

Imad Nakshabendi MD FRCP FACG PA
Diplomat, American Board of Internal Medicine and Gastroenterology
Tel; (813) 972-3750 Fax; (813) 972-3749

Welcome to our practice. Your appointment will be,
on _____ at _____.

To help ensure that you will be seen in a timely basis please remember to bring the following items to your appointment. Do not rely on your doctor's office to fax these items.

1. Please complete all attached documents fully
2. Bring all relevant medical records, lab work and scans with reports related to your condition with you.
3. if you are in an HMO program, make sure that you bring a referral with you to your appointment. If you can not get a referral with you, we have to reschedule until the referral can be obtained from your primary care physician.
4. Bring a list of all your medications or bring in the bottles
5. Bring your insurance card(s) with you. All copays, co-insurance and percentages are due at the time of the visit.
6. Bring a note from your doctor stating the reason for the referral.
7. Do not bring small children to the office.
8. We recommend that you plan to be in the office 30 minutes before your scheduled appointment.
9. We require 24 hour notice for canceling or changing an appointment.
10. If you are unable to speak or understand the English Language, you must bring an interpreter to the appointment with you.

We look forward to your visit. If you have any questions, please do not hesitate to contact us.

Thank you,

Medical Office Staff

Imad Nakshabendi MD FRCP FACG PA
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Patient Consent to the Use and Disclosure of Health Information

I, _____ understand that as part of my health care, Imad Nakshabendi MD PA, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planing my health care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third party-party payer can verify that services billed were actually provided , and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals,

I understand and have been provided with a "Notice of Privacy Policies" which provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Imad Nakshabendi MD PA, may refuse to treat me as permitted by Section 164.508 of the Code of Federal Regulations. I further understand that this organization reserves the right to change their notice and policies, in accordance with Section 164.520 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosures of my health information:

My signature below indicates that I have been given the chance to review a current copy of the "Notice of Privacy Policies" and I fully understand and accept the terms of this consent.

Signature

Date

HISTORY AND PHYSICAL HISTORY

Name:
Address:
SS#:
Telephone #:
CC:

Date:
DOB/AGE:

Allergy:

HPI:

PMH:

S H: Tobacco: Alcohol: Coffee/Tae: Drugs:
F H:

Medicines:

R O S: (Circle all that applies)

General:	Hearing Eye pain	Vision Appetite change	Sore throat Fever	ringing in ears Nose bleed Hoarseness of voice
Cardiovascular:	High blood pressure Irregular pulse Swollen ankle	Coronary heart disease Palpitation Varicose veins	Leg pain Cold numb feet	Heart murmur Chest pain Phlebitis
Respiratory:	COPD Asthma	Emphysema Chronic cough	Bronchitis Wheezing	Pneumonia Shortness of breath
Endocrine:	Diabetes	Thyroid	Hypercholesterolemia	Loss of energy
Genitourinary:	Urine infection Blood in urine Sexual problems	Kidney stones Urine leakage	Renal Failure Bed wetting	Prostate Frequency
Hem/Oncology:	Cancer	Anemia	Blood disease	Bleeding
Gastrointestinal:	Heartburns Vomiting Constipation Colitis	Difficulty in swallowing Abdominal pain Hernia Peptic ulcer disease	Hepatitis Blood in stool	Nausea Diarrhoea Hemorrhoids GERD
Musculoskeletal:	Arthritis Gout	Rheumatism Bone fracture	Back pain	Osteoporosis
Skin:	Eczema Itching	Hives Hair loss	Psoriasis Nail changes	Skin rash
Neurological:	Headache Depression Memory loss Concentration problems Dementia	Dizzy spells Anxiety Tremor Migraine Mental illness	Seizures Decreased life enjoyment Stroke Mood swing Decreased work performance	Numbness Sleep problems Phobias
Infections:	Tuberculosis Measles	Chicken pox Rheumatic fever	Polio Herpes	Mumps HIV/AIDS
Gynecological:	Periods Pap smear date	Pregnancies Birth Control.	Abortion	Hysterectomy

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PHYSICAL EXAMINATION

Vital Signs: HT: WT: BMI: IBW
PR: BP: RR: Temp:

General:

HEENT:

Heart:

Chest:

Abdomen:

CNS:

Extremities:

Lab. Results: (Please bring your labs and X-rays with you)

CBC	CMP	X-rays	CAT scans	EKG
Lipids	Others			

Assessment:

Plan:

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