SAINT THOMAS CLINIC, PLLC
Hany Abskhroun, M.D
7056 Mariner Blvd.
Spring Hill, FL 34609-1000
T: (352) 610-4408/ F:(352) 606-3960

IDENTIFYING INFORMATION & CONTACT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

___ Male ___ Female Date of Birth: _____ SSN: _____ Height: _____

Email: _____ Home/Mobile Ph.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

INSURANCE

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder: ____ Self ____ Spouse ____ Other (If Policy holder is other than self pls. provide below information.)

Policy Holder Name: _____ Relation: _____

SS#: _____ Date of Birth: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder: ____ Self ____ Spouse ____ Other (If Policy holder is other than self pls. provide below information.)

Policy Holder Name: _____ Relation: _____

SS#: _____ Date of Birth: _____

SURGICAL HISTORY (Please indicate below any surgeries done)

(Name & Year) (Name & Year)

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES

Are you allergic to any medication? ____Yes ____No (If yes, please indicate below)

Allergy: Reaction:

_____ _____

_____ _____

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PAST MEDICAL HISTORY – Please check whether you have ever had the following:

✓	CONDITION	✓	CONDITION
	Acid Reflux / GERD		High Cholesterol
	Allergies (other than medication)		Irritable Bowel Syndrome
	Alzheimer's Disease		Kidney Disease
	Anemia (Low Blood Count)		Liver Disease
	Arthritis		Migraine
	Asthma		Obesity
	Cancer		Osteoporosis
	COPD / Emphysema		Peripheral Artery Disease
	Depression		Seizures / Epilepsy
	Diabetes		STD
	Enlarged Prostate		Sleep Apnea
	Erectile Dysfunction		Stroke
	Gastrointestinal Disease		Thyroid Disease
	Glaucoma		Others:
	Heart Disease		Others:
	Hepatitis C		Others:
	High Blood Pressure		None

FAMILY MEDICAL HISTORY

Please indicate if any of patient's primary family members has/had any of the following conditions. Pls. specify which family member.

CONDITION	FAMILY MEMBER
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Stroke	

Others / Not Listed (pls. specify): _____

_____

PREVENTIVE CARE

Have you ever done or visited the following:

PROCEDURE	YES	NO	WHEN?
Colonoscopy			
Bone Density (DEXA Scan)			
Mammogram (*Female Only*)			
PAP Smear (*Female Only*)			
Eye Dr. (*Diabetics Only*)			
Podiatry/Foot Dr. (*Diabetics Only*)			

Do you have a living will? _____Yes ____No

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SOCIAL HISTORY

Do you smoke? ____ Yes ____ No ____ Past smoker How many cigarettes/pack per day? _____

Any alcohol abuse? ____ Yes ____ No Any drug abuse? ____ Yes ____ No

MEDICATION LIST

NAME OF MEDICATION	STRENGTH	FREQUENCY	COMMENT

Please ask front desk for additional Medication List if space provided is not enough. Thank You.

DESIGNATED RELATIVE

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment health issues with: ( ) Spouse ( ) Children ( ) Other _____

Please list the family members or significant others, is any, whom we may inform about your medical consdition, and/or treatment in case of an emergency:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Messages may be left on my answering machine regarding my health and appointment made: ___Yes ___No

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ACKNOWLEDGMENT OF HIPAA & PRIVACY NOTICE

Please sign below to acknowledge that you have read, understood & received Saint Thomas Clinic's HIPAA & Patient Privacy Notice.

Signature: _____ **Date: _____**

Patient Name (Print): _____ **SS#**: _____

Witness: _____ **Relationship:_____**

CONSENT TO MECICAL CARE

The undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by **Saint Thomas Clinic, PLLC,** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: _____ **Date: _____**

AUTHORIZATION & ASSIGNMENT

Please sign below to acknowledge that you have read, understood & received Saint Thomas Clinic's Financial Policy Notice.

Signature: _____ **Date: _____**

Patient Name (Print): _____ **SS#**: _____

Witness: _____ **Relationship:_____**

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Saint Thomas Clinic, PLLC and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Patient Date

_____ _____

Witness Date

Pharmacy Information

Please list below the pharmacy you use

Address:

_____

_____

Phone: _____ Fax: _____

7056 Mariner Blvd, FL 34608
Ph: 352-610-4408
www.sthomasclinic.com

SAINT THOMAS CLINIC, PLLC

Dear Patients,

IT HAS COME TO OUR ATTENTION THAT SOME INSURANCE COMPANIES ARE DENYING PAYMENT ON CERTAIN TESTS ORDERED. IN ORDER TO GIVE OUR PATIENTS THE BEST CARE POSSIBLE, YEARLY SCREENINGS OF VARIOUS TESTS ARE NEEDED. YOU MAY CONTACT YOUR INSURANCE TO INQUIRE ABOUT THE COVERAGE OF A REQUESTED TEST.

OUR PATIENTS ARE VERY IMPORTANT TO US AND YOUR HEALTH CARE IS TOP PRIORITY. PLEASE UNDERSTAND OUR POSITION ON THIS MATTER AND ALLOW US TO GIVE YOU THE BEST CARE POSSIBLE.

SINCERELY,

DR. ABSKHROUN AND STAFF

PLEASE VERIFY THAT YOU HAVE READ AND FULLY UNDERSTOOD THE ABOVE BY SIGNING BELOW. THANK YOU!

_____

PATIENT SIGNATURE