Xenophon P. Xenophontos, M.D., F.A.C.S., F.S.V.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

Eyes
Blurred vision
Double vision
Loss of vision

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

Endocrine
Heat/cold intolerance
Thyroid problems
Excessive urination
Excessive Thirst

Hematologic/Lymphatic
Easy Bruising
Bleeding gums
Enlarged Nodes
Anemia

***Patient Signature* ______________________________________ *Date:* ____________________**