Winchester Family Practice
Amina Shalash, MD
4 N. Highland Street, Suite A
Winchester, KY 40391

PATIENT INFORMATION

Name_____
Address_____
City _____State _____ZIP___
Home phone_____
Work phone_____
Sex ☐M ☐F Birthdate_____
Employer Name_____
Employer Address_____
Social Security Number_____
Marital Status_____

GENERAL INFORMATION

Who is Financially Responsible for payment? _____
Primary Care Physician?

_____
Whom may we thank for referring you?
_____

IN CASE OF EMERGENCY NOTIFY

Name _____
Relationship_____
Phone_____
Address_____
City _____State ____Zip_____
Home phone_____
Daytime phone_____

PRIMARY INSURANCE INFORMATION

PLEASE GIVE CARD(S) TO RECEPTIONIST TO COPY

Name of Insurance_____
Mail claims to_____

_____
Phone_____
Effective Date_____
Plan Code_____
Subscriber ID#_____
Group#_____

CARDHOLDER INFO:

Name of Cardholder_____
Date of Birth _____
Social Security Number _____
Address_____
City _____State____ Zip_____
Insurance ID#_____
What is the patient's relationship to the cardholder?
_____

SECONDARY INSURANCE INFORMATION

Name of Insurance _____
Insurance ID# _____
Name of Cardholder _____
Cardholder Address _____

_____
Date of Birth _____ Soc. Sec. # _____
Patient's relation to the insurance cardholder?
_____

Permission is hereby granted to Winchester Family Practice, PSC to release information to my insurance company, employer, attorney, worker's compensation, carrier, physician, or facility referred to for further treatment or testing, and/or my referring or family physician. Permission is hereby granted to any facility at which I have been previously treated to release medical records or x-rays to Winchester Family Practice, PSC. I also, hereby authorize Winchester Family Practice to obtain Medication History related to me from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of continued treatment.
I consent to treatment by Winchester Family Practice. I understand and agree that I am ultimately responsible for payment and certify that this information is true and correct. I authorize payment of medical benefits to Winchester Family Practice, PS for services rendered.

Signed _____ Date _____

MEDICARE PATIENTS ONLY
I authorize payment of Medicare benefits to Winchester Family Practice, PSC for services rendered and I authorize the release of medical information to HCFA and its agents.

Signed_____ Date _____

Winchester Family Practice, PSC
Amina A. Shalash, M.D.
4 N. Highland St. Suite A
Winchester, KY 40391

Patient Name _____ Today's Date _____

Age _____ Birth Date _____ Date of last physical exam _____

What is the reason for your visit? _____

SYMPTOMS Check ✔ symptoms 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
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GENITO-URINARY
- ❑ Blood In Urine
- ❑ Frequent Urination
- ❑ No 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? _____

CONDITION 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*

_____

_____

_____

ALLERGIES

_____

_____

_____

Pharmacy Name _____

Phone Number _____

FAMILY HISTORY *Fill in health information about your family*

	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
❑ 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

PREGNANCIES

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS, IF ANY

Have you ever had a blood transfusion? ❑ yes ❑ no

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

LIFESTYLE/HABITS

Check ✔ habits that apply and write the frequency

❑ Caffeine _____

❑ Tobacco _____

❑ Alcohol _____

❑ Drugs _____

❑ Exercise _____

❑ Vitamins _____

OCCUPATIONAL

Occupation _____

Check ✔ if your work exposes you to the following:

❑ Stress ❑ Heavy Lifting

❑ Hazardous Substances ❑ Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

Winchester Family Practice, PSC
Amina Shalash, M.D.
4 North Highland, Suite A
Winchester, KY 40391
(859) 744-1445

Privacy Consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I herby consent to Winchester Family Practice, PSC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I also consent to Winchester Family Practice, PSC using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and healthcare operation, if it is in part of my protected health information. (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

◦If you do not check the below items, we are not authorized to bill your insurance if these are ever discussed in a visit.

- o Chemical Dependency/Substance Abuse
  - o Drugs
  - o Alcohol

- o Sexually Transmitted Diseases

I further acknowledge Winchester Family Practice, PSC has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority