Xenophon P. Xenophontos, M.D., F.A.C.S.
PATIENT REGISTRATION

PATIENT INFORMATION

Name: Last_____ First_____ Middle Initial _____

Address: _____
(Street) (Town/City) (State) (Zip Code)

Home Phone: _____ Work Phone_____ Cell Phone _____

Date of Birth:_____/___/_____ Male_____ Female _____

Single _____ Married _____ Divorced _____ Widow ____ Widower _____

SS#_____/____/_____ Primary Language _____ Email: _____

Referred By: _____ Address & Phone: _____

Primary Doctor: _____ Address & Phone: _____

Race: ( ) Asian ( ) African American/ Black ( ) White ( ) Decline
Ethnicity: ( ) Hispanic/Latino ( ) Non- Hispanic/ Non - Latino ( ) Decline

INSURANCE INFORMATION
Primary Insurance:

Plan Name: _____ _____ID# _____

Relationship to Policyholder: ( ) Self ( ) Spouse ( ) Child ( ) Other If not self

Policyholder Name:_____ Date of Birth: _____ SS #: _____

Secondary Insurance:

Plan Name: _____ ID# _____

Relationship to Policyholder: ( ) Self ( ) Spouse ( ) Child ( ) Other If not self

Policyholder Name:_____ Date of Birth: _____ SS #: _____

Workers Compensation/ No Fault

Carrier Name: _____Mailing Address _____

Claim #: _____ Date of Injury _____Policy #: _____

Case Manager Name _____ Phone: _____

EMPLOYMENT

Employer: _____ Address _____

Phone: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone_____ Work Phone_____

RELEASE OF INFORMATION- Please Check ✓

Is it okay to leave messages on your phone? ( ) Home ( ) Cell
Is it okay to discuss your health information with another person?
( ) YES ( ) NO If Yes, Who _____

PHARMACY

Name: _____ Phone: _____

Address: _____ Fax: _____
(Street) (Town/City) (State)

ADVANCED DIRECTIVES – Please Check ✓

Do you have a Living Will or an Advanced Directives Document? Please check all that apply.
( ) NONE ( ) DNR (Do Not Resuscitate) ( ) Power of Attorney ( ) Living Will
If none, our staff will be glad to provide you with information.
( ) I wish to receive Advanced Directive Information
( ) I do not wish to receive Advanced Directive Information
( ) OFFICE USE ONLY Information given to patient

Ask at the Front Desk if you want to review a copy of Patient Rights and Responsibilities

NOTICE OF PRIVACY PRACTICES

I have received and read the HIPPA disclosure and request the following restrictions to the use or disclosure of my health information. **Please Check ✓**
( ) NONE
( ) RESTRICT: _____

REQUIRED: PATIENT'S SIGNATURE BELOW CONFIRMS RECEIPT OF HIPPA AND AUTHORIZATION TO BILL YOUR INSURANCE ON YOUR BEHALF

Please read, sign and date the following to allow us to bill your insurance company for your medical care:
The above information is true to the best of my knowledge. I clearly understand and agree that all services rendered to me are charges directly to me and I am personally responsible for payment. In the event I receive any checks from my insurance company for services rendered by X.P. Xenophontos, M.D. I agree to endorse and forward such checks to X.P. Xenophontos, M.D. upon receipt. I understand that if I fail to forward payment I will be responsible for the entire balance plus any cost which may result from collection proceedings. I also agree to receive from your office or collection representatives calls/texts to my cell and phone numbers provided. I also authorize X.P. Xenophontos, M.D. to release any information required to process my claims and I authorize my insurance benefits be paid directly to X.P. Xenophontos, M.D..

_____ _____
Signature of Patient or Authorized Representative Date

XENOPHON P. XENOPHONTOS, M.D., F.A.C.S.

HEALTH INFORMATION

Name: _____ Male_____ Female _____

Approximate Weight _____ Height_____ Age:_____

REASON FOR VISIT: (describe) _____

Conditions **CIRCLE** conditions you have **currently** or **have had in the past year**

Alcoholism	Emphysema	High Blood Pressure	Prostate Disorders
Anemia	Epilepsy	High Cholesterol	Rheumatic Fever
Arthritis	Gout	HIV Positive	Sickle Cell Disease
Asthma	Glaucoma	Kidney Disease	Stomach Ulcer
Cancer- _____	Goiter	Liver Disease	Stroke
Deep Vein Thrombosis	Heart Disease	Migraines	Thyroid problems
Diabetes- Non Insulin	Hemophilia	Pacemaker	Tuberculosis
Diabetes – Insulin	Hepatitis	Pneumonia	Varicose veins

Other:_____

Previous Surgeries and Dates:

AAA _____	Cervical Back _____	Lumbar Back _____
Aortic Valve Replacement ____	Prostate_____	Mastectomy_____
Appendectomy _____	D & C _____	Mitral Valve Replace ____
Bilateral Knee Replacement _____	Gallbladder_____	Pacemaker _____
C- Section _____	Hernia _____	Right Knee Replacement_____
Carotid _____	Hip Replacement____	Thoracic Back Surgery _____
Cataract _____	Left Knee Replacement_____	

Other:_____
_____

Family Health History:

	Medical Condition	Date of Birth	Living(L) Deceased (D)	Age diagnosed	Date of Death
Father:	_____	____/____/___	_____	_____	____/_____/____
Mother:	_____	____/____/___	_____	_____	____/_____/____
Children:	_____	____/____/___	_____	_____	____/_____/____
Siblings:	_____	____/____/___	_____	_____	____/_____/____

Social History: CIRCLE

Smoking Status:	Alcohol:	Recreational Drug Use :
Never	None	None
Former: QUIT _____	# drinks/weekly _____	Cocaine
# packs /day _____	Drink occasionally	Marijuana
Chew Tobacco Y or N		Injectables
Cigars a day _____		

Allergy to medications	**Reaction**	**Severity(Mild/Mod/ Sev)**
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS:

Name & Dosage	How taken	How often	Name & Dosage	How Taken	How Often

Symptoms **CIRCLE** symptoms you have **currently** or **have had in the past year**

General
Chills
Fever
Fatigue
Weight loss ____lbs
Weight gain ____lbs

Respiratory
Cough
Shortness of breath
Pain w/deep breathing
Wheezing

Cardiovascular
Chest pain
Palpitations
Lightheadedness

Psychiatric
Anxiety
Depression

Gastrointestinal
Dysphagia
Nausea
Vomiting
Abdominal pain
Abdominal distention
Diarrhea
Constipation
Rectal bleeding

Genitourinary
Burning when urinating
Blood in urine
Frequent urination
Hesitancy in urinating
Incontinence

Endocrine
Heat/cold intolerance
Thyroid problems
Excessive urination
Excessive Thirst

Eyes
Blurred vision
Double vision
Loss of vision

Hematologic/Lymphatic
Easy Bruising
Bleeding gums
Enlarged Nodes
Anemia

Patient Signature **_____** ***Date:*** **_____**