GHASSAN
E. HADI, M.D.
INTERNAL MEDICINE

Foothill Medical Plaza 1060 E Foothill Blvd. Ste 103
Upland, CA 91786 // (909) 981-8904 // info@hadimd.com

1. PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ☐ M ☐ F Age____ DOB _____

☐ Married ☐ Widowed ☐ Single
☐ Minor ☐ Separated ☐ Divorced
☐ Partenered for____ years

Occupation _____

Patient Employer/School _____

_____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

2. INSURANCE

Who is responsible for this account?

_____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is Patient covered by additional insurance?

☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

and assign directly to Dr. _____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benfits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic.

for any services furnished to my by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Print name of Beneficiary, Guardian or Personal Representative

_____
Signature of Beneficiary, Guardian or Personal Representatative

_____
Date

_____
Relationship to Beneficiary

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3. PHONE NUMBERS

Home Phone _____ Cell Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

4. FAMILY HISTORY

Date of Lasty Physical Examination _____

What is the reason for your visit? _____

	FATHER	Present Health or Cause of Death	MOTHER	Present Health or Cause of Death	SPOUSE	Present Health or Cause of Death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	

	No. Alive	Health	No. Deceased	Cause of Death
BROTHERS				
SISTERS				
CHILDREN		Ages & Health		

CHECK ILNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Nervous Illness
- ☐ Cancer
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Allergy
- ☐ Bleeding Tendency
- ☐ High Blood Pressure
- ☐ Other _____

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5. HEALTH HISTORY All information is strictly confidential.

Check ✔ symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Loss of Weight
- ☐ Numbness
- ☐ Sweats
- ☐ HIV
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Syphilis

MUSCLE/JOINT/BONE
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

NEUROLOGIC
- ☐ Headaches
- ☐ Seizures/Convulsion
- ☐ Numbness Sensation
- ☐ Weakness
- ☐ Tremors
- ☐ Concussion/Whiplash
- ☐ Ataxia/Balance Problems
- ☐ Trouble Sleeping
- ☐ Speech Difficulty
- ☐ Dizziness
- ☐ Motion Sickness
- ☐ Double Vision
- ☐ History of Stroke
- ☐ Syncope
- ☐ Confusion
- ☐ Memory Problems

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Veins

PULMONARY
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma
- ☐ Cough

ENDOCRINE
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Excessive Thirst

EYE, EAR, NOSE, THROAT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache/Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision - Flashes/Halos

SKIN
- ☐ Bruise Easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars
- ☐ Sore that won't Heal

PSYCHIATRY
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal
- ☐ Stress
- ☐ Hallucinations
- ☐ Mood Swings
- ☐ Delusions
- ☐ Eating Problem

NEPHROLOGY
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones

MEN ONLY
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pao Smear
- ☐ Bleeding Between Periods
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of Last Menstrual Period _____

Date of Last Pap Smear _____

Have you had a Mammogram? _____

Are you pregnant? _____

Number of Children _____

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

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7. HEALTH HABITS

Check ✔ which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check ✔ if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

8. SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

_____ _____

Reviewed by | Date

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MEDICATION POLICY 1

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We want to make sure we are giving you the best possible care. In order to do that we ask that you bring a list of your current medications or your medication bottles, to each appointment. This will ensure an efficient office visit. Failure to do so may cause a cancellation of your appointment, and will be rescheduled for a later date. By signing this form you are acknowledging our Medication Policy.

PLEASE ALLOW 72 BUSINESS HOURS TO PROCESS YOUR REQUEST.

If you have not seen in more than 6 months, or have recent bloodwork, we will not refill your medications, and if you are prescribed controlled substances you must be seen every 2 months. To avoid any delays in refilling your medications please make sure to keep all your scheduled appointments.

PRESCRIPTION REFILLS - It is most efficient for you to contact your pharmacy to request refills on your regular medications. Please monitor your medication supplies so that you don't run out on weekends or after hours. Prescription refills are only done during office hours.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

_____ _____ _____
Date of Birth Pharmacy Name Pharmacy Phone Number

_____
Drug Allergies

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MEDICATION LIST

2

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Please list all medications that you are currently taking and please include any over the counter medications and/or supplements.

MEDICATION NAME OR SUPPLEMENT NAME	DOSAGE	QTY/DAY	PRESCRIBING DOCTOR

Notes _____

_____

_____

_____

Date

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RELEASE OF (PHI) PROTECTED HEALTH INFORMATION TO OTHERS INVOLVED IN YOUR HEALTH CARE

As our patient here at Dr. Ghassan Hadi's office, you have the choice in which we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individuals with whom we may discuss your protected health information.

Patient's Name _____ DOB _____

Can Dr. Ghassan Hadi's office acknowledge that you are a patient here? ☐ Yes ☐ No

I, _____ give Dr. Ghassan Hadi & Staff permission to discuss my protected health information with the following persons:

Name & Relation	Phone Number
_____	( ) _____
_____	( ) _____
_____	( ) _____
_____	( ) _____
_____	( ) _____

Emergency Contact Information

Name _____ Phone Number ( ) _____

Address _____

I also give permission to Dr. Ghassan Hadi's personnel to leave messages on voice mail, telephone recorder or with person answering the phone. *Please select one:* ☐ Yes ☐ No

Name and Address of nearest relative not living at your address:

Name _____ Phone Number ( ) _____

Address _____

Relationship _____

_____ _____

Patient Signature Date

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OFFICE POLICIES

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OFFICE HOURS - We are open Monday thru Thursday 8:30a-5p and Friday 8:30a-3p. We do not close for lunch.

APPOINTMENTS - Please call (909) 981-8904 to schedule an appointment. In the vast majority of cases, we are able to accept walk-ins. Please arrive 15 minutes early for your scheduled appointments, this allows us to better respect your time and start the appointment on time.

LATE/CANCELLED APPOINTMENTS - If you are more than 15 minutes late for your scheduled appointment you may be asked to reschedule your appointment. We request that you contact us at least 24 hours in advance to cancel appointments. Failure to cancel appointments or failure to show up for an appointment may result in you being billed for that missed appointment, we do have an automated call back system that will remind you of your scheduled appointment, therefore it is your responsibility to inform our office of any changes in phone numbers

PAYMENT POLICY - You are responsible for any co-payment due at the time services are rendered. It is also expected that you will pay any unpaid balances on your account. We are happy to work out a payment arrangement if you are having financial difficulties. We accept cash, personal checks and major credit cards for payments. There is a fee of $25 for any returned checks. For questions about billing, please contact our outside billing service:
ACI Billing Services at (909) 946-5221.

MEDICAL RECORDS - There is a $25 fee for any copies of medical records. Please allow 15 business days to complete your request.

I have read and understand the office policies and agree to abide by these guidelines as a patient of the office of Dr. Ghassan Hadi.

**RESULTS WILL NOT BE DISCUSSED OVER THE PHONE.
PLEASE SCHEDULE AN APPOINTMENT.**

Signature of Patient or Responsible Party

Date

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ADVANCED HEALTH CARE DIRECTIVE

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As your physician, we are required to ask any patient over the age of 18, if they have an existing Advance Health Care Directive so that we can incorporate the information into your medical record.

You are not required to give us this information, but we are required to ask.

Please complete the form and return it to the receptionist.

Patient's Name _____ **DOB** _____

I decline to answer these questions. ☐ Yes ☐ No

Do you have an Advanced Health Directive? ☐ Yes ☐ No
If yes, please indicate which type of directive:

☐ Durable Power of Attorney for Healthcare
☐ California Natural Death Act
☐ Living Health Care Will

Will you provide us a copy of your directive? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Type of Health Care Directive Received:

☐ Durable Power of Attorney for Healthcare
☐ California Natural Death Act
☐ Living Health Care Will
☐ Other: _____

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TUBERCULOSIS (TB) RISK ASSESMENT QUESTIONNAIRE

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Last Name _____ First Name _____

Date of Birth _____ Date _____

1. Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe?

☐ No ☐ Yes *If yes, list countries:* _____

2. Have you been diagnosed with a chronic condition that may impair your immune system?

☐ No ☐ Yes *If yes, check all that apply below:*

- ☐ Chronic Steroid Use
- ☐ HIV Positive
- ☐ Cancer of the head or neck
- ☐ Silicosis
- ☐ Leukemia, Lymphoma or Hodgkin's Disease
- ☐ Gastrectomy/Intestinal Bypass
- ☐ Crohn's Disease
- ☐ Rheumatoid Arthritis
- ☐ Use of TNF-or antagonist
- ☐ Low Body Weight (10% or more below ideal)
- ☐ Diabetes Mellitus
- ☐ Dialysis/Renal Failure
- ☐ Chronic Malabsorption Syndromes

3. Have you ever resided, worked or volunteered in any of the following facilities?

☐ No ☐ Yes *If yes, check all that apply below:*

- ☐ Prison
- ☐ Homeless Shelter
- ☐ Hospital
- ☐ Nursing Homes
- ☐ Other Long Term Treatment Center: _____

4. Do you currently have any of the following symptoms?

☐ No ☐ Yes *If yes, check all that apply below:*

- ☐ Cough>3 Weeks
- ☐ Productive cough (coughing up something)
- ☐ Coughing Up Blood
- ☐ Unexplained Fever
- ☐ Loss of Appetite
- ☐ Unexplained Fever
- ☐ Night Sweats
- ☐ Unexplained Weight Loss
- ☐ Chest Pain
- ☐ Weakness
- ☐ Respiratory Difficulty (shortness of breath)
- ☐ Fatigue
- ☐ Chills

5. Have you ever had contact with a person known to have active tuberculosis? ☐ No ☐ Yes

6. Have you ever used injection drugs? ☐ No ☐ Yes

7. Have you had a tuberculin skin test before? ☐ No ☐ Yes

If yes, list where given: _____ *Date:* _____

The information above is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

_____ _____

Signature of Patient or Responsible Party Date