
__ heartburn
__ ulcers

Skin/ Breasts:
__ rash
__ mass
__ implant

Neurological:
__ seizure
__ stroke
__ dizziness
__ weakness

Psychiatric:
__ depression
__ anxiety

Endocrine:
__ hypothyroid
__ hyperthyroid
__ adrenal mass

Hematological:
__ anemia
__ bleeding disorder
__ clotting disorder

Musculoskeletal:
__ arthritis
__ limited movement

Urinary:
__ pain with urination
__ frequency
__ blood in urine

Patient Signature ______________________________

Physician Signature ____________________________

Date ____