Dr. Malaz Almsaddi, MD

Neurodiagnostic and Sleep Disorder Center NSD PC

Patient Name:________________ Date of Birth: ______________ SS#: ____________

Address:__________________ Apt #____________

City:____________________ State:______________ Zip:____________

Home Phone: ______________ Cell Phone:___________ Work Phone:_____________

Email: ____________________________________________________

Sex: _____Male ______Female Marital Status: ___S ___M____D_____W

Primary Care Physician: ____________________________________

Address: __________________ City:_______________ State:______ Zip:_______

Phone: ____________________ Fax:________________

Is this visit Medical_________ Worker's Comp__________ Motor Vehicle Accident ________

Medical Insurance________________________ Policy Holder:____________________

Policy#______________________________ Group:________________________

Policy Holder's Social Security # ________________ Date of Birth: ___________________

Emergency Contact: _______________________ Relationship: _________________

Phone: ____________________

I hereby assign medical benefits due to me to be paid to Malaz Almsaddi, M.D. I voluntarily consent to health care treatment from the physician and staff of this facility. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor to continuation of my medical care. I understand that I am financially responsible for all co-pays, coinsurance, deductibles, and rejected claims. I understand that a photocopy of this release is a valid as the original.

Patient Signature, Parent or Guardian____________________ Date: ___________

Print Name ______________________________

Neurodiagnostic and Sleep Disorder Center, PC

## PLEASE CIRLCE ANY SYMPTOMS YOU ARE HAVING

| | |
|---|---|
| General: | Appetite loss, excessive crying, fatigue, tiredness, weight loss |
| Head, Eyes, Ears, Nose: | Double vision, eye pain, facial numbness or tingling, head injury, ringing in ears, sleep apnea, snoring, vertigo, visual disturbances, vision loss, sleep difficulties, confusion |
| Respiratory: | Difficulty swallowing, difficulty breathing, shortness of breath(dyspnea) |
| Cardiovascular: | Chest pain, difficulty breathing on exertion, heart stint, hypertension, palpitations |
| Musculoskeletal: | Neck stiffness, neck pain, back ache, back pain, joint pain, joint stiffness, leg cramps, muscle cramps, physical disability, leg pain, arm pain, generalized body pain |
| Neurologic: | Attention deficit, auras, decreased memory, dizziness, fainting, headaches, hyperactivity, migraines, numbness, seizures, spinning sensation, stroke, tingling, tremor, trouble walking, unusual sensation, unsteadiness, vertigo, weakness, speech difficulties, loss of balance |
| Psychiatric: | Anxiety, change in sleep pattern, depression, early awakening, fearful, memory loss, mood changes, inability to concentrate, insomnia |

Name: ________________________________________

# Medicine List

Please list ALL medicines you take. Include prescriptions, vitamins, over-the-counter, supplements, and herbal medicines.

| Medication | Dosage | How you take it |
|---|---|---|
| Example: Aspirin | 81 mg | 1 pill in the morning |
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Allergies_______________________________

Pharmacy: ______________________________

Location: ______________________________

## Social History:

Tobacco Yes________ Pack ______ No________ quit______

Alcohol Yes _______ No________ How often? ____________________

Caffeine Yes ______ No_______ What? _____________ How often? ________________

## Surgeries:

_________________________________________________________________________________

Neurodiagnostic & Sleep Disorder Center

Malaz Almsaddi, MD

By signing this, I acknowledge that I have read and comprehend this authorization. Further, I allow Neurodiagnostic & Sleep Disorder Center to use or disclose my Protected health information in accordance with the terms of this authorization.

Signature of Patient: ______________________________

Printed name of patient: ______________________________

Date: ______________

## Authorization for the Use and Disclosure of Protected Health Information

Protected Health Information is any information, whether electronically transmitted, oral, or recorded in any format or medium that is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school, university or clearinghouse. This relates to past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment of the provision of health care to an individual.

By my signature, I ______________________________, authorize the use and disclosure of my personal health information which pertains to me for the following purpose(s):

______________________________________________________________

- The office of Neurodiagnostic and sleep disorder center may release my personal health information via fax to another treating physician's office/ hospital center in order to assist in my medical treatment
- The office of Neurodiagnostic and sleep disorder center may leave a voice message on my answering service at home/work/ cellular telephone regarding my appointment(s) and/or test results: however, not giving the results by phone but indication that "your test results are in"
- The office of Neurodiagnostic and sleep disorder center may disclose my medical treatment with the following individual(s) such as a particular family member, friend, or companion