New Patient Registration

Name: ____

First   Middle Initial   Last

Address: ____

Street (not P.O. Box)

____________________   __________   ____________

City   State   Zip Code

Phone: ______________   ______________   ______________

Home   Work   Cell

Birth Date: __________ SS# ______________ Sex: ______ Marital Status: ________

Spouse's Name or Emergency contact: ____________________Cell# ______________

Referring Physician: ______________ Primary Care Physician: ______________

Required Laboratory (circle one): Bayhealth Labcorp Quest Other ____________

Pharmacy & Location: ____

May we leave a message on your answering machine? YES or NO (circle one)

May we leave a message with members of your household? YES or NO (circle one)

I give Dr. Samaha or the office staff permission to speak with ____________________

regarding my care. ______________________   ______________

Signature   Date

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR MYSELF DIRECTLY TO MILFORD PULMONARY AND SLEEP CONSULTANTS, LLC, ON BEHALF OF DR. MICHEL R. SAMAHA.

Signature: ______________________________ Date: ______________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS THIS CLAIM.

Signature: ______________________________ Date: ______________

PLEASE FILL IN THE FOLLOWING INFORMATION

Medications & Dosages (list all prescription & over the counter)

1 ______________________________ 7 ______________________________

2 ______________________________ 8 ______________________________

3 ______________________________ 9 ______________________________

4 ______________________________ 10 ______________________________

5 ______________________________ 11 ______________________________

6 ______________________________ 12 ______________________________

Allergies to medications

1 ______________________________ reaction ______________________________

2 ______________________________ reaction ______________________________

3 ______________________________ reaction ______________________________

4 ______________________________ reaction ______________________________

Medical Conditions

(example: diabetic, high blood pressure, high cholesterol, asthma, heart disease etc.)

1 ______________________________ 6 ______________________________

2 ______________________________ 7 ______________________________

3 ______________________________ 8 ______________________________

4 ______________________________ 9 ______________________________

5 ______________________________ 10 ______________________________

Surgeries

1 ______________________________ 4 ______________________________

2 ______________________________ 5 ______________________________

3 ______________________________ 6 ______________________________

Please circle the following medical conditions that your family members have or had

Mother: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Father: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Sister: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Brother: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Daughter: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Son: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Grandmother: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Grandfather: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

Other: heart disease high blood pressure diabetes high cholesterol
depression asthma alcohol abuse cancer (type ____________)

OFFICE POLICY AND SERVICE AGREEMENT

1. All co-pays are required to be paid at the time of the office visit. We accept cash, check or credit cards.
2. You must present an active insurance card at every visit. If you do not have your card, your appointment will be rescheduled.
3. If you cancel an appointment without giving 24 hours notice or if you do not show up for an appointment you will be charged a $50.00 fee. We cannot bill the insurance for this fee, it is your responsibility.
4. If a check is returned unpaid from the bank, you are responsible for all charges, including the $50.00 returned check fee.
5. If your account goes over 90 days past due without payment or any communication from you, it may be turned over to a collection agency and you will be responsible for any additional fees.
6. If your insurance requires an authorization or referral, it is your responsibility to obtain it or your appointment will be rescheduled.
7. If 3 appointments are missed without giving proper notification to our office, you will be dismissed from the practice.
8. All self-pay patients are required to pay the full amount of the day's charges at the time of the office visit (cash, check or credit cards).
9. It is your responsibility to notify our office if your insurance requires a specific lab to be used for lab work.
10. Please allow us 72 hours for all prescription refills.
11. Please be advised that there is a charge from the doctor to complete any type of disability or insurance forms.
12. Our office does not do prior authorizations on medications. It is your responsibility to contact your insurance company to find out what equivalent medication will be covered.

I certify that I have completed these forms to the best of my ability and that I have read and understand the office policy and service agreement. I am aware of the legal duty and privacy practices with respect to protected health information that must be obtained by law.

______________________________ ____________________

Patient Signature Date