O.M. SULIMAN, M.D.
COSMETIC AND PLASTIC SURGERY

WELCOME TO OUR OFFICE! PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE SO THAT WE WILL GET TO KNOW YOU AND BE OF GREATER ASSISTANCE.

PATIENT INFORMATION (Personal)

Name____**Date of Birth**_____________**Age**_____

Social Security #:____

Address____
Street City State Zip

Phone________________**Cell** #__________________EMAIL____________________________

Referred by:__________________________Family Doctor____________________________

Single_______Married______Widow____Divorced______

Patient's Employer_______________________Occupation______________________________

Employer's Address______________________Telephone #:____________________________

Emergency Contact______________________Relationship____________Phone #__________

Spouse's First Name:____

Spouse's Employer:______________________Telephone #:____________________________

INSURANCE INFORMATION

Primary Insurance Company____

Secondary Insurance Company____

Policy Holder's Name and Birthdate:____

I hereby authorize Dr. Suliman to release any pertinent information necessary for treatment of my condition and or processing insurance claims. I also authorize payment directly to Dr. Suliman for surgical and or medical benefits for services rendered to me. I understand that I am financially responsible for those charges not paid by the insurance company and will pay whatever collection costs are necessary to collect the unpaid amount, including court cost and a reasonable attorney's fee.

Signature of Patient or Guardian:___________________________________Date_________________

FOR OFFICE USE ONLY- TODAY'S DATE_______________________

Case History-Please fill in ALL information

Name:____

Date:____

Chief complaint/Reason for visit____

Duration of Present Condition:____

Past Medical History: (Please Circle)
High Blood Pressure-Diabetes Mellitus-Bleeding Problems-Hepatitis-Skin Cancer
Other____

Any Surgeries you've had: (and Dates)
____
____

Social History: Do you smoke?_________If so, how many cigarettes per day? __________

Family History:____

Review of Systems: (Please Circle if the condition applies to you, if not please circle **NONE**)

Eyes: Visual Problem Blurry Vision Red Eyes
Other **NONE**

Ears: Hearing Problem Ringing in the Ears Discharge
Other **NONE**

Throat: Swallowing Difficulty Frequent Sore Throats Speech Problems
Other **NONE**

Mouth: Dental Problems Tongue Problems Canker Sores
Other **NONE**

Neck: Swollen Glands Thyroid Problems
Other **NONE**

Chest: Asthma Shortness of Breath Cough TB Emphysema
Other **NONE**

Heart: Murmurs Pace Maker Palpitations Valve Problems Heart Failure
Heart Attack Angina
Other **NONE**

Intestinal: Colitis Ulcer Gastritis Barrett's Esophagus Polyps Constipation
Other **NONE**

Urinary: Urinary Problems Frequency Burning Kidney Stones
Other **NONE**

GYN Last menstrual period_______Pregnant_____Breastfeeding_______

Spine: Neck Pain Mid Back Pain Low Back Pain Scoliosis Herniated Disc
Sciatica
Other **NONE**

Upper Extremity: Pain in arm Carpal Tunnel Shoulder Pain Elbow Pain Wrist Pain
Other **NONE**

Lower Extremity: Pain in Legs Knee Pain Hip Pain Ankle Pain Tingling
Other **NONE**

Systemic: Weight Loss Fever Night Sweats Trouble Sleeping Loss of Energy
Arthritis
Other **NONE**

Neuro: Headache Convulsions Seizures Fainting ADD Stroke
Other **NONE**

Psychiatric: Depression Anxiety Stress/Excess Worry Drug/Alcohol Issues
Other **NONE**

______________________________________ __________________
Signature of Patient or Guardian Date

PATIENT CONSENT FORM

I grant consent to O.M.Suliman, M.D. to use and disclose my protected health information for the purposes of diagnosing or providing treatment, obtaining payment for my health care bills, conducting health care operations and medical quality assurance and peer review.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, peer review, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review Dr. Suliman’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, quality assurance, per review or in the performance of health care operations of Dr. Suliman’s practice. The Notice of Privacy Practices for Dr. Suliman is provided in the waiting room and on the website www.suliman.com. This Notice of Privacy Practices also describes my rights and Dr. Suliman’s duties with respect to my protected health information.

I understand that diagnosis or treatment of me by Dr. Suliman will be conditioned upon my consent as evidenced by my signature on this document. I have the right to revoke this consent in writing, except to the extent my protected health information has already been disclosed in reliance on this consent.
I acknowledge receipt of the Notice of Privacy rights and practices and have been given the opportunity to review that notice.

I give permission for Dr. Suliman or his staff to leave messages concerning appointment dates, treatments, diagnosis, payment information and other protected health information:
Please indicate location:
______on my home phone.
______on my cell phone.
______on my work phone.

______I do not give permission for Dr. Suliman or staff to leave messages on my home or work phone.

Please indicate below any individuals that we may release your protected health information to:

Name:______________________________________Relationship:_____________________

Name:______________________________________Relationship:_____________________

By signing this statement I am giving Dr. Suliman and staff the consent to release and/or obtain my protected health information as indicated above.

___________________________________ ____________________
Signature of Patient or Guardian Date

PATIENT MEDICATION QUESTIONNAIRE

O. M. SULIMAN, M.D.
6255 Central Avenue
ST. PETERSBURG, FL 33710
727-344-6000

Patient Name_________________________________Date__________________________

Are you allergic to any medication(s)? YES NO

If yes, what medication(s)? ____

What is your reaction to this medication? _______________________________________

Do you take any blood thinners? YES……NO……NOT SURE

If yes, please list…____

List below ALL medications, herbal supplements, over the counter, & vitamins taken:
IF YOU HAVE A PRE-TYPED LIST, PLEASE ATTACH. IF NOT, PLEASE PRINT IN THE SPACE PROVIDED BELOW:

Name	Dose	How often	Reason for taking	Prescribed by

Pharmacy Name:____
For the following, please fill out (1) or more…we can find your Pharmacy with (1) or more of these selections:
-Phone # ________________________________ OR
-Address_________________________________ OR
-Zip Code_________________________________

Signature of Patient: ____