Dr. Sameh Fayek

Board Certified Surgeon – General and Transplant Surgery

1650 W. Rosedale St. Suite 301, Fort Worth TX 76104

(P) 817-885-7575 (F) 817-885-7546

Patient Information

Patient Name:____ DOB:_________________
Last First M.I.

Home Address:____

City:____________________________________ State:___________ Zip:___________________

Home Phn:__________________ Cell Phn:__________________ Alt. Phn:____________________

SSN:____________________________ Email:____

Employer Name:_________________________________ Work Phn:__________________________

______ Check here if you have no insurance (Cash Account)

Insurance #1:____ Insured DOB:_________________

Insurance #2:_______________________________________ Insured DOB:____________________

I, the undersigned, hereby authorize payment directly to Premier Surgical Associates for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company. I also understand that I am responsible for a fee of $ 25.00 for not showing up for the scheduled appointment.

Printed Name:____

Signature:____**Date:**____________________

** Please be advised, you will be required to complete this form at your first office visit of each year. The information that you provide is updated yearly and ensures we have accurate information to file a claim on your behalf. Thank you for your assistance with this process.

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Acknowledgement of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA,) patients have certain rights to privacy regarding their protected health information. Your protected health information will be used to:

- Conduct, plan, and direct treatment by the physicians employed by Premier Surgical Associates and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers.
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, you agree that you have either received or waved your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Premier Surgical Associates has previously released relying on this consent.

Print Patient Name:____

Do we have permission to:

1. Leave a message at your home regarding appointments and/or treatments?.................. ___Yes ___No
2. Leave a message at your place of employment regarding appointments/treatments?...... ___Yes ___No
3. Leave a name and call back number at your home and place of employment?...............___Yes ___No
4. Mail test results and appointment information to your home address currently on file? ___Yes ___No
5. Email at filed email address regarding appointments and treatments?........................... ___Yes ___No
6. Discuss your personal information, including appointments and treatments with someone other than yourself? …………………………………………………………….…..... ___Yes ___No

Name	Relationship	Contact Number

Patient Signature:____ **Date:**_________________

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Authorization to Release Healthcare Information

Autorizacion para Divulgar Informacion Sanitaria

Patient Name/Nombre del Pacienete:____

DOB/Fecha de Nacimiento:______________

SSN/Seguro Social:__________________________________

Previous Name/Nombre Anterior:______________________

I request and Authorize/Solicito y Autorizo:_____________________________

(Name of Clinic/Practice/Physician) (Nombre de la Clínica / Práctica / Médico)

____

To release the medical records of the person named above to:

Para liberar los registros médicos de la persona nombrada arriba a

Name/Nombre:____

Address/Direccion:____

City/Ciudad:______________________ State/Estado:_____Zip Code/Código Postal:__________

This request and authorization applies to:

Esta solicitud y autorización se aplica a

____ All healthcare information/ Toda la información de la salud

____ Other/Otro:____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus,) sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all healthcare information relating to such diagnosis, testing or treatment.(Entiendo que se requiere mi consentimiento expreso para liberar cualquier información sanitaria relativa a las pruebas, el diagnóstico y / o tratamiento para el VIH (virus del SIDA), enfermedades de transmisión sexual, trastornos psiquiátricos / de salud mental o de drogas y / o alcohol, usted está específicamente autorizadas para liberar toda la información sanitaria relacionada con dicho diagnóstico, pruebas o tratamiento.)

Signature/Firma:____
Date/Fecha:_____________________________

Relationship if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)
Relación si está firmada por alguien que no sea el paciente (padre, tutor legal, representante personal, etc.)

____

PREMIER SURGICAL
ASSOCIATES

Physician List

Patient Name:____DOB:_________________

Physician/Specialist Address:

____
Primary Care Physician

____
Cardiologist

____
Pulmonologist

____
Endocrinologist

____
Neurologist

____
Gastroenterologist

____
Hematologist

____
Urologist

____
Other

Phone & Fax Number:

____
Primary Care Physician

____
Cardiologist

____
Pulmonologist

____
Endocrinologist

____
Neurologist

____
Gastroenterologist

____
Hematologist

____
Urologist

____
Other

PREMIER SURGICAL
ASSOCIATES

Medication List

Patients Name:____ DOB:___________________

Pharmacy:_____________________________________ **Phn:**_________________________

Allergies:____

Medication Name	Dose	Directions

Patient Medical History Questionnaire

Name:____ DOB:_______________

Dialysis Days and Times:____

Please indicate if you have any of the following conditions below:

Cardiology:
___ Hypertension
___ Angina
___ Heart Attack
___ Heart Failure
___ Atrial Fibrillation
___ Irregular Heart Beat
___ Heart Murmur
___ Peripheral Vascular Disease
___ Aortic Aneurysm

Pulmonary:
___ Asthma
___ Chronic Bronchitis
___ Emphysema
___ COPD
___ Pneumonia
___ Pulmonary Hypertension
___ Clot in the lungs
___ Sleep Apnea
___ Lung Cancer

Endocrine:
___ Diabetes Type 1
___ Diabetes Type 2
___ Thyroid Issues (high/low)
___ Addison's Disease
___ Cushing's Syndrome
___ Pituitary Adenoma
___ High Cholesterol
___ Obesity

Gastrointestinal:
___ Acid Reflux
___ Ulcer Disease
___ Gall Bladder Disease
___ Vomiting Blood
___ Blood in Stool
___ GI Cancer
___ Diverticulosis
___ Polyps

Liver Disease/Pancreas:
___ Hepatitis (type___)
___ Cirrhosis
___ Liver Cancer
___ Gallbladder Stones
___ Pancreatitis
___ Pancreatic Cancer

Genitourinary:
___ Recurrent UTI
___ Kidney Stones
___ Chronic Kidney Disease
___ Nephritis
___ Prostate Problem
___ Kidney Cancer
___ Bladder Cancer

Hematology:
___ Anemia
___ Leukemia
___ Bleeding Disorder
___ Blood Clots (legs)
___ Multiple Myeloma
___ Varicose Veins
___ HIV

Neurology:
___ Neuropathy
___ TIA
___ Stroke
___ Migraine
___ Seizure
___ Parkinson's Disease
___ Alzheimer's/ Dementia

Arthritis & Musculoskeletal:
___ Rheumatoid Arthritis
___ Osteoarthritis
___ Gout
___ Osteoporosis/Osteopenia
___ Lupus (SLE)
___ Scleroderma
___ Sjogren's Syndrome
___ Fibromyalgia

Patient Medical History Questionnaire

Name:____ DOB:_____________________

Surgeries:

	Date/Year	Surgeon Name	Nature of Surgery
1.			
2.			
3.			
4.			
5.			

Hospitalizations:

	Date/Year	Hospital Name	Reason for Hospitalization
1.			
2.			
3.			
4.			
5.			

Procedures:

	Date/Year	Performed By	Result
Upper GI Endoscopy			
Colonoscopy			
Biopsy			
Cardiac Stress Test			
Pap Smear			
Mammogram			

PREMIER SURGICAL
ASSOCIATES

Patient Medical History Questionnaire

Name:____ DOB: ________________

Family History:

Please make a check in the boxes that apply:

	Status: A=Alive D=Deceased	Diabetes	High BP	Heart Disease	Kidney Disease	Stroke	Cancer
Mother	A D						
Father	A D						
Paternal Grandfather	A D						
Paternal Grandmother	A D						
Maternal Grandfather	A D						
Maternal Grandmother	A D						
Brother(s)	A D						
Sister(s)	A D						
Sons(s)	A D						
Daughter(s)	A D						

Social History:

	Current Use	Frequency	If use, When?
Smoking			
Alcohol			
Illicit Drug Use			

Please CIRCLE your answer below:

Married: Y N   Living With: Spouse Alone Other:_______________________________

Flu Shot: Y N   Date Received:____

Pneumococcal Vaccine: Y N   Date Received:__________________________________