Malek Medical Center

Sherif Malek, MD
232 Norwood Avenue, West Long Branch, NJ 07764
(732)-222-6637

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ Apt/Unit: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____ Pharmacy/Town: _____

Social Security #: _____ Race: _____ Primary Language: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____ Preferred Language: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Member ID: _____

Group #: _____ Policy Holder: _____ DOB: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Secondary Insurance Company: _____ Member ID: _____

Group #: _____ Policy Holder: _____ DOB: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

PATIENT AUTHORIZATIONS AND ACKNOWLEDGMENTS

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I consent to medical evaluation and treatment by this practice and its healthcare professionals. I acknowledge that I am financially responsible for charges not covered by my insurance plan, including applicable deductibles, copayments, coinsurance, non-covered services, and other patient-responsibility amounts.

I authorize the release of medical and other information necessary to process insurance claims and obtain payment for services rendered. I authorize payment of insurance benefits directly to the provider or practice when permitted. I understand that insurance verification or authorization is not a guarantee of payment.

Communication Authorization: I authorize the practice to contact me regarding appointments, treatment, billing, and other healthcare-related matters using the contact methods I have provided, subject to applicable law and the practice's policies. The practice may provide patient billing statements electronically using the email address and/or mobile number on file. If you would like to opt out of any electronic communication, please contact the office to update your profile.

Patient / Legal Representative Signature: _____ Date: _____

Printed Name: _____ Relationship (if applicable): _____

MALEK MEDICAL CENTER

PREFERRED WAY OF COMMUNICATION AND DESIGNATION FOR HEALTH INFO DISCLOSURE

Acknowledgement of Practice's Notice of Privacy:

I have received a copy of Notice of HIPAA Privacy for the Physician Practice.

Name of Patient	Date of Birth	Signature of patient/Resp. Party	Date

I wish to be contacted in the following manner:

Home Telephone Number:

_____

( ) Ok to leave message with detailed information
( ) Leave message with call back numbers only

Cell Telephone Number:

_____

( ) Ok to leave message with detailed information
( ) Leave message with call back numbers only

I designate the following persons listed below involved with my health care- or payment related to my health care- for the purpose of the practice making limited Medical disclosures as described below.
I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Name: _____Relationship _____ Tel _____

Name: _____Relationship _____ Tel _____

Name: _____Relationship _____ Tel _____

The Privacy rule generally requires healthcare providers to take reasonable steps to limited the use or disclose of, and request for, Patient Health Information 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 patient/parent/guardian. Healthcare entities must keep a record of Patient Health information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and health care Operations may be permitted without prior consent.

MALEK MEDICAL CENTER
Dr. Sherif Malek
232 Norwood Avenue, W.L.B. NJ 07764
Tel# (732)222-6637 Fax# (732)222-6645

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient's name: _____

D.O.B. _____

Address: _____

Attn: _____

I hereby authorize and request the release of:
___My complete medical history records in your possession concerning my illnesses and/ or treatment.
___The specified reports indicated: _____

Please release it to:

Dr. Sherif Malek
232 Norwood Avenue,
West Long Branch, NJ07764

I understand that I have the right to revoke this Authorization anytime. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.
I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and or/copy the information to be disclosed. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.
I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

Signature of patient or authorized Representative: _____

Description of Representative's authority: _____

Date: _____

MALEK MEDICAL CENTER
SHERIF MALEK, MD
232 NORWOOD AVENUE
WEST LONG BRANCH, NJ 07764
TEL (732)222-6637 fax (732)222-6645

NOTICE OF ACCEPTANCE OF RESPONSIBILITY FOR REFERRALS AND PRIOR-AUTHORIZATIONS

Patient's Name: _____

Responsible Party (if different from the patient): _____

I, (the patient or the responsible party on behalf of the patient) understand and agree to the following:

1- My medical insurance coverage is pursuant to a contract between myself and my insurance company. I am responsible for understanding my rights and responsibilities under my medical insurance policy, for understanding what procedures are covered or not, and for understanding the general policies of my insurance contract as they pertain to me.

2- Some medical procedures, tests or services may not be covered by my medical insurance policy. It is my responsibility to inquire with my insurance company to determine whether any procedure or test ordered by Malek Medical Center is a covered item under my plan, and if so, to what extent. I understand that I am fully responsible for all uncovered procedures, tests and services, or any portion thereof not covered by my insurance company.

3- My insurance company may require that I obtain a referral or a prior-authorization from Malek Medical Center, for certain procedures, tests or services, I understand that informing the front desk staff and obtaining such a referral or prior-authorization is my responsibility. I further understand that the referral and approved prior-authorization forms must be obtained before going for that procedure, test or service.

4- I accept full responsibility for the consequences of not obtaining necessary referrals and/ or prior authorizations at the time for my appointment. I agree to pay all charges for services rendered to me by Malek Medical Center, including charges for non covered procedures by my insurance plan for any reason, including for lack of a referral and/ or prior-authorization.

Patient/ responsible party's signature: _____

Office staff signature: _____ **Date:** _____

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

– Symptoms –

Check (✓) conditions you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

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
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ 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 _____

– Conditions –

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

– Medications –

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name _____ Phone _____

– Allergies –

_____

_____

_____

_____

_____

– Health History –

– Family History –

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

– Hospitalizations –

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

– Pregnancies –

Year of Birth	Sex of Birth	Complications if any

– Health Habits –

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

– Occupational –

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

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

_____ _____

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

_____ _____

Reviewed By — Date