FORT WAYNE MEDICAL INSTITUTE

HASSAN N TAKI MD
MOHAMED A TAKI MD

FIRST VISIT: 1 - 3 hours NO antihistimines 72 hour prior to appointment

Patient's Last Name _____ First Name_____ Middle Initial ____

SSN _____ Date of Birth _____ Age _____ Sex: F ☐ M ☐

Address _____ Apt.#_____ City _____ State _____ Zip _____ County_____

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian Other _____ Language: _____

Name & Address of Primary Care (Family) Physician / Pediatrician _____

Referring Physician Name & Address (if different) _____ Send copy of notes to primary care phys. ☐

Guardian's Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Student Status: PT ☐ FT ☐

Home Phone _____ Day Phone _____ Cell Phone _____

E-mail Address _____

Employer: _____ Employer Address: _____

What is or was your occupation? _____ ☐ Retired?

Name of Spouse/Parent/Legal Guardian _____ DOB _____ SSN _____

Primary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Secondary Medical Insurance

Policy Holder Name _____ Policy Holder SSN _____ Policy Holder DOB _____

Plan Name _____ Policy Holder # _____ Patient's Policy # _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Ins. Co. Address _____ Ins. Co. Phone Number _____

Effective Date _____ Co-pay Amount _____ Deductible _____

Emergency Contact: _____ Phone #: _____

I WILL BE PAYING BY: CASH ☐ CHECK ☐ CREDIT CARD ☐

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full. **I have received Fort Wayne Medical Institute's notice of privacy practice.**

Responsible Party Signature: _____ ***Date:*** _____

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

What is the reason you are here today? _____

How would you prefer the doctor to address you? Mr. Ms. Mrs. Dr. First Name Nickname: _____

Drug Allergies? Or ☐ **No Known Drug Allergies**

Medication	Type of Reaction		Medication	Type of Reaction

Have you ever had an allergy test? ☐ Yes ☐ No

Have you ever taken allergy shots? ☐ Yes ☐ No

If yes, are you still taking them? ☐ Yes ☐ No How much relief from shots? ☐ minimal ☐ partial ☐ significant

LIST ALL MEDICATIONS YOU ARE TAKING (Prescription, over-the-counter or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

Pharmacy Name (Include Address &/or Phone)_____

***MEDICAL / SURGICAL HISTORY*: HAVE YOU EVER BEEN *DIAGNOSED* WITH ANY OF THE FOLLOWING?**

☐ **No Medical / Surgical History**

Cardiovascular: **Surgery/Management**

Coronary Artery Disease ☐ _____

Elevated Cholesterol (hyperlipidemia) ☐ _____

High Blood Pressure (hypertension) ☐ _____

Gastrointestinal:

Hepatitis ☐ _____

Hernia ☐ _____

Gastroesophageal Reflux ☐ _____

Genitourinary:

Prostate enlargement (Benign Prostate Hyperplasia) ☐ _____

Kidney Stones (Nephrolithiasis) ☐ _____

Renal Failure (Acute) ☐ _____

Ear / Nose / Throat: (HEENT)

Cataracts ☐ _____

Glaucoma ☐ _____

Chronic Ear Infections (Otitis Media) ☐ _____

Hearing Loss ☐ _____

Sinus Problems (chronic sinusitis) ☐ _____

Nasal Polyps ☐ _____

Nasal Allergies ☐ _____

Recurrent Tonsillitis ☐ _____

Tinnitus ☐ _____

Vertigo ☐ _____

Hematologic :

Anemia ☐ _____

Immunologic: **Surgery/Management**

Allergies Type: _____ ☐ _____

Food Allergies Type: _____ ☐ _____

Infectious Disease:

Mononucleosis ☐ _____

STD Type: _____ ☐ _____

Metabolic/endocrine:

Diabetes Type: _____ ☐ _____

Thyroid deficiency (hypothyroidism) ☐ _____

Thyroid excess (hyperthyroidism) ☐ _____

Neoplastic:

Cancer Type: _____ ☐ _____

Neurologic:

Migraine ☐ _____

Obstetric:

Pregnancy Date(s): _____ ☐ _____

Psychiatric:

Adjustment Disorder - Anxiety ☐ _____

Major Depression ☐ _____

Pulmonary:

Asthma ☐ _____

COPD ☐ _____

Emphysema ☐ _____

Sleep Apnea ☐ _____

Tuberculosis ☐ _____

If YES to any of the above Diagnosis was surgery performed?

What_____ **Where/When**_____ **By Who**_____

FAMILY HISTORY:

ADD/ADHD	☐	CVA (Stroke)	☐	Learning disability	☐
Alcoholism	☐	Depression	☐	Mental illness	☐
Allergies	☐	Developmental delay	☐	Migraines	☐
Alzheimer's Disease	☐	Diabetes	☐	Obesity	☐
Asthma	☐	Eczema	☐	Osteoarthritis	☐
Blood disease	☐	Hearing deficiency	☐	Osteoporosis	☐
CAD (Coronary Artery Disease)	☐	Hyperlipidemia	☐	PVD	☐
CAD-Premature	☐	Hypertension	☐	Renal disease	☐
Cancer Type: _____	☐	Irritable Bowel Syndrome	☐	Seizure disorder	☐

Other Family History: _____

Tobacco Use? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Tobacco	Packs/ Day	For ? Years	Yr. Quit?
Cigarettes			
Other: (list type)			

Do you consume alcohol? ☐ **Yes** ☐ **No** ☐ **Former**

Type of Alcohol	Frequency?	Amt?	Last Drink?

Exposed to second hand smoke? ☐ **Yes** ☐ **No**
Caffeine Consumption? ☐ **Yes** ☐ **No** **Type:** _____ **Amount per day?** _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

☐ Fatigue
☐ Fever
☐ Night sweats
☐ Weight loss
☐ Weight gain

Eye problems

☐ Double vision
☐ Itchy eyes
☐ Redness

Ear problems

☐ Drainage
☐ Hearing loss
☐ Infections
☐ Dizziness
☐ Itchiness
☐ Exposure to Excessive Noise
☐ Ear pain
☐ Ringing /noise in ears

Nose & Sinus problems

☐ Congestion
☐ Facial Pain
☐ Mouth Breathing
☐ Nose Bleeds
☐ Sneezing
☐ Runny Nose
☐ Post Nasal Drainage

Mouth & Throat problems

☐ Difficulty Swallowing
☐ Sleep Apnea
☐ Snoring
☐ Sore Throat
☐ Hoarseness
☐ Sores/Ulcers in Mouth

Heart or circulation problems

☐ Heart Murmur
☐ Chest pain
☐ Swelling of Ankles/Edema
☐ Blacking Out
☐ Irregular Heartbeat/Palpitations

Lung or respiratory problems

☐ Cough
☐ Shortness of Breath
☐ Wheezing

Musculoskeletal:

☐ Leg pain

Stomach problems

☐ Abdominal Pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea
☐ Vomiting

Brain or Nervous system problems

☐ Headache
☐ Seizures
☐ Focal Weakness
☐ Numbness

Glands & Hormone problems

☐ Heat Intolerance
☐ Cold Intolerance
☐ Neck Enlargement/Goiter

Blood or Lymph nodes problems

☐ Easy Bleeding
☐ Easy Bruising

Allergy problems

☐ Food Allergies
☐ Bee Sting Allergies
☐ Environmental Allergies
☐ Urticaria / Hives

Skin

☐ Itchy Skin/ Pruritis
☐ Rash
☐ Contact Allergy

Patient Name: _____ **DOB:** _____

Responsible Party Signature: _____ **Date:** _____

FINANCIAL AGREEMENT 2024

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. **WE REQUIRE YOUR INSURANCE CARD(S) AND LEGAL ID FOR COPY TO YOUR RECORD**.

- **APPOINTMENTS** – Failure to arrive within 15mins of appointment or cancel at least 24hrs prior will result in a $25 NO-SHOW fee.
- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.
- **CO-PAYMENTS** – We are reequired to collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Provider Agreement requires that claims be paid within 30 days of receipt by payor. Failure to do so may result in loss of discount.
  Accounts over 30 days will also recieve a $2.00 postal mailing fee per mailing.
- **OUT OF NETWORK PLANS** – You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.
  Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Fort Wayne Medical for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Please meet with our payment staff prior to office visit.
- **MEDICARE** – We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Fort Wayne Medical for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The parent who consents to the treatment of a minor child is responsible for payment of services rendered. Fort Wayne Medical will not be involved with separation or divorce disputes.

I agree to pay for any and all balances due for services provided. By insurance contracts, you may lose discounts by failing to pay balances within 30 days of reciept. Unpaid balances will be assesed late fees, as well as court/interest/filing and collections fees loss of "discounts" is substantial so timely payment is important
This agreement is to stay in place until mutually discharged by both parties and all obligations are met.
All overdue accounts subject to 21% interest and $2 per month billing fee

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, OR DISCOVER CARD.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient's Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Print Name: _____ Relationship: _____

FORT WAYNE MEDICAL INSTITUTE HASSAN N TAKI M.D.

Preferred Pharmacy and History Request

As part of our electronic medical records system, we are now able to transmit perscriptions directly to your pharmacy or online vendor.

In order to do this, we will need to know your pharmacy preferences. While addresses are helpful, we can get by with approximate location of your preferred pharmacy.

Primary Pharmacy

Pharmacy _____ Street(s) _____ City _____ State ____

Secondary Pharmacy

Pharmacy _____ Street(s) _____ City _____ State ____

Online/Mail Order Pharmacy

Pharmacy _____ Web Address _____

Permission to Obtain Medications History Accept: ☐ Decline: ☐

Patient Signature _____ Date _____

Release of Patient Records

For Fort Wayne Medical Institute (FWMI) to release any information about your or your childs medical records to any person, we must have on file that persons name, their relationship to you, their date of birth along with your signature.

This is accordance with federal HIPAA regulations concerning your privacy.

We are unable to release information without this signed authorization.

I _____ hereby authorize FWMI to release my medical information to the people listed on this form. I may revoke or modify this list at any time but it must be done in writing.

Patient Signature: _____ Date: _____

Persons I would allow information about my medical records:

NAME:	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____