ANGELA AZAR, MD PC

DATE:

92-11 Roosevelt Ave. Jackson Heights, NY 11372

PATIENT INFORMATION

Name: Last_____ First_____

Phone Numbers: Home_____ Work: _____

Cell: _____ Ok to leave detailed message? (Circle) Yes No

Email Address: _____

Home Address: _____

_____

Social Security: ___-___-____ DOB: ___-___-____

Sex: (circle) Male Female Other Place of Birth: _____

Language: (circle) English Spanish Other _____

Race: (circle) White American Indian or Alaskan Native Asian

Black or African American Other_____

Ethnicity: (circle) Hispanic Not Hispanic Decline to specify Other

Marital Status: (circle) Married Single Divorced Widowed Other

Primary Care Physician:

Name/ Address: _____ Phone: _____

Who referred you to us? _____

Emergency Contact: _____ Relationship to patient _____

Phone: _____ Address: _____

Pharmacy Name, Address and Phone number: _____

_____

Notice of Privacy Practices

I acknowledge that the Notice of Privacy Practices from Dr. Azar was available for my review.

Signature _____ Date _____

EMPLOYER INFORMATION

Employer's Name: _____

Occupation: _____

Phone Number/ Address: _____

INSURANCE INFORMATION

Please present your insurance cards for copying

Policy Provider: _____ Self Pay ☐

Policy Number: _____ Group Number: _____

Phone Number: _____ Co-Pay Amount: _____

Responsible Party (If other than Patient) _____

Phone Number: _____ Employer: _____

RELEASE OF INFORMATION:

I agree that Dr. Azar may disclose certain health information to a person(s) other than me because such person(s) is involved in my health care or payments related to my health. In that care, we will only disclose information that is directly relevant to the person's involvement in my health care or payments related to my health care. I designate the following persons for the limited purposes described above. I understand that I am not required to list anyone, and can change this list at any time in writing.

Name: _____ DOB: _____

Name: _____ DOB: _____

PAST MEDICAL HISTORY: (please circle all that apply

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Pacemaker
COPD	High Cholesterol	
Coronary Artery Disease	Thyroid Problems (Hyper or Hypo)	NONE

Other _____

PAST SURGICAL HISTORY: (please circle all that apply)

Appendix Removed

Bladder Removed

Mastectomy (Right, Left, Bilateral)

Lumpectomy (Right, Left, Bilateral)

Breast Biopsy (Right, Left, Bilateral)

Breast Reduction

Breast Implants

Colectomy: Colon Cancer Resection

Colectomy: Diverticulitis

Colectomy: IBD

Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years

Kidney Biopsy (Nephrectomy)

Gallbladder Removed

Coronary Artery Bypass

Mechanical Valve Replacement

Biological Valve Replacement

Heart Transplant

Joint Replacement, Knee (Right, Left, Bilateral)

Kidney Transplant

Ovaries Removed: Endometriosis

Ovaries Removed: Cyst

Ovaries Removed: Ovarian Cancer

Prostate Removed: Prostate Cancer

Prostate Biopsy

TURP (Prostate Removal)

Kidney Stone Removal

Spleen Removed

Testicles Removed (Right, Left, Bilateral)

Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer

NONE

Other _____

SKIN DISEASE HISTORY: (please circle all that apply)

Acne

Actinic Keratosis

Asthma

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Squamous Cell Skin Cancer

Psoriasis

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Precancerous Moles

Melanoma

Poison Ivy

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

If female, are you, or is there a chance you may be pregnant? Yes No

When was your last menstrual period?

Are you nursing? Yes No

MEDICATIONS: (Please enter all current medications, including dosage and frequency)

ALLERGIES: (Please enter all allergies)

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:

Never Smoked

Quit: Former Smoker

Smokes Less Than Daily

Smokes Daily

FAMILY HISTORY: (please circle all that apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other
Non-Melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Other
High Cholesterol	Mother	Father	Sister	Brother	Daughter	Son	Other
High Blood Pressure	Mother	Father	Sister	Brother	Daughter	Son	Other

ANGELA AZAR MD

Your Name----------

1. Do you have any of the following?
   - Heart failure
   - Coronary Artery Disease (CAD)
   - Chronic obstructive pulmonary disease (COPD)
   - Diabetes
2. Did you receive the flu vaccine before this part flu season? Y or N
3. Have you ever received the Pneumonia vaccine? Yes or No
4. Do you have a history of Melanoma? Yes or No
5. Do you smoke? Yes or No
6. Number of alcoholic drinks per day
   - None
   - 1-2 per day
   - 3 or more per day
7. Who is your Primary Care Physician?
   Month and Year of last visit
8. Health care proxy(lets you to appoint another person(a proxy or agent) to express your wishes and make health care decisions for you if you cannot speak for yourself)
   Name----------
   Relationship to patient----------
   Phone ----------

Angela Azar MD

Statement of Patient Financial Responsibility

DATE:

Patient Name: _____ **DOB:** _____

The Offices of Dr. Angela Azar appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Dr. Angela Azar, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to The Practice Name, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment

I hereby authorize Dr. Angela Azar, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Dr. Angela Azar to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Patient/Guarantor Signature _____ Date _____

ANGELA AZAR M.D. PC

DIANA ELISH, M.D
LILIYA BESEDINA, M.D
RONIT SHABATIAN RPA-C
INESSA KRAMMERMAN RPA-C
92-11 ROOSEVELT AVENUE,JACKSON HEIGHTS, NY 11372
TEL:(718)424-3001 FAX:(718)424-5001

COVID-19
INFORMED CONSENT

I understand I am giving consent to **ANGELA AZAR MD PC** (the "Practice") evidencing my educated decision to receive services at the Practice prior to any vaccine or known effective treatments to the CoronaVirus-COVID-19. I have been advised that the Practice has adopted recommended protocols for the prevention of COVID-19 at its facility. I have been advised I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the Practice response to COVID-19.

By signing below, I acknowledge my understanding that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the Practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualified as "recovered" in accordance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time, even as testing becomes readily available. I understand it is my responsibility to notify the Practice if I am medically "high risk" for any reason.

By signing below hereby agree to release **ANGELA AZAR MD PC** ,and its owners, employees, and representatives, and covenant not to commence or maintain any action or proceeding against any Practice Representatives, for or from any and all claims action, liabilities, damages ,fees (including attorneys fees and costs of defense) and demands whatsoever, in law or equality ("Claims"), which I (and my heirs,execuators,administratorsand assigns) shall or may have, or from any person or entity other than myself, for, upon or by reason of my contracting COVID-19,including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the Practice Representatives harmless from and against and all claims from or against any person or entity other than myself relating to my having or transmitting COVID-19.

By signing below, I acknowledge I have read this Informed Consent and I hereby agree to its terms and I assume the risk of potential COVID-19 exposure by receiving treatment at the Practice.

Patient Name:_____

Patient Signature:_____

Date:_____