INFORMATION SHEET

Dr. Adel Ibrahim, MD

Last Name	First	Middle		Birth Date	Social Security #
Address				Home Phone	Cell Phone
City		State	Zip	Email Address	
Height	Sex	Marital Status		Religion	Employer
Emergency Contact		Relation		Home Phone	Cell Phone
Local Pharmacy Name/Town				Mail Order Pharmacy Name	
Referred By		Living Will		Adv. Directive	Power Of Attorney

Race	Ethnicity	Language
American Indian or Alaskan Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Other
Native Hawaiian or Other Pacific Islander	Refuse to Report	Indian
Black or African American		Spanish
White		Portuguese
Hispanic		
Other Race		
Unreported/Decline to Report		

HIPAA

PATIENT NOTIFICATION APPROVAL FORM

To help us ensure your privacy, please circle Yes or No for the following:

I authorize the release of my results, such as laboratory results, x-ray results, clinical findings and the like, by phone to the following number _____

This information may also be left on the answering machine at the same phone number Yes No

Is it okay to leave appointment reminders on your voicemail? Yes No

Is it okay to leave detailed messages regarding your medical treatment with a family member? Yes No

Please list anyone that you give your permission to receive information regarding your medical condition, treatment, and results.

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient Name _____

Patient Signature _____

Date _____

Dr. Adel Ibrahim

Diplomate, American Board of Internal Medicine

Board Certified Hematology/Oncology

551 Newman Springs Road Unit 1

Lincroft, NJ 07738

Phone: 732-530-9200

Cancellation and Missed Appointment Policy

We are now informing you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for all our patients in need of medical care. Our goal is to provide better quality individualized medical care in a timely manner. "No shows" and late cancellations delay appointments for those other patients who need access to medical care in a timely manner.

Cancellation of an Appointment

As a courtesy we will remind you of an upcoming appointment. If you are web-enabled, you will receive email confirmation as well.

If it is necessary to cancel your appointment, we require that you call the office 24 hours prior. All re-scheduled cancellations and no-shows are recorded in your medical record.

If there is an emergency that of course is taken into account if a late cancellation occurs.

How to Cancel your appointment

To cancel appointments please call 732-530-9200. If you do not reach the receptionist (such as after hours or weekends) you may leave a message with the answering service or call during next business day. We will return the call and give you next available appointment time. Frequently missed appointments for chronic care are not acceptable.

"No Show" Policy

A no-show is someone who misses an appointment without calling to cancel or re-schedule. A failure to be present at time of scheduled appointment will be recorded in your medical record as a "no-show."

First missed appointment: $25.00 fee due upon receipt

Second missed appointment: $50.00 fee due upon receipt

Third missed appointment: $60.00 fee due upon receipt and you may be asked to leave our practice

Print Name of Patient _____

Signature _____

Date _____

Patient Name _____

Insurance Carrier _____

Medicare & Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of insurance/Medicare benefits be made to: Dr. Ibrahim, for any services provided to me by Dr. Ibrahim. I understand that I am financially responsible for any amount not covered by my contract. I authorize any type of medical information concerning me to be released to the Health Care Financing Administration (if applicable) and its agents or other parties in authority, in order to determine these benefits payable for related services. I also authorize you to release to my insurance company or other parties in authority information regarding health care, advice, treatments, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims and benefits.

Date _____ Signed _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of Privacy Practices, which states how we may use or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the Privacy Practices.

Print Name Signature Date

HEALTH HISTORY

Welcome to our practice. To the best of your ability, please fill out the information found below.

Date _____

Patient Name _____Birthdate _____

Chief Complaint _____

History of Present Illness:

Location_____ Quality _____

(Where is the pain/problem) (i.e normal v. abn color, activity, etc)

Severity _____ Duration _____

(How severe is pain/problem on 1-5 scale, 5 most severe) (How long have you had pain/problem, or when did it start)

Timings _____ Context _____

Associated signs/symptoms _____ Modifying Factors _____

_____ _____

(What other associated problems have you been having) (What makes pain/problem better or worse)

Past Medical History

Have you ever had any of the following? Circle yes or no (Leave blank if uncertain)

Measles	Y N	Epilepsy	Y N	Asthma/COPD	Y N
Mumps	Y N	Migraines	Y N	Hives/Eczema	Y N
Chicken Pox	Y N	Tuberculosis	Y N	AIDS/HIV +	Y N
Whooping cough	Y N	Diabetes	Y N	Hepatitis	Y N
Scarlet fever	Y N	Cancer	Y N	Mitral Valve Prolapse	Y N
Diphtheria	Y N	Anxiety/Depression	Y N	Stroke	Y N
Smallpox	Y N	Glaucoma	Y N	Kidney Disease	Y N
Pneumonia	Y N	Hernia	Y N	Ulcers	Y N
Rheum. Fever	Y N	Blood transfusion	Y N	COVID19	Y N
Heart Disease	Y N	High blood pressure	Y N	Last Tetanus vaccine _____	
Arthritis	Y N	Low blood pressure	Y N	Last flu vaccine _____	
Venereal Disease	Y N	Bleeding tendency	Y N	Last pneumonia vaccine _____	
Anemia	Y N	Back trouble	Y N	COVID19 vaccine	Y N
Bladder infection	Y N	Hemmorhoids	Y N		

HEALTH HISTORY

continued

Previous Hospitalizations/Surgery/Serious Illness	When	Hospital, City & State
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (Including non-prescription/herbal/supplements) _____

_____
_____
_____

Patient Social History

Marital Status Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of Alcohol Never _____ Rare _____ Moderate _____ Daily _____

Use of Tobacco Never _____ Previous but quit _____ Current, packs/per day _____

Use of non-Rx drugs Never _____ Type/Frequency _____

Excessive exposure at work/home to Fumes _____ Dust _____ Solvents _____ Noise _____

Airborne particles _____ Secondhand smoke _____

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Sibling	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____