Renaissance
HEALTH AND SURGICAL ASSOCIATES

Rena A Azar, MD
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PATIENT DEMOGRAPHIC FORM

(THIS FORM IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

PATIENT INFORMATION

Patient Name: _____ (First) (Middle) (Last) Patient's Social Security Number: ___-___-___ Date of Birth: ___/___/___

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

Marital Status: ___S ___M ___D ___W Gender: ___F ___M Language Preference if not English: _____ Other communication Issues? N___ Y____ (What?)_____

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

Ethnicity: NOT Hispanic or Latino____ Hispanic or Latino___ Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____ Preferred Method of Contact: ____ Phone (please circle preferred phone number above) _____ Mail

Employer's Name: _____ Work Phone: (_____)_____

SPOUSE/GUARANTOR/PARENT INFORMATION

Responsible Party Name: _____ (First) (Middle) (Last) Relationship to Patient: _____

Responsible Party Date of Birth: _____ Guarantor's Social Security Number: ___-___-___

Guarantor's Address _____ (Street) (PO Box/Apt #) (City) (State) (ZIP)

Home Phone: (___)_____ Cell Phone: (__)_____

Employer's Name: _____ Employer's Address: _____ (Street) (City) (State) (Zip) Work Phone: (____)_____

PATIENT's INSURANCE INFORMATION * Please provide Insurance Card and Photo ID to Receptionist

Primary Insurance Company's Name: _____ Insurance Address: _____ (Street) (PO Box) (City) (State) (Zip)

Primary Insurance Company's Phone Number (____)_____ Name Of Policy Holder: _____ (First) (Middle) (Last) Policy Holder's Date of Birth; ____/____/____

Policy Holder's Social Security Number: ___-___-___ Policy Holder's Gender: __M ___F Policy Holder's Relationship to Patient: _____

Employer: _____ Insurance ID Number: _____ Group Number: _____

Secondary Insurance Company's Name: _____ Insurance Address: _____ (Street) (PO Box) (City) (State) (Zip)

Secondary Insurance Company's Phone Number (____)_____ Name Of Policy Holder: _____ (First) (Middle) (Last) Policy Holder's Date of Birth; ____/____/____

Policy Holder's Social Security Number: ___-___-___ Policy Holder's Gender: __M ___F Policy Holder's Relationship to Patient: _____

Employer: _____ Insurance ID Number: _____ Group Number: _____

PATIENT's REFERRAL INFORMATION

Primary Care Physician: _____ Address: _____ (Street) (PO Box) (City) (State) (Zip) Phone: (____) _____

Referring Physician: _____ Address: _____ (Street) (PO Box) (City) (State) (Zip) Phone: (____) _____

How did you hear about us? ____Family ____Friend _____Radio _____TV _____Newspaper _____Other

EMERGENCY CONTACT INFORMATION (Please include other parent when applicable)

Contact #1 _____ First Last

Home Phone_____ Cell Phone_____

Work Phone_____

Patient Relationship to Contact _____

Contact #2 _____ First Last

Home Phone_____ Cell Phone_____

Work Phone_____

Patient Relationship to Contact _____

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 understand that I may be billed directly from other labs and/or facilities for charges incurred by multiple providers for services. 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 may be subject to a fee. 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

Please COMPLETELY fill out all information for all medications you are currently taking: Date a column, place a '√' beside each medication, and initial at the bottom.
*****At follow up visits: Please date a new column, place a '√' beside each medication that has not changed and place an 'x' in the column if you have discontinued a medication. Add any new medications to the list and initial at the bottom.**

Name:_____ DOB:_____ Date:_____

Pharmacy:_____ Pharmacy #:_____

			Date at top and '√' or 'x' beside each medication:								
MEDICATION:	**STRENGTH:**	**DIRECTIONS:**	1/1/16								
Example: Prilosec	10 mg	Once Daily	√								
		INITIAL:									

DRUG ALLERGIES:

☐ I have no drug allergies.

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

Patient Signature: _____ **Date:** _____

RENA AZAR, MD

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 Surgery

Have you had any other surgeries, not listed above?_____

Have you had any hospitalizations?_____

Do you have any new medical conditions?_____

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 (Tetanus___ Influenza___ Pneumovax __ HPV___)

Habits (circle) Alcohol Drug Use Tobacco Use *(now or in past)*

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
___ Fewer than three negative Pap tests
___ Current smoker
___ You have used birth control pills for five years or more
___ 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 effects my management of your current health. Please take care to provide a thorough and accurate a 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: _____

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. Any additional concerns will need to be addressed at another visit. By not adding additional services, this will minimize patient wait times while increasing a better quality of service to our patients.

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

GENERAL
- ❑ Fever
- ❑ Chills
- ❑ Headache
- ❑ Fatigue
- ❑ Loss of appetite
- ❑ 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
- ❑ Leg pain
- ❑ Foot swelling
- ❑ Weakness of muscles or joints
- ❑ Difficulty walking
- ❑ Limited mobility of arms or legs

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

CARDIOVASCULAR
- ❑ Chest pain or angina
- ❑ Difficulty breathing with activity
- ❑ Palpitations
- ❑ 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
- ❑ Bright red blood 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 cancer
- ❑ Colon polyps

GENITOURINARY
- ❑ Frequency of urination
- ❑ Urgency of urination
- ❑ Hesitancy of urination
- ❑ Blood in urine
- ❑ Pain with urination
- ❑ Burning with urination
- ❑ Emptying bladder at night
- ❑ Excessive bleeding during period
- ❑ Sexual difficulty
- ❑ Kidney disease/failure
- ❑ Changes in urinary habits
- ❑ Sexually transmitted disease
- ❑ Kidney stones
- ❑ Frequent bladder infections
- ❑ Undesired loss of urine

GYNECOLOGIC
- ❑ Sexual difficulty or pain with intercourse
- ❑ 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
- ❑ Difficulty walking
- ❑ Frequent headaches
- ❑ Weakness
- ❑ Stroke
- ❑ Head injury

PSYCHOLOGIC
- ❑ Anxiety
- ❑ Depression
- ❑ Sleep disturbance
- ❑ Loss of interest in activities
- ❑ Loss of sexual desire
- ❑ Suicidal thoughts

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

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

I confirm that I have completed this form personally. I understand that follow-up discussions regarding my healthcare and/or test results may be in the form of a telehealth visit or an office visit.

Patient Signature: _____

Rena Azar, MD