Mohammad Elbatta, MD, Inc.
714.937.9400

17400 Irvine BLVD, Suite F, Tustin,
CA 92780

PATIENT INFORMATION

LAST ______________________ FIRST ______________________ MI __________

SEX ____ M ____ F BIRTHDATE ______/______/______ (MO. DAY YEAR) SS# ______________________ PHONE ______________________

ADDRESS ______________________ CITY ______________________ ST ________ ZIP ______________

EMPLOYER ______________________ ADDRESS ______________________

OCCUPATION ______________________ WORK PHONE ______________________ EXT __________

DRIVER'S LICENSE ______________________ ST ________ MARITAL STATUS ______________________

WHO IS YOUR PRIMARY CARE PHYSICIAN? ______________________ WHAT IS YOUR CO-PAY? ______________________

WHO MAY WE THANK FOR REFERRING YOU? ______________________

MAY WE CONTACT YOU AT HOME WITH RESULTS? ☐ YES ☐ NO CELL PHONE ______________________

LEAVE A MESSAGE AT YOUR: ☐ HOME ☐ OFFICE ☐ OFFICE VOICE MAIL ☐ OTHER ______________________

EMERGENCY CONTACT:

LAST ______________________ FIRST ______________________ RELATIONSHIP ______________

ADDRESS ______________________ CITY ______________________ ST ________ ZIP ______________

HOME PHONE ______________________ WORK PHONE ______________________

INSURANCE: PRIMARY

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME ______________________ ID# ______________________ GRP NO. ______________

INSURED NAME ______________________ SS# ______________________ BIRTHDATE ______/______/______ (MO. DAY YEAR)

CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER ______________________

INSURANCE: SECONDARY

PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

NAME ______________________ ID# ______________________ GRP NO. ______________

INSURED NAME ______________________ SS# ______________________ BIRTHDATE ______/______/______ (MO. DAY YEAR)

CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER ______________________

AUTHORIZATION

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE, AND I CONSENT TO ANY MEDICAL OR SURGICAL TREATMENT RENDERED THE PATIENT UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF THE PHYSICIAN.

____
SIGNATURE OF PATIENT

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I, HEREBY, ASSIGN ALL BENEFITS TO Mohammad Elbatta MD, INC. FOR SERVICES RENDERED TO ME OR SAID MINOR PATIENT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME OR SAID MINOR TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE TO Mohammad Elbatta MD INC. AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. I HAVE GIVEN ALL MY INSURANCE INFORMATION FOR BILLING PURPOSES AND UNDERSTAND THE BILLING PROCEDURES.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY INCLUDING BUT NOT LIMITED TO, CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES. I ALSO AGREE TO COMPLETE ALL NECESSARY PAPERWORK IN ORDER FOR MY CLAIM TO BE PAID BY MY INSURANCE COMPANY AND ACCEPT FULL LIABILITY FOR ALL CHARGES IF PAYMENT IS NOT MADE IN MY BEHALF BY MY INSURANCE COMPANY.

SIGNED, PATIENT (OR PARENT IF MINOR) ______________________ **DATE** ______________

IF OTHER THAN PARENT, RELATIONSHIP ______________________

Mohammad Elbatta, MD, Inc.

Patient Health History

Date: ______________________________

Name	Date of Birth
Name of Referring Doctor:	Name of Primary Doctor:
Reason for Your Visit Today (Please Be Specific):	

Chronic Problems

Please indicate what medical conditions **YOU** either currently have or have been diagnosed with in the past and the approximate year of diagnosis:

Mo./Year

Eyes
- ☐ Glaucoma ________

Ears, Nose, Throat
- ☐ Allergic Rhinitis ________
- ☐ Sinusitis ________

Pulmonary
- ☐ Asthma ________
- ☐ Chronic obstructive lung disease ______
- ☐ Emphysema from smoking ________
- ☐ Pneumonia ________
- ☐ Pulmonary Edema ________
- ☐ Pulmonary Embolism ________
- ☐ Sleep Apnea ________

Endocrine
- ☐ Diabetes ________
- ☐ Thyroid Problem ________
- ☐ Other Endocrine Disorders ________

Gastrointestinal
- ☐ Crohn's Disease ________
- ☐ Ulcerative Colitis ________
- ☐ Hemorrhoids ________
- ☐ Pancreatitis ________
- ☐ Irritable Bowel Syndrome ________
- ☐ History of Colon Polyps ________
- ☐ Acid Reflux/GERD ________
- ☐ History of Colon Cancer ________
- ☐ Gallstones ________
- ☐ Diverticulosis/Diverticulitis ________
- ☐ Peptic Ulcers ________
- ☐ Small Bowel Obstruction ________

Mo./Year

Cardiovascular
- ☐ Congestive Heart Failure ________
- ☐ Heart Attack ________
- ☐ Angina ________
- ☐ Coronary Artery Disease ________
- ☐ Arrthymias ________
- ☐ Atrial Fibrillation ________
- ☐ Aneurysm ________
- ☐ Elevated Cholesterol ________
- ☐ Valvular Heart Problem ________
- ☐ Heart Valve Replacement ________
- ☐ Irregular heartbeat ________
- ☐ Hypertension ________
- ☐ Heart Murmur ________
- ☐ Defibrillator Implant / Pacemaker ________

Rheumatologic
- ☐ Osteoarthritis ________
- ☐ Rheumatoid Arthritis ________
- ☐ Other Rheumatologic Issues ________

Liver
- ☐ Hepatitis A ________
- ☐ Hepatitis B ________
- ☐ Hepatitis C ________
- ☐ Other types of liver disease ________
- ☐ Abnormal liver tests ________
- ☐ Jaundice ________
- ☐ Cirrhosis ________

Mo./Year

Blood Disorders
- ☐ Anemia ________
- ☐ Clotting Problems ________
- ☐ Leukemia/Lymphoma ________

Neurological/Orthopaedic
- ☐ Neuropathy ________
- ☐ Chronic Migraine/headache ________
- ☐ Parkinson's Disease ________
- ☐ Seizures ________
- ☐ Multiple Sclerosis ________
- ☐ History of Stroke/CVA ________

Psychiatric
- ☐ Depression ________
- ☐ Bipolar Disease ________
- ☐ Anxiety ________
- ☐ Schizophrenia ________

Cancer (Type and Treatment)
- ☐ ____________ ________
- ☐ ____________ ________
- ☐ ____________ ________

OTHER (Please list):
- ☐ ____________ ________
- ☐ ____________ ________
- ☐ ____________ ________
- ☐ ____________ ________
- ☐ ____________ ________

Patient Health History

Date: ___________________________________

Name	Date of Birth

Please list any previous surgeries and dates:

Surgery Type	Date (Approximate Year)

Have you ever had a Colonoscopy? ☐ YES ☐ NO Date: ___________ Findings: ______________________

Have you ever had an Upper Endoscopy? ☐ YES ☐ NO Date: ___________ Findings: ______________________

Please list any medication(s) you currently take:

Medication	Dose

List Allergies to Medications: ____

Pharmacy Name/Address: ____ Pharmacy Phone/Fax: ___________________

Do you take any blood thinning medication(s) such as Aspirin, Ecotrin, Motrin, Ibuprofen, Aleve, Naprosyn, Coumadin, Warfarin, Plavix, Pradaxa, or Dabigatran? ☐ YES ☐ NO

If so, please list which one and how often you take it:

Medication	How Often?

Patient Health History

Date: ______________________________________

Name	Date of Birth

Marital Status:

☐ Married ☐ Single ☐ Widow / Widower

Who lives with you? ____

Current Occupation / Employer: ____

What kind of work do you do? ____

Do you smoke?	☐ YES	☐ NO	☐ QUIT
How many packs per day? ____________ How many years? ________________			
Do you drink alcohol?	☐ YES	☐ NO	☐ QUIT
How many drinks per week? _______________			
Do you drink caffeine? Type: ___________________	☐ YES	☐ NO	
How many cups per day? ________________			
Do you use any illicit drugs? Type: __________________	☐ YES	☐ NO	☐ QUIT
Do you have a personal history of colon cancer, rectal cancer, stomach or uterine (endometrial) cancer **diagnosed under the age of 50?**	☐ YES	☐ NO	
Do you have a history of both colon **and** uterine (endometrial) cancer?	☐ YES	☐ NO	
Do you have a personal history of **more than 10 total** colon polyps found in a lifetime?	☐ YES	☐ NO	
Do either of your parents, children, or siblings have a history of colon cancer, rectal cancer, or uterine (endometrial) cancer diagnsed **under the age of 50?**	☐ YES	☐ NO	
Do you have **three or more** cases of colon, rectal, stomach, or uterine cancer on the **same** side of the family?	☐ YES	☐ NO	
Do any of your female relatives (mother, sister, daughter, aunt, grandmother) have a history of having both colon **and** uterine cancer in the same individual?	☐ YES	☐ NO	
Do either of your parents, children or siblings have a history of having **more than 10 total** colon polyps found in a lifetime?	☐ YES	☐ NO	

If so, in whom and at what age?

	Polyps	Colon Cancer	Age at Diagnosis
☐ Mother	☐	☐	________
☐ Father	☐	☐	________
☐ Brother/Sister	☐	☐	________
☐ Children	☐	☐	________
☐ Other Relatives	☐	☐	________

Please list any additional family history of cancer:

	Type of Cancer:	Age at Diagnosis
☐ Mother	______________________________	________
☐ Father	______________________________	________
☐ Brother/Sister	______________________________	________
☐ Children	______________________________	________
☐ Other Relatives	______________________________	________

Have you had any past problems with anesthesia or sedation for procedures or surgeries? ☐ YES ☐ NO

If Yes, please explain: ____

Date: ____________________________________

Name	Date of Birth

Review of Systems

Please indicate if you have any **CURRENT** problems, signs, or symptoms in any of the following areas:

Constitutional

- ☐ Chills
- ☐ Fever
- ☐ Malaise/Weakness
- ☐ Weight loss

HEENT

- ☐ Double vision/Change in vision
- ☐ Ear infections
- ☐ Eye pain
- ☐ Nasal congestion
- ☐ Sinus infection
- ☐ Sore throat
- ☐ Change in Voice/Hoarseness
- ☐ Hearing changes
- ☐ Swollen lymph nodes

Respiratory

- ☐ Dyspnea
- ☐ Frequent cough
- ☐ Pleuritic pain/Pain with breathing
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Shortness of breath w/ exertion

Cardiovascular

- ☐ Chest pain
- ☐ Extremity edema/Swelling
- ☐ Palpitations

Gastrointestinal

- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dysphagia/Trouble swallowing
- ☐ Heartburn
- ☐ Hematemesis/Vomiting blood
- ☐ Hematochezia/Blood in stool
- ☐ Loss of appetite
- ☐ Melena/Black Stool
- ☐ Nausea
- ☐ Reflux
- ☐ Vomiting

Genitourinary

- ☐ Dysuria/Pain with urinating
- ☐ Hematuria/Blood in urine
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

Reproductive

- ☐ Penile discharge
- ☐ Sexual dysfunction
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Vaginal discharge

Metabolic/Endocrine

- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Breast enlargement

Neurological

- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Tremors
- ☐ Vertigo/Room spinning

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Increased stress

Integumentary

- ☐ Contact allergy
- ☐ Hives
- ☐ Pruritus/Itching
- ☐ Rash

Musculoskeletal

- ☐ Back pain
- ☐ Myalgia/Generalized muscle ache
- ☐ Joint

Hematologic/Lymphatic

- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Lymphadenopathy / Enlarged lymph nodes

Immunologic

- ☐ Asthma
- ☐ Chemicals in work place
- ☐ Food allergies
- ☐ Immunosuppression
- ☐ Seasonal allergies

Mohammad Elbatta, MD, INC

Cancellation Policy/No Show Policy
For Doctor Appointments and Procedures

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a heavily committed schedule.

If an appointment is not canceled at least two (2) business days in advance you will be charged a one-hundred dollar ($100) fee for a New Patient Consultation or a fifty dollar ($50) fee for a Follow Up Visit; this will not be covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen, however we must try to keep the other patients and doctor on time.

If you arrive 15 minutes past your scheduled appointment time, we reserve the right to reschedule your appointment.

3.*Cancellation/ No Show Policy for Procedures*

Due to the large block of time needed for procedures, last minute cancellations can cause problems and added expenses for the office and surgery center.

If your scheduled procedure is not canceled at least three (3) business days in advance, you will be charged a $200 fee; this will not be covered by your insurance company. In addition, you may be charged a cancellation fee by the surgery center as well.

4. *Account balances*

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan options may call and ask to speak to a business office representative with whom they can review their account and concerns.

______________________	_________________________	____/____/____
Print Patient Name	**Signature Patient/Guardian**	**Date**