Dalia Ibrahim, M.D.
24411 Health Center Drive, Suite #430
Laguna Hills, CA 92653
Phone: (949)-452-3933
Fax: (949)-458-1291
IbrahimMD.com

PATIENT INFORMATION SHEET

FIRST NAME: _____ **MIDDLE INT:** _____ **LAST NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:**_____ **ZIP:**_____

HOME #: _____ **WK#:** _____ **CELL#:** _____

BIRTHDATE: _____ **SS#:** _____ **E-MAIL:** _____

AGE: _____ **SEX:** F M **MARITAL STATUS:** S M W D OTHER **RELIGION:** _____

RACE _____ **PREFERRED LANGUAGE**_____ **ETHNICITY:** HISPANIC____ NON HISPANIC ____

REFERRED BY: _____ **FAMILY DOCTOR:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SPOUSE/NEAREST RELATIVE: _____ **PHONE:** _____

SPOUSES EMPLOYER: _____ **BIRTHDATE:** _____ **SS#:** _____

EMERGENCY CONTACT: _____ **RELATION/PHONE:** _____

PRIMARY INSURANCE

COMPANY: _____

ID#: _____

GROUP#: _____

INSURED: _____

CO-PAY: _____

SECONDARY INSURANCE

COMPANY: _____

ID#: _____

GROUP#: _____

INSURED: _____

CO-PAY: _____

I guarantee payment to Dalia Ibrahim, M.D. I authorize my insurance company(ies) to pay any and all charges rendered on my behalf directly to Dalia Ibrahim, M.D. I will be responsible for and will guarantee payment on any and all charges, which may not be paid or covered by my insurance company(ies). I understand payment in full may be required at the time of service (for your convenience we accept money orders, checks, cash, Visa, and MasterCard). I certify that the information given, including insurance coverage is complete and correct. I have read and understand Dr. Ibrahim cancellation fee policy. I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency. I understand the returned check fee is $25.00.

SIGNATURE:_____ **DATE:**_____

Dalia Ibrahim, M.D.
HEALTH QUESTIONNAIRE

Patient Name: _____ **DOB**: _____ **Date**: _____

Past Medical History:

Have You ever had (or have) the following: (Please check if "yes", leave blank if "no")

Heart Problems	Yes__ explain: _____		Pacemaker/heart stent or valve	Yes__ explain: _____	
Infectious disease	Yes__ explain: _____		High Blood Pressure	Yes__ explain: _____	
Respiratory problems	Yes__ explain: _____		Prolonged bleeding	Yes__ explain: _____	
Cancer	Yes__ explain: _____		Thyroid disease	Yes__ explain: _____	
Liver disease	Yes__ explain: _____		High cholesterol	Yes__ explain: _____	
Diabetes	Yes__ explain: _____		Anemia	Yes__ explain: _____	

Other Medical Conditions (please list):

_____

_____

Past Surgeries (please list):

_____

_____

History of Anesthesia (Reaction?): _____

Sleep Apnea: Yes___ No ___ **Joint Replacement**: Yes___ Hip___ Knee___ Other_____ No__

Drug Allergies: _____

Medication Name/Dose: _____
(Prescription, over the counter, vitamins, & herbs)

Patient Social History:

Marital Status: Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____
Use of Alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____
Use of Tobacco: Never:_____ Quit:_____ (if so, When?):_____ Current pack/day:_____
Use of Recreational Drugs: Never:_____ Type/Frequency:_____

Family Medical History:

	Age	Disease/Health Issue	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

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Name: _____ Age: _____ Date: _____

Who referred you for this examination? _____

Have you ever had a sigmoidoscopy or colonoscopy? _____

If so, when? _____ What doctor? _____

Have you had any significant change in your bowel habits? _____

Do you regularly have diarrhea or constipation? _____

Do you have any rectal bleeding? _____

If so, is it bright red, burgundy, or maroon? _____

Do you see blood with the stool, on the toilet, or associated with a mucous discharge?

_____

Do you have a <u>family history</u> of: Colon Cancer?_____
Colon Polyps?_____
Ulcerative Colitis?_____
Crohn's Disease?_____

If so, who?_____

Do you have a <u>personal history</u> of: Colon Cancer?_____
Colon Polyps?_____
Breast, Uterine, Ovarian, or Cervical Cancer?_____

Please add any additional information, if pertinent.

_____

_____

Please list the name(s) of doctor(s) that you would like us to send a report.

_____

Please list your pharmacy name, phone number, and/or address.

_____

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CREDIT CARD ON FILE POLICY

We are committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. Credit cards on file will be used to pay co-pays when you are seen in our office, including account balances, after your insurance processes your claim. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. We require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will charge for each month that the bill remains unpaid.

If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

I give the medical office of Dr. Dalia Ibrahim permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

I authorize the medical office of Dr. Dalia Ibrahim to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ CVV code _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

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PATIENT RECORD OF DISCLOSURES

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- **Best Contact Number** _____
  - O.K. to leave message with spouse
  - O.K. to leave message with detailed information
  - Leave message with call-back number only
- Work Telephone_____
  - O.K. to leave message with detailed information
  - Leave message with call-back number only
- Written Communication
  - O.K. to mail to my home address
  - O.K. to mail to my work/office address
  - O.K. to fax to this number_____
  - O.K. to exchange information with referring doctors and treatment facilities
- Other_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record. **Note: Uses and disclosures of PHI may be permitted without prior consent in an emergency.**

I authorize your office to disclose my health information to the following people if needed.

1.
2.

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Cancellation Policy

Time has been specifically reserved for your office visits and procedures. Due to our high patient volume and long waiting patient list, you are required to give us a 72 hour (3 days) notice if you cancel your procedure (EGD or Colonoscopy). This will enable us to schedule another patient and follow the required procedure preparation. If you fail to cancel before a 72 hour period, you will be charged a $200.00 cancellation fee. You are required to give us a 24 hour notice if you wish to cancel an office visit. If you fail to cancel before a 24 hour period, you will be charged a $75.00 cancellation fee. These fees are non-refundable, even if you decide to reschedule.

We make every effort to confirm procedures 2-3 days before the scheduled date as a reminder to start your preparation. We confirm office visits 1-2 days before scheduled appointment. This is a courtesy call only. It is your responsibility to call us 3 days before your office procedure or 24 hours before an office visit if you are unable to keep your scheduled appointment. If an emergency arises and you need to cancel your procedure after hours, we ask that you call our office and have the doctor on call paged for notification.

Cancellation Agreement:

Effective: January 1, 2008

I understand Dr. Ibrahim's Cancellation Policy above and agree to follow this office policy.

_____ _____

Patient Name (Please Print) **Patient Signature**

_____ _____

Date **Witness**

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Acknowledgment and Receipt of Notice of Privacy Practices

I have been provided with a copy of the Notice of Privacy Practices for Dalia Ibrahim, M.D as it is currently in effect. I have read and understand that I am entitled to receive a paper copy of the notice at any time I request one. Dalia Ibrahim, M.D. reserve the right to make changes to the notice and an updated copy will be available on subsequent office visits.

Patient Name: _____

Patient Signature: _____

Date: _____

For Office Use Only:

Documentation of a patient's inability, refusal, or choice not to read the Notice or Sign the acknowledgment.

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

_____

_____

_____

I, _____ D.O.B:_____, request a copy of my medical records be faxed or mailed to Dr. Dalia Ibrahim as soon as possible.

Please include:

- ❑ **Colonoscopy report**
- ❑ **Endoscopy report**
- ❑ **Pathology**
- ❑ **Recent lab work**
- ❑ **Ultrasound**
- ❑ **CT scan**
- ❑ **Other_____**

Patient/Guardian Signature: _____

Date: _____