Mohamad Eloubeidi, M.D. Eloubeidi Gastroenterology & Associates 256-237-1001

Please Bring Insurance, Driver's License, and co-pay. We do accept debit/credit, but the CREDIT CARD company will add a 3.95% charge.

Check and Cash is accepted.

Name:		Age:	Da	ate of Birth:	
Sex (circle) M F Marital Status (circle): Social Security No:				Separated	
Doctor:					
Email phone:	Phone:				lternate
Mailing Address:		City:		St:_	Zip:
Occupation:			Employ	/er:	
Pharmacy: Local		City_			St
Mail Order:					
Emergency Contact:		Relati	onship:		_ Phone
Primary Insurance Company			F	Policy #:	
Subscribers Name:				Date of Birth:	
Relationship to Patient:	Employer:				
Secondary Insurance Company				_ Policy #:	
Subscribers Name:				Date of Birth:	
Relationship to Patient:	Employer:				

I hereby authorize the treating physician to furnish the above insurance company(s) all information which said insurance

company(s) may request. I hereby assign to above named physician all money in which I am entitled for medical and / or surgical expense relative to medical services rendered but not to exceed my indebtedness to above named physician. I understand that I am financially responsible to treating physician for all medical services rendered and for charges not covered by this assignment.

I understand that any co-payments required by my insurance is my responsibility and is due at the time of my office visit.

I agree to notify the office of any changes of address, telephone number, or insurance carrier promptly. If I fail to do so, I will be responsible for the charges.

This gives Dr. Eloubeidi the authorization to file and receive any direct payment from my insurance company for all medical care provided to me either at his office or as an outpatient or inpatient at the hospital.

In the event of non-payment for medical charges rendered, I agree to pay all costs of collection, including a reasonable attorney's fee, court cost, and I further agree to pay the legal rate of interest on the account until paid in full. I waive, to the extent allowed by the law, all personal property rights of exception under the constitution and laws of the State of Alabama, or any other state, in connection with or related to the collection of any indebtedness incurred by me in the connection with medical services rendered.

Signature:	D	ate:

NO Show appointments will be charged to your account if we do not get a 72 hour notice of a cancellation or reschedule. \$25 for office visit no show, \$200 for procedure (hospital no show)

Eloubeidi Gastroenterology & Associates Mohamad Eloubeidi, MD 912 Snow St Oxford, AL 36203

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date	
Date: The undersigned acknowledges receipt of a copy of the current Practices for this healthcare facility. A copy of this signed, dated As the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOC SENT TO OTHER ATTENDING DOCTOR/FACILITYS IN THE FUTUR	d document shall be as effective CUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE
Please Print your Name	Please Sign your name
Legal Representative	Description of Authority
Your comments regarding Acknowledgements or consents:	
HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE Oth	
Please list any other parties who can have access to your health inform (This includes step parents, grandparents and any care takers who car	
Name: Relation	onship:
Name: Relatio	

I authorize contact from this office to confirm my appointments, treatment & billing information via:

Cell phone Confirmation	text message to my Cell phone	
Home Phone confirmation	Email Confirmation	
Work Phone confirmation	Any of the Above	
I authorize information about my health be	conveyed via:	
Cell phone Confirmation	text message to my Cell phone	
Home Phone confirmation	Email Confirmation	
Work Phone confirmation	Any of the Above	
Lannrove heing contacted about special se	vices, events, fund raising efforts or New He	ealth info on hehalf of this facility via:
Cell phone Confirmation	text message to my Cell phone	euten mjo on benuij oj tins jucinty viu.
Home Phone confirmation	Email Confirmation	
Work Phone confirmation	Any of the Above	
		that this office may recommend products or services to
promote your improved health. This office in HIPAA Omnibus rule, provide you this inform		ration from these affiliated companies. We, under current
Office use only		
·	e patient's (or representatives) signature on	this Acknowledgement but did not because:
It was emergency treatment		
I could not communicate with	the patient	
The patient refused to sign		
Other (please Describe)		Signature of privacy Officer
	Personal History N	lew Patient
		Today's Date:
Name:	Age: Date	e of Birth:
Referred By:	Primary Care Phy	ysician:
Describe the reason for your visit:		
Medications: Please list all your supplements. If you have a list you € None	current prescription and non-presou may bring the list with you at yo	scription medications, vitamins and
If you need more room you may I Name of Medication	oring a complete list of medication Strength	ns or write on back. Thanks When to take/how often
Allergies: None Penicillin Su		

Acid Reflux	Cirrhosis of liver	Groin hernia	Kidney stones	Psoriasis
Anal Fissure	Colon Cancer	Heart Attack	Lupus/Scleroderma	Radiation Therapy
Anemia	Colon Polyps	Heart Failure	Migraines	Rheumatic Fever
Arthritis	Crohn's Disease	Heart Murmur	Milk Intolerance	Sciatica
Artificial Heart Valve	Depression	Hepatitis	Mitral Valve Prolapse	Seizures
Asthma	Diabetes	Hiatal Hernia	Multiple sclerosis	Sleep apnea
Bleeding Disorder	Diarrhea	High Blood Pressure	Osteoporosis	Stroke or Paralysis
Blood Clots	Diverticulitis	High Cholesterol	Ovarian Cyst	Tuberculosis(TB)
Blood Transfusion	Duodenal Ulcer	HIV or Aids	Pacemaker	TB skin test positive
Cancer	Emphysema	Irregular Heart beat	Pancreatitis	Thyroid disease
Chest pain/ angina	Fatty Liver	Irritable Bowel Syndrome	Parkinson's disease	Ulcers
Chronic Anxiety	Glaucoma	Kidney Disease/failure		Ulcerative colitis
Chronic lung disease	Atrial Fibrillation	Scoliosis		
Surgeries or Procee	dures			
None	Colostomy	Groin Hernia	Hiatal Hernia	Obesity surgery
Appendectomy	C-Section	Heart bypass	Hysterectomy	Ovary
Breast	EGO	Heart Stent	Joint	Prostate
Colon Surgery	ERCP	Heart Valve	Kidney	Sigmoidoscopy
Colonoscopy	Gallbladder	Hemorrhoid surgery	Liver biopsy	Stomach
Thyroid	Tonsillectomy	Tubal ligation	Uterus	Other
Knee Replacement	Hip replacement			
Previous Hospitalizat	tions			
Reason			<u>Date</u>	

Mohamad Elaubaidi M D	Flouboidi Costroenterology 9 Associates
ivionamad Eloupeidi. ivi.D.	Eloubeidi Gastroenterology & Associates

Name:	DOB:	

Family History

raililly mistory	Family History							
	Father	Mother	Grandparents	Siblings	Children			
Healthy								
Deceased								
Colon Polyps					,			
Colon Cancer								
Ulcer Disease								
Liver Disease								
Pancreas Disease								
Crohn's Disease								
Ulcerative colitis								
Stomach Cancer								
Diabetes Mellitus								
Heart Attack								
Breast Cancer								
Other Cancer								

Social History			
Marital Status	Single	Married Divorced Widowed	
Occupation		Unemployed Retired	
Smoking History	Never	Yes Packs per day for years Qu	it Date
Currently Smoking	Yes	No	
Other tobacco use	No	Yes: details	
Alcohol Use (Beer W	/ine Liquor)	No Yes: amount per day	
IV or Recreational di	ug use	No Yes: specific drugs and last used:	
Exercise	No	Yes: how much and how often:	
Recent travel outside	e the US	No Yes: where	

Review of systems (circle all that apply at present time)

General		Gastroir	ntestinal	Muscuk	oskeletal	Ear, Eye	s, Nose, Mouth and throat
•	Fever or chills	•	Poor appetite	•	Stiff or painful joints		Hearing loss
•	Loss of Appetite	•	Rectal bleeding	•	Swollen joints		Ear pain/ ringing
•	Unintentional weight gain	•	Rectal pain or	•	Back pain		Mouth ulcers/ sores
•	Unintentional weight loss		itching	•	Muscle pain		Poor dentition
•	Weakness, fatigue	•	Regurgitation of food	Hemato	lania.		Nose bleeds
Gastroin	testinal		Soiling /	nemato	iogic		Visual changes
•	Abdominal distention		incontinence	•	Frequent bruising		Enlarged or swollen glands
•	Abdominal pain/cramping	•	Vomiting blood	•	Bleeding doesn't stop easily		Contacts or glasses
•	Belching	Cardiov	ascular	Endocri	ne	Neurolo	gic
•	Black stools	•	Chest pain or		Heat or cold intolerance	Ι.	Numbress or tingling
•	Blood in stool/rectal		tightness	•	Excessive thirst or urination	١.	Dizziness or
	bleeding	•	Rapid or irregular	•	Steroid therapy (prednisone)	Ι.	lightheadedness Vertigo
-	Change in bowel habits		heartbeat			Ι.	Headaches
•	Constipation		Swelling of legs	Dermate	•		Weakness in arms and legs
•	Diarrhea		Varicose veins		Rash or hives		
•	Difficulty swallowing	Respirat	tory		Itching		Blurred vision
•	Fat intolerance	•	Chronic cough		Tattoos	Psychia	Difficulty with memory tric
•	Full after eating small amounts	•	Wheezing	Gastro	reproductive- Male	•	Anxiety
•	Gas/bloating	•	Shortness of breath	<u> </u>	Discharge from penis	•	Depression
•	Heart burn	•	Need for oxygen	•	Testicular pain or lump	•	Panic attacks
•	Indigestion		therapy	Gastro	reproductive – Female	•	Tired on waking up in the
•	Hemorrhoids	Urinary		•	Heavy periods	Immunic	morning rations list date of last inj
•	Jaundice (yellowing of	•	Pain or difficulty with urination		Date of last period	•	Hepatitis A
	eyes or skin)		Frequent urination		Last		Hepatitis B
•	Mucus in stool		Blood in urine		Mammogram		Pneumovax
•	Nausea or vomiting			•	Last Bone Scan		- Hedinovax
		-	Incontinence of urine	•	Last pap smear		Flu