Renaissance
HEALTH AND SURGICAL ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Social Security Number: _____/_____/_____ Date of Birth: _____/_____/_____

Address: _____
(Street) (PO Box/Apt #) (City) (State) (Zip)

Home Phone:(____)_____- _____ Cell Phone: (____)_____- _____ Preferred Method of Contact: ☐ Text ☐ Phone

Birth sex: _____ Age: _____ Marital Status: _____ Email Address: _____

Gender Identity: ☐ F ☐M ☐Choose not to disclose ☐Additional gender category or other, please specify_____

Sexual Orientation: ☐Straight or Heterosexual ☐ Bisexual ☐ Lesbian, gay, or homosexual ☐ Something Else ☐ Unknown

Ethnicity: ☐NOT Hispanic or Latino ☐Hispanic or Latino

Race: ☐ White ☐Black or African American ☐Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐Other

Language Preference if not English:_____ Other communication Issues? ☐ N ☐Y (What?)_____

Patient's Employer Name: _____ Employer's Phone: (____)_____- _____

Patient's Employer Address: _____

Patient Employment Status ☐ Full Time ☐ Part Time ☐Retired ☐Disabled ☐ Self Employed ☐Other, Occupation _____

Spouse's Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician:_____ Referring Physician_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Address:_____
(Street) (City) (State) (Zip)

Preferred Method of Contact Home Phone:(____)_____- _____ Cell Phone: (____)_____- _____

INSURANCE INFORMATION

Primary
Insurance Company _____ ID # _____ Group #_____

Policy Holder's Name _____Policy Holder's DOB _____/_____/_____

Policy Holder's Social Security # _____ Policy Holder's Employer_____

Secondary
Insurance Company _____ ID # _____ Group #_____

Policy Holder's Name _____Policy Holder's DOB _____/_____/_____

Policy Holder's Social Security # _____ Policy Holder's Employer_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS, NOTICE OF PATIENT PRIVACY PRACTICES

I hereby authorize my commercial insurance and/or Medicare benefits to be paid directly to RHASA for services rendered. I also authorize RHASA to release any information requested by the insurance company with regards to payment of benefits. **I acknowledge financial responsibility for all charges relating to my care at RHASA that are not covered by insurance.** I consent to treatment of the patient above as deemed necessary and appropriate by the attending provider. **Financial Policy:** All balances are due and payable within thirty (30) days of the initial statement date unless prior arrangements have been made. Patient balances which are not resolved in a timely manner will be sent to an outside collection agency and/or attorney, and additional fees will apply. The person requesting treatment is responsible for all services rendered. I understand if problems are found or discussed during my annual visit, my insurance plan may require me to pay a co pay or deductible for the problem evaluation and management visit. However, if the patient is a minor, the custodial parent or guardian is responsible for all services rendered. Patients who do not show up on time or cancel appointments with less than 24 hour notice will be subject to a $30.00 fee. This fee may be higher for procedures other than routine office visits. By my signature below, I acknowledge that I may receive a more comprehensive financial policy by visiting www.rhasa.com, requesting a copy at any of RHASA's locations, or viewing the policy in the reception area of any of RHASA's offices. **Notice of Patient Privacy Practices:** RHASA's Notice of Patient Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information. RHASA reserves the right to change its practices regarding the protected health information it maintains. If RHASA makes changes, they will update this Notice. By my signature below, I acknowledge that I may receive the most recent copy of this Notice by visiting www.rhasa.com, requesting the Notice at any of RHASA's locations, or viewing the posted Notice in the reception area of any of RHASA's offices.

_____ _____ _____
Signature of Responsible Party Relationship to Patient Date

MEDICATION LIST

Name:_____ DOB: _____

Pharmacy:_____ Pharmacy #:_____

MEDICATION:	STRENGTH:	DIRECTIONS:	Date	Date	Date	Date	Date	Date	Date	Date
		Patient Initial:								
Staff Purpose only:		Reviewed by:								

DO YOU HAVE A LATEX ALLERGY? YES NO

ARE YOU TAKING A FORM OF BIRTH CONTROL? YES NO
IF SO, _____

☐ I have drug allergies, as listed below. ☐ I have no drug allergies.

Name:	Reaction:
1.	
2.	
3.	
4.	
5.	

Patient Signature: _____ Date: _____

RENA AZAR, MD

Revised 4.25.24

Renaissance Health and Surgical Associates, PC.
New / Established Patient Information

Date_____ **Name**_____ **DOB**_____ **Primary Care Doctor**_____

Have you had a: ___ Tubal Ligation ___ Appendectomy ____Hysterectomy ___ Gallbladder ____ Other not listed? _____

Have you had any falls in the last year? YES NO If yes, did it result in an injury? _____

Do you have any new medical conditions? YES NO Do you have a latex allergy? YES NO

Health Maintenance-Indicate the month and year that the following were last done.
PAP smear ___ Mammogram ___ Breast Exam ___ Colonoscopy ___ Thyroid Level ___ Cholesterol Level ___
Vaccinations (Covid 19___ Influenza___ HPV___ Pneumovax ___ Tetanus___) If Diabetic, A1C ____

Tobacco: Never ___ Yes, Occasional ___ Yes, but quit ___ Yes, Active ___
Number of years?___ Packs per day? ___ Years since quit? ___
Alcohol: Never ___ Yes, Occasional ___ Yes, but quit ___ Yes, Active ___
Number of days per week?___ Number of drinks per day? ___ Years since quit? ___
Other Drugs: Never ___ Yes, Occasional ___ Drugs _____

Do you exercise regularly? (more than 3 times per week) YES NO

Do you have 4 servings of dairy products daily or take calcium supplements? YES NO

Have you ever been abused or injured by someone you know? YES NO

Do you feel threatened by anyone in your household? YES NO

Marital status: Single Married Separated Divorced Widowed

Family History (please list family members who have had each)
Cancer _____ Thyroid Disease _____ Stroke/Heart Attack _____ Arthritis _____
Diabetes _____ Osteoporosis _____ Hypertension _____ None of the above_____

Below are risk factors for cervical and/or vaginal cancer—please check all that apply.
___ Sexual activity when less than 16 years of age
___ Five or more sexual partners in a lifetime
___ Sexually transmitted infection in past including gonorrhea, chlamydia, PID
___ Your mother took DES when she was pregnant with you
___ HIV positive
___ No PAP test done for last seven years
___ History of abnormal pap test
___ Current smoker
___ None of these apply to me

Are you sexually active? YES NO

How many pregnancies have you had? ___ How many children did you give birth to? ____

Your above medical history is very important and affects the management of your current health. Please take care to provide a thorough and accurate record of past or current problems. Please sign below to indicate that you have provided the above information yourself and have not withheld or misrepresented your medical history.

Patient Signature: _____ RENA AZAR, MD

Name: _____ DOB: _____ Date: _____

What would you like to discuss with the doctor today: _____

What medication refills do you need today: _____

Are you requesting time off work related to this visit: Yes / No

Due to the changing guidelines of insurance companies, we will be required to address ONE TYPE of service during your visit. Please choose below the office visit type that relates to the reason you wish to be seen today.

❑ Annual exam ❑ Discuss problems or test results ❑ Post op visit ❑ Procedure

GENERAL
- ❑ Fever
- ❑ Chills
- ❑ Fatigue
- ❑ Unexplained weight change

EYES
- ❑ Blurred vision/double vision
- ❑ Light sensitivity
- ❑ Pain in/around eyes
- ❑ Worsening vision
- ❑ Light sensitivity at night
- ❑ Eye disease or glaucoma
- ❑ Wear glasses/contacts

ENT
- ❑ Earache
- ❑ Ringing in ears
- ❑ Nasal drainage
- ❑ Nasal congestion
- ❑ Difficulty swallowing
- ❑ Sore throat or voice change
- ❑ Loss of hearing
- ❑ Hoarseness
- ❑ Nosebleeds
- ❑ Chronic sinus problems
- ❑ Mouth sores or bleeding gums
- ❑ Bad breath or bad taste

NECK
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Swollen glands
- ❑ Lump or swelling

BREAST
- ❑ Breast lump
- ❑ Nipple discharge
- ❑ Change in breast skin
- ❑ Breast pain
- ❑ Breast discharge
- ❑ Do you do self-breast exams monthly Yes/No

MUSCULOSKELETAL
- ❑ Back pain
- ❑ Muscle pain or cramps
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Difficulty walking
- ❑ Limited mobility of arms or legs

RESPIRATORY
- ❑ Sleep Apnea
- ❑ Chronic or frequent cough
- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Post-nasal drip
- ❑ Asthma or wheezing
- ❑ Emphysema
- ❑ TB (Tuberculosis)
- ❑ Use home oxygen

CARDIOVASCULAR
- ❑ Chest pain or angina
- ❑ Difficulty breathing with activity
- ❑ Shortness of breath when lying flat
- ❑ Swelling in legs/ankles
- ❑ Pain in legs with walking
- ❑ Cold hands/feet
- ❑ Heart murmur
- ❑ Racing or irregular heart beat
- ❑ High blood pressure

GASTROINTESTINAL
- ❑ Nausea/vomiting
- ❑ Frequent diarrhea
- ❑ Black/tarry stool
- ❑ Abdominal pain
- ❑ Blood or mucous in stool
- ❑ Belching/bloating
- ❑ Bowel movement changes
- ❑ Constipation
- ❑ Lactose intolerant
- ❑ Difficulty swallowing
- ❑ Heartburn
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Mucous in stool
- ❑ Pain with bowel movements
- ❑ Urgency with bowel movements
- ❑ Rectal bleeding
- ❑ Peptic ulcer (stomach or duodenal)
- ❑ Undesired loss of stool or gas
- ❑ History of hepatitis
- ❑ Colon polyps

GENITOURINARY
- ❑ Frequency of urination
- ❑ Urgency of urination
- ❑ Hesitancy of urination
- ❑ Blood in urine
- ❑ Pain with urination
- ❑ Emptying bladder at night
- ❑ Kidney disease/failure
- ❑ Sexually transmitted disease
- ❑ Kidney stones
- ❑ Frequent bladder infections
- ❑ Undesired loss of urine

GYNECOLOGIC
- ❑ Sexual difficulty or pain
- ❑ Heavy periods
- ❑ Irregular periods
- ❑ Vaginal discharge
- ❑ Last menstrual period _____
- ❑ Feels like your vagina/uterus is falling out at times
- ❑ Hot flashes
- ❑ Night sweats

ENDOCRINE
- ❑ Excessive urination
- ❑ Excessive thirst
- ❑ Temperature intolerance
- ❑ Hair problems
- ❑ Thyroid disease
- ❑ Diabetes
- ❑ Gland problems

HEMATOLOGIC (BLOOD)
- ❑ Easy bleeding tendency
- ❑ Easy bruising tendency
- ❑ Excessive bleeding
- ❑ Swollen nodes
- ❑ Slow to heal after cuts
- ❑ Anemia
- ❑ Blood clots
- ❑ Prior transfusion
- ❑ Enlarged glands

NEUROLOGIC
- ❑ Numbness/tingling
- ❑ Dizziness or light-headedness
- ❑ Fainting
- ❑ Memory loss or confusion
- ❑ Paralysis
- ❑ Speech difficulties
- ❑ Tremors
- ❑ Seizures or convulsions
- ❑ Frequent headaches
- ❑ Weakness
- ❑ Stroke
- ❑ Head injury

PSYCHOLOGIC (PHQ-2)
- ❑ Anxiety
- ❑ Sleep disturbance
- ❑ Loss of sexual desire
- ❑ Suicidal thoughts
- ❑ Thoughts of hurting someone else
- ❑ Loss of interest in activities
- ❑ Feeling down, depressed, or hopeless

SKIN
- ❑ Rash
- ❑ Itching
- ❑ Hives
- ❑ Eczema
- ❑ Lesions
- ❑ Dry skin
- ❑ Jaundice
- ❑ Varicose veins

INFECTIOUS
- ❑ HIV/Aids
- ❑ Staph infection/MRSA

Have you ever had cancer? Yes/no
Type: _____
Treatment : surgery / chemo/ radiation

I give permission for Dr. Azar to remotely pull up results/records from other facilities, including Parkridge and Erlanger hospitals. I also give consent to receive communication through email and/or text and to be billed for audio/visual phone call (Telehealth) visits.

Patient Signature: _____