Issa F. Baroudi MD PA
3222 Tamiami Trail
Port Charlotte, FL 33952
Voice: (941) 627-5155
www.BaroudiMD.com

Patient Name: ____
First Middle Initial Last

Nickname: ____

Date of Birth: ______________________ **Gender:** Male Female

Marital Status (Circle one): Single Married Divorced Legally Separated Widowed

Address: ____
Street Apt. #

____
City State Zip

Home Phone: ( ) ______________________

Work Phone: ( ) ______________________

Cell Phone: ( ) ______________________

Email Address: ____

How did you hear about us? Physician Referral ______________________ Previous Patient

Video Ad Google Search / Our Website Our Facility / Electronic Sign

Friend Referral ______________________ Other ______________________

Place of Employment: ______________________ **Retired:** Y / N

Emergency Contact: ____

Relationship: ______________________ **Phone:** ( ) ______________________

Signature: ______________________________ **Date:** ______________

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Patient Name: ____

What is your current height? ________________What is your current weight? _________________

WOMEN: Have you had breast cancer screening Mammogram Yes:_______, If yes When:____________________ No:_______
Are you pregnant? (If applicable) Yes __________ No________

Allergies to any medications or foods: ____
____
Have you ever had a serious infection? (An infection in which you had to be on IV antibiotics)______________________

Vaccinations: Influenza: Yes:_______, If yes When:______________________ No:___________
Pneumonia: Yes:_______, If yes When:______________________ No:___________

Medication (Including Prescription, Over-the-Counter, Vitamins, Herbal Supplements)	**Dosage**	**How Often**	**How taken (oral, topical, etc.)**
See Attached List Yes ☐ No ☐			

Surgical History:

Pacemaker/ Defibrillator	Yes ☐ No ☐	Stents	Yes ☐ No ☐
Coronary Artery Bypass	Yes ☐ No ☐	Angioplasty	Yes ☐ No ☐
Hernia	Yes ☐ No ☐	Prostate	Yes ☐ No ☐
Cholecystectomy (Gall Bladder)	Yes ☐ No ☐	Appendectomy (Appendix)	Yes ☐ No ☐
Hysterectomy	Yes ☐ No ☐	Cesarean Section	Yes ☐ No ☐
Carpal Tunnel	Yes ☐ No ☐	Breast Surgery	Yes ☐ No ☐
Mastectomy	Yes ☐ No ☐	Tonsillectomy	Yes ☐ No ☐
Hip replacement	Yes ☐ No ☐	Knee Replacement	Yes ☐ No ☐
Joint Replacement	Yes ☐ No ☐	Cataracts	Yes ☐ No ☐
Face Lift	Yes ☐ No ☐	Skin Cancer Surgery	Yes ☐ No ☐

Other: ____
____
____

Have you ever had difficulties with Local Anesthesia? _______________ General Anesthesia? ___________________

Immediate Family History (Father, Mother, Brother, Sister)
Heart Disease ______ Cancer______(If so, what type________________) Diabetes______
Malignant Hyperthermia______ Stroke______ High Blood Pressure______ Heart Attack______

Social History:

Do you consume alcohol?	Yes ☐ No ☐	How often?
Do you smoke? (E-cigs, Cigarettes, Cigars, Pipes)	Yes ☐ No ☐	How many packs per day?
Did you ever smoke?	Yes ☐ No ☐	When did you quit?

Signature:____ **Date**:____________________

Medical History

Cardiovascular:

Heart Attack	Yes ☐ No ☐	Abnormal Heart Rhythm (A-Fib)	Yes ☐ No ☐
High Blood Pressure	Yes ☐ No ☐	Congestive Heart Failure (CHF)	Yes ☐ No ☐
High Cholesterol	Yes ☐ No ☐	Mitral Valve Prolapse (MVP)	Yes ☐ No ☐
Chest Pain/ Angina	Yes ☐ No ☐	Vascular Disease	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Coronary Artery Disease (CAD)	Yes ☐ No ☐

Respiratory:

Pneumonia	Yes ☐ No ☐	Pulmonary Embolism	Yes ☐ No ☐
Emphysema	Yes ☐ No ☐	Short on breath on exertion	Yes ☐ No ☐
Sleep Apnea	Yes ☐ No ☐	Chronic obstructive pulmonary disease (COPD)	Yes ☐ No ☐
Asthma	Yes ☐ No ☐		

Endocrine:

Hypothyroid (Under active)	Yes ☐ No ☐	Goiter	Yes ☐ No ☐
Hyperthyroid (Over active)	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐

Dermatological:

Skin Cancer	Yes ☐ No ☐	Skin Conditions ________________	Yes ☐ No ☐

Hearing/Eyes/Throat:

Blindness	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐
Sinusitis	Yes ☐ No ☐	Difficulty Swallowing (Dysphagia)	Yes ☐ No ☐
Hard of Hearing	Yes ☐ No ☐		

Gastrointestinal:

GI Bleed	Yes ☐ No ☐	Gastroesophageal reflux- GERD/ Acid Reflux	Yes ☐ No ☐
Bowel	Yes ☐ No ☐	Ulcers	Yes ☐ No ☐
Diverticulosis	Yes ☐ No ☐	Crohn's Disease	Yes ☐ No ☐

Hepatic:

Liver Failure	Yes ☐ No ☐	Yellow Jaundice	Yes ☐ No ☐
Hepatitis A, B, C	Yes ☐ No ☐	Cirrhosis	Yes ☐ No ☐

Genitourinary:

Incontinence	Yes ☐ No ☐	Renal Failure/ Insufficiency	Yes ☐ No ☐
Urinary Tract Infection	Yes ☐ No ☐	Peritoneal Dialysis	Yes ☐ No ☐
Kidney Stones	Yes ☐ No ☐	Hemodialysis	Yes ☐ No ☐
Prostate Disease	Yes ☐ No ☐	Vaginal Bleeding	Yes ☐ No ☐

Neurological:

Alzheimer's Disease	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Transient Ischemic Attack (TIA)	Yes ☐ No ☐	Migraines	Yes ☐ No ☐
Epilepsy	Yes ☐ No ☐	Parkinson's Disease	Yes ☐ No ☐
Neuropathy	Yes ☐ No ☐	Dementia	Yes ☐ No ☐

Psychiatric:

Anxiety	Yes ☐ No ☐	Depression	Yes ☐ No ☐
Bipolar	Yes ☐ No ☐	Sleep Disturbance (Insomnia)	Yes ☐ No ☐

Musculoskeletal:

Osteoporosis	Yes ☐ No ☐	Gout	Yes ☐ No ☐
Back/Neck Injury	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Spinal Disease	Yes ☐ No ☐	Paralysis	Yes ☐ No ☐

Hematological:

Leukemia	Yes ☐ No ☐	Anemia	Yes ☐ No ☐
Clotting Disorders	Yes ☐ No ☐		

Any condition not listed above:

____

____

____

Signature:____ **Date:**______________________

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PATIENT CONSENT FORM

Patient Payment Responsibility

I understand I am responsible for payment of services and/or procedures rendered by Issa F. Baroudi, M.D., P.A and Promenades Surgery Center LLC I understand all balances deemed my responsibility by my insurance carrier for services and/or procedures provided by Issa F. Baroudi, MD PA at Promenades Surgery Center LLC will be invoiced to me and payable to the provider of service within (30) thirty days of receipt. In the event it is deemed medically necessary for me to be transferred to an area hospital, I understand I will be responsible for all services incurred with this transfer. Patient responsibilities can include all applicable co-payments, deductibles, and co-insurance amounts. In the event my insurance carrier sends payment of services directly to me, I understand I must forward this payment onto the provider of service. All procedures and/or services deemed not medically necessary or are not covered by my insurance carrier are my responsibility. I understand it is my responsibility to know the terms of my insurance contract. It is my responsibility to notify Issa F. Baroudi, MD PA and Promenades Surgery Center LLC of any changes on my account which include insurance information, change of address, change of phone number or name change.

Medicare Assignment

I have been informed Issa F. Baroudi, MD PA and Promenades Surgery Center, LLC participate and accept Medicare Assignment.

Payment Policies and Assignment of Benefits

A statement for unpaid balances will be sent to me on a monthly basis. It is my responsibility to ensure full payment within 30 days of receipt. I understand if my balance remains unpaid after (90) ninety days, the provider of service will post my account as a collection account. I understand all accounts having a “collection status” will be settled in a court of law. I understand I will be responsible for any and all attorney and court fees. Payments can be made by Credit Card, Check, Cash, or Money Order. If paying by check and it is returned by my bank for any reason, I understand I will receive a separate invoice for the Return Check Fee as well as the amount of the check. This amount must be paid within (7) Seven Business days by Money Order, Cash, or Credit Card. All returned checks not paid will be forwarded to the Florida District Attorney’s office. I have been informed Issa F. Baroudi, MD PA and Promenades Surgery Center LLC operate as separate entities. I understand I may receive a separate statement from a laboratory if testing is required and also for anesthesia if required. I hereby assign my insurance benefits to be paid directly to the provider of service.

Release of Medical Information

I understand Issa F. Baroudi, MD PA and Promenades Surgery Center LLC are permitted to make uses and disclosures of my health information for the purposes of treatment, payment, such as contacting credit card companies should any dispute over charges arise, and health care operations. Protected health information is the information created and obtained in providing the services to me. Such information may include documenting my symptoms, test results, surgical procedures, diagnoses, and complications. It also includes billing documents for those services.
I hereby authorize the provider of service to disclose my health information as outlined in the Notice of Privacy Practices. This form is provided to me to comply with Federal Privacy Law (HIPPA) the Health Insurance Portability and Accountability Act of 1996. The Practice has a Notice of Privacy Practices and I understand I have the opportunity to review it.

Consent to Taking of Photographs

I hereby consent and agree: Photographs may be taken of me or parts of my body with the consent of Issa F. Baroudi, MD PA and under such conditions and at such times as may be approved by Issa F. Baroudi MD PA.

I release and discharge Issa F. Baroudi, MD PA and Promenades Surgery Center LLC, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to, my pictures being taken.

Signature: ____ **Date:** ______________________