Patient Information

Name: Date of Birth:

Social Security Number: Gender: M / F

Email Address:

Home Address:

City: State: Zip Code:

Telephone Number: Cell / Home

Marital Status: Single / Married / Widowed / Seperated / Divorced

Ethnicity: Race:

Emergency Contact Information:

Name: Relationship:

Phone Number:

Pharmacy Information:

Pharmacy Name: Phone Number:

Street Address: City:

Primary Care Physician Information

Physician Name: Telephone Number:

Reason For Being Seen Today

Medications

Medication Name	Strength (mg, mcg)	Number of Pills You Take at One Time	Times Per Day You Take It

Patient Information

Medical History

Diabetes	Y / N	Thyroid Disease	Y / N
High Blood Pressure	Y / N	Mental Illness	Y / N
Heart Disease	Y / N	Osteoporosis	Y / N
High Cholesterol	Y / N	Neuropathy	Y/N
IBS	Y / N	Anxiety	Y / N
Glaucoma	Y / N		
Cancer	Y / N	Cancer Type	

Diabetic Questions

Eye Exam	Y / N	Foot Exam	Y / N
Date		Date	
Diabetic Retinopathy	Y / N	History of Foot Ulcers	Y / N
Laser Suregery	Y / N	Hand or Feet Numbness	Y / N

Drug Allergies:

Drug Name:	Reaction Type

Hospitalizations and Surgeries

Year	Procedure

Family History

	Diabetes	Thyroid Disease	Hormone Abnormalities	Osteoporosis	Heart Disease
Father	Y / N	Y / N	Y / N	Y / N	Y / N
Mother	Y / N	Y / N	Y / N	Y / N	Y / N
Grandparent	Y / N	Y / N	Y / N	Y / N	Y / N

Social History

Do you use:

	Alcohol	Y/N	
If Yes:	How Often?		How many drinks in one setting?
	Tobacco	Y/N	
If Yes:	How Often?		How many cigarettes?
	Are you ready to quit?		Y/N

Patient Name:_____

Patient Consent and HIPAA Policy Acknowledgement

Consent to Treat and Financial Authorization

I hereby authorize my provider to treat my symptoms and apply for benefits on my behalf for any services rendered by him or his order. I request that payments of authorized benefits from Medicare/my Insurance Company be made directly to my provider. I authorize my provider to release any medical information about me to HCFA/my Insurance Company and its agents, any information needed to determine these benefits or the benefits payable to related services. I authorize the use of this authorization for any of my insurance submissions. I understand that I am responsible for any amount not covered by my insurance company(s). I certify the information that I have reported and provided is correct. I permit a copy of this authorization to be used in place of its original. This Authorization may be retrieved by either me or my insurance company at any time in writing.

_____ _____

Patient/Guardian Signature Date

Consent to Access Pharmacy History and E prescribe

I give permission for my provider to access pharmacy benefits data electronically through the secure Rx Hub of his choosing. This consent will enable my provider to determine my eligibility as well as the formulary of my insurance and allow for electronic prescribing to my pharmacy and downloading my medication history.

_____ _____

Patient/Guardian Signature Date

HIPAA Consent

This notice describes how medical information about you may be used and disclosed and how you can get access to this information and should be reviewed carefully and entirely.

We are committed to protecting the privacy of our patient's personal and health information. All of our employees are required to sign a confidentiality agreement and are required operate within our HIPAA policies. We may use or disclose your protected health information (PHI) for the purpose of treatment, payment, or practice operations only with your written consent. For example, coordination of care, submit an insurance claim, or look at your file for internal quality monitoring. We must obtain your written consent for any other use or disclosure. You may revoke your authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization is in effect.

We will provide you access to your information, without your consent or authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefits programs, employers (in case of work-related illness or injury), courts, and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may provide written permission for a family member or friend to access, discuss, or manage your PHI.

You have the right to access and amend your information request an accounting of any disclosures, request restrictions on use and disclosure of your information, request a copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this Notice.

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the most current notice in effect. We reserve the right to change terms of our notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice.

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of the US Department of Health and Human Resources. We will not retaliate against you for filing a complaint. For more information please contact us at (313)278-7100. This notice effective 12/29/12

Please indicate if there is a friend or family member to whom we are allowed to release medical information to:

_____ _____

Name Telephone Number

The undersigned acknowledges that they have received a copy of this notice of privacy practices.

_____ _____

Patient/Guardian Signature Date

Mohammad Saleh, MD, FACE.
Diplomate American Board of Endocrinology and Diabetes Management
1637 Monroe Street
Dearborn, MI 48124
Phone: 313-757-0157
Fax: 313-757-7495

I _____ give Dr Saleh and staff permission to give test results over the phone with the number I have provided on file.

I DO OR DO NOT give permission to Dr. Saleh or staff to leave a message on the phone number I have provided on file.

If you have a certain phone number that you prefer to be reached at please provide our staff with that number. _____

NEW POLICY EFFECTIVE
APRIL 2, 2018

WE WILL NEED
24 HOUR NOTICE
TO RESCHEDULE OR CANCEL YOUR APPOINTMENT OR THERE WILL BE A $25.00 CHARGE

_____ _____

Print Name **Sign Name**

_____ **Date**