Metro Health Physicians
Markos Koutsos MD Helen Gouzoulis MD
Gastroenterology · Liver Disease · Internal Medicine

PATIENT INFORMATION

Date: _____

Patient Name:

_____ Date of Birth _____/_____/_____

SS# _____ sex ☐ **MALE** ☐ **FEMALE** **MARITAL STATUS** ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOW** ☐ **DIVORCE**

Address: **Apt:** **City:** **State:** **zip:**

Cellphone: **Home phone:** **Work phone**

email:

Emergency Contact Relationship Phone:

How did you hear about our office?

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

PHARMACY NAME _____ Phone: _____

Address: _____ Zip: _____

INSURANCE

Primary Insurance: _____ policy # _____ Group # _____

Policy Holder Name _____ Date of birth of Insured _____

Relationship to insured _____ Sex of insured ☐ **male** ☐ **female**

Secondary Insurance: _____ policy # _____ Group # _____

Policy Holder Name _____ Relationship to insured _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information pertaining to my medical history, services rendered or treatment given to me or tomy dependents for the purpose of review, investigation or evaluation of this exam.

AUTHORISATION TO PAY PHYSICIAN

I authorize all payments of surgical and/or medical benefits be paid directly to the physician

Patient/Legal Guardian: _____ Date: _____

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Name_____ **For Female only - Are you Pregnant? ☐yes ☐no**

Gender :_____ Age: _____ Height: _____(ft/cm) Weight _____(lbs/Kg)

Reason for Visit (how is your health?)

Current Medication:

Name	dosage	frequency

Allergies

Are you allergic to any of the following:
☐ Adhesive Tape ☐Aspirin ☐Latex
☐ Barbiturates (sleeping pills) ☐Sulfa ☐ Iodine
☐ Codeine ☐Local Anesthetics
☐ Antibiotics _____
Do you have any other allergies
Name reaction:

Past Medical History

☐ Alcoholism
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Back Problems
☐ Blood Clots
☐ Bipolar Disorder
☐ Chronic Wounds
☐ ? COPD
☐ COVID
☐ Diabetes 1 or 2
☐ Depression
☐ Fatigue
☐ Fibromyalgia
☐ Eating Disorder
☐ Epilepsy
☐ Erectile Dysfunction
☐ Glaucoma
☐ GI Bleeding
☐ Gout
☐ Headaches
☐ Hearing loss
☐ Hepatitis A,B or C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Incontinence
☐ Joint disorder
☐ Kidney Stones
☐ Liver Disorder
☐ Mac. Degen.
☐ Migraine
☐ Osteoporosis
☐ Pneumonia
☐ Prostate Disease
☐ Rheumatic Fever
☐ Seizure
☐ Stroke
☐ Skin Disorder
☐ Stomach Ulcer
☐ Thyroid disorder
☐ Tuberculosis
☐ UTI
☐ Venereal Disease
☐ Cancer type
_____
_____
_____
☐ Heart Disease specify:
_____
_____
_____
Orthopedic/joint:
_____
_____
_____
_____

Past Surgical History:

☐ Adenoidectomy
☐ Appendectomy
☐ Bariatric Surgery
☐ Bladder
☐ Bowel/Stomach Resection
☐ C- Section
☐ Cardiac Stents
☐ Cataracts
☐ Coronary Bypass
☐ Hysterectomy
☐ Hemorrhoidectomy
☐ Heart Valve
☐ Hernia Repair
☐ Lasik
☐ Prostate
☐ Spinal Surgery
☐ Tonsillectomy
☐ Tubal ligation
Other, Please specify:
_____
_____
_____
_____

FAMILY HISTORY - Has anyone in your family ever had any of the following conditions? (Mother - Father- GrandParents- Siblings)

☐ Alcoholism
☐ Anemia
☐ Allergies
☐ Alzheimer's
☐ Asthma
☐ Anxiety
☐ Arthritis
☐Bleeding Disorder
☐ Blood Disorder
☐ Cancer
☐ Depression
☐ Dementia
☐ Diabetes
☐ Epilepsy
☐ Genetic disorder
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure ☐ Joint disorder
☐ Kidney Disease
☐ Liver Disease
☐ Lung Disease
☐ Migraines
☐ Psychiatric disorder
☐ Osteoporosis
☐ Stroke
☐ Substance Abuse
☐ Thyroid Disorder (Low or High)
☐ **None**

Lifestyle Factors:

Are you sexually active? ☐ yes ☐ no
Do you wish to be checked for STDs?☐ yes ☐ no
Have you ever Smoked? ☐ yes ☐ no
Do you smoke? ☐ yes ☐ no **#packs/day____**
Do you use recreational drugs? ☐ yes ☐ no
What type? _____
☐ regularly ☐ occasionally ☐ rarely
Do you drink Alcohol? ☐ yes ☐ no -
☐ Socially ☐ occasionally ☐ rarely ☐ not at all

Last Date of Screening:

☐PAP _____ ☐MAMO _____
☐Colonoscopy _____ ☐Endoscopy _____

Last DATE of Vaccination

☐ COVID 1st dose _____2nd dose_____ ☐**Pfizer** ☐ **Moderna**
☐ COVID J & J _____
☐Flu Shot _____☐Pneumonia _____ ☐ Shingles Shot _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian:_____ Date: _____

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Metro Health Physicians Notice of Privacy Practices and Patient acknowledgement

To our Valued Patient:

The misuse of Personal Health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so they may understand and comply with government's rules and regulations regarding the Health Information Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information MARGINS about the patient that is needed to carry out treatment, payment or health care operations.

As our patient we want you to know that we support your full access to your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operation.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. YOu have the right to review our entire notice of privacy policies upon request. Please sign this form to acknowledge that you have read this notice of your privacy policies.

Patient Name: _____

Patient Signature: _____ Date: _____

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Patient Financial Agreement Form

Patient Name: _____

I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc.

_____(Patient/Guardian Initials)*

Certain insurance companies and/or policies do not cover recommended care which may include vaccinations, lab work and other procedures and services. These services, if not covered by your insurance plan, will become your financial responsibility.

_____ (Patient/Guardian Initials)*