Dr. Mahmoud Aly, Dr. Yumi Kim

M. H. ALY, M.D., P.C.
1910 Richmond Road
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PATIENT INFORMATION

Name _____ SS # _____
Last First MI

Date _____ Cell Phone _____ Home Phone _____

Email _____ DOB _____ Marital Status _____

Address _____
Street City State Zip

Race/Ethnicity _____ Gender _____ Preferred Language _____

REFERRAL INFORMATION

Who shall we thank for referring you? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First MI

Relation to Patient _____ DOB _____ SS # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

ADDITIONAL INSURANCE

Is Patient Covered by additional Insurance? Yes No

Subscriber Name _____ DOB _____ Relation to Patient _____

Insurance Company _____ SS # _____

Contract # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I Certify that I, and/or my dependent(s), have insurance coverage with_____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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 benefits 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.

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

_____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

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ALLERGIES

Please list your allergies:

1	6
2	7
3	8
4	9
5	10

MEDICATION

Please list your current medications:

Name	Dose/Daily Amount
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

PREFERRED PHARMACY

Please list your preferred Pharmacy:

Name Address Phone #

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CONSUMPTION HISTORY

Do you currently consume Alcohol? If YES please indicate how many drinks per week.

Please Circle YES / NO

Do you currently/have you ever smoked cigarettes? If YES please indicate for how many years and daily amount.

MEDICAL CONDITIONS

Please list your past medical conditions:

1	6
2	7
3	8
4	9
5	10

PAST SURGERIES

Have you undergone Surgery / Surgical Procedures in the past? Please Circle YES / NO

If YES please indicate what type of Surgery / Surgical Procedures were performed:

1	6
2	7
3	8
4	9
5	10

FAMILY HISTORY

Please list any significant Family Health History / Conditions and the pertaining family member.

1	6
2	7
3	8
4	9
5	10

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name DOB

Signature Date

Please print the persons to whom we can release medical information:

Name Relationship

Name Relationship

Name Relationship