Our office is located at 11652 Studt Avenue, St. Louis, MO 63141.

Please arrive at least 15 minutes prior to your appointment with the enclosed "New Patient Forms" filled out. If your forms are not completed at the time of your appointment, the doctor may not be able to see on that day.

Also, bring your insurance cards so we can copy them for our records. **If required by your insurance company, it is your responsibility to contact your primary physician's office to make sure a referral is faxed/mailed to our office.** Failure to do so may result in greater out of pocket expense for you.

Co-payments are required at the time of each visit. Cash, checks MasterCard, Visa, Discover and American Express are accepted.

Please bring a list of your current medications. **You will be responsible to verify that your records have been forward to our office from your referring physician prior to your appointment**.

Out of concern and safety for our patients on chemotherapy, we ask that you refrain from bringing children under the age of 12 to the office.

If you have any questions or if we can be of assistance, please feel free to give us a call at **(314) 991-5445 between 9:00 a.m. and 4:00 p.m.**

Sincerely,

Al Elbendary, MD.

Al Elbendary MD

11652 Studt Avenue
Saint Louis, MO 63141-7025
(314) 991-5445

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP		HOME PHONE		
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME		CONTACT HOME PHONE		

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
	$	
CITY, STATE ZIP	DEDUCTIBLE	
	$	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I request that payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to the doctor or group indicated on the claim for any services furnished me by the physician. I understand that execution of this assignment in no way relieves me of my financial responsibility. I understand I am financially responsible for payment of this account regardless of insurance or third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any agency or collection fee and/or court costs.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Date: _____

PATIENT FORM

Name: _____ Birthdate: _____ Age: _____
Primary Care Physician: _____ Referring Physician: _____
Problems: (State reason you want to see a doctor. List in order of importance to you.)

1. _____
2. _____
3. _____

Medical Conditions (Please check all that apply)

___ AIDS/HIV	___ Bronchitis	___ Epilepsy	___ Hypertension	___ Parkinson's Disease
___ Alcoholism	___ Cancer	___ Headache	___ Pneumonia	___ Alzheimer's Disease
___ Anemia	___ Herpes	___ Heart Problems	___ Psychiatric Problems	
___ Asthma	___ Chemical Dependency	___ Hepatitis	___ Stroke	
___ Arthritis/Gout	___ High Cholesterol	___ Jaundice	___ Thyroid Dysfunction	
___ Bleeding Disorder	___ Diabetes	___ Kidney Problems	___ Tuberculosis	
___ Breast Lump	___ Emphysema	___ Liver Problems	___ Ulcers	

Surgeries (List all surgeries and the year)

_____ _____
_____ _____

Obstetrical and Gynecologic History: Number of Pregnancies:_____ Number of Deliveries:_____

Medications (dose and frequency; including over-the-counter medications)

_____ _____
_____ _____
_____ _____
_____

How many aspirin/Advil a month do you take? _____

DO YOU HAVE ANY DRUG ALLERGIES? (List all drug allergies and their effect on you; if you are allergic to shellfish please include that as well. Shellfish contains iodine)

_____ _____
_____ _____

Family History:

	Age	Significant Illness (if deceased, cause of death)
Father	____	_____
Mother	____	_____
Brother(s)	____	_____
	____	_____
Sister(s)	____	_____
	____	_____
Children	____	_____
	____	_____
	____	_____

Smoking History: Packs per day _____ How many years _____ Smoking now? Yes___ No ___
Drinking History (ALCOHOL): Ounces per day _____ How many years _____
IV Drug Use: How many years _____ Date of last use _____ Type of drug(s) used: _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Separated _____ Divorced
Education: (circle level completed) High School: 9 10 11 12 College: 1 2 3 4 Other _____
Occupation: Yours _____ Spouse _____ Religious Preference _____

PATIENT FORM

Symptoms: Check symptoms you currently have or have had in the past year

GENERAL
__ Chills
__ Sweats
__ Fever
__ Tiredness
__ Weakness
__ Lack of appetite
__ Weight gain
__ Weight loss
__

CARDIOVASCULAR
__ Heart palpitations
__ Irregular heart beat
__ Chest pain at rest
__ Chest pain with exertion
__ Wake up short of breath
__ Sleep with 2 or more pillows
__ High blood pressure
__ Low blood pressure
__ Poor circulation
__ Swelling of ankles/legs
__ Varicose veins

GASTROINTESTINAL
__ Loss of appetite
__ Nausea/vomiting
__ Bloating
__ Constipation
__ Black stools
__ Change in stool color
__ Change in bowel habits
__ Rectal bleeding
__ Diarrhea
__ Laxative use
__ Excessive bleeding
__ Indigestion
__ Stomach pain
__ Vomiting blood
__ Hemorrhoids

GENITOURINARY
__ Excessive urination
__ Urinary dribbling/incontinence
__ Kidney/bladder infections
__ Blood in urine
__ Night time urination
__ Pain/burning with urination
__ Urgency in urination
__ Vaginal discharge/itching
__ Painful intercourse
__ Bleeding between periods
__ Extreme menstrual pain
__ Abnormal pap smear
__ Last Pap Smear __/__/__
__ Hot flashes/night sweats
__ Breast lump
__ Nipple discharge
__ Last mammogram __/__/__
__ Last menstrual period __/__/__

SKIN
__ Bruising
__ Change in moles
__ Change in hair texture
__ Change in nail texture
__ Change in skin color
__ Extreme dryness
__ Exema
__ Hives
__ Lumps
__ Rashes

RESPIRATORY
__ Asthma
__ Wheezing
__ Bronchitis
__ Pneumonia
__ Dry cough
__ Cough up phlegm
__ Cough up blood
__ Pain in chest when you cough, sneeze, or move
__ Shortness of breath

NEUROLOGIC
__ Fainting
__ Blackouts
__ Paralysis or weakness of limb(s)
__ Difficulty in speaking
__ Dizziness
__ Double vision
__ Headache
__ Loss of balance
__ Loss of coordination
__ Loss of sensation
__ Numbness
__ Seizures

PSYCHIATRIC
__ Difficulty with memory of past events
__ Difficulty with memory of recent events
__ Difficulty with thinking of problem solving
__ Anxiety
__ Depression
__ Difficulty falling asleep
__ Loss of sleep
__ Early morning awakening
__ Forgetfulness
__ Nervousness

HEENT
__ Blurred vision
__ Crossed eyes
__ Decreased ability to see
__ Eye pain
__ Earache
__ Ear drainage
__ Ringing in ears
__ Nosebleeds
__ Hoarseness
__ Sore throat
__ Difficulty swallowing
__ Pain with swallowing

MUSCULOSKELETAL
__ Back Pain
__ Arthritis
__ Gout
__ Joint aches
__ Joint stiffness/swelling
__ Redness of any joint
__ Muscle aches
__ Muscle stiffness
__ Pain down back of legs
__ Weakness

ENDOCRINE
__ Excessive hunger
__ Excessive thirst
__ Heat intolerance
__ Cold intolerance

List other physicians seen in the last two years and why: _____

Who in your family had:	Father	Mother	Sister(s)	Brother(s)	Other
Cancer (state type)					
Cervical Precancers					
Stroke					
Diabetes					
Heart Attack					
High Blood Pressure					
Bleeding Problems					

_____ _____ _____ _____
Patient's Signature Date Physician's Signature Date

CONSENT FORM

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I, _____, consent to medical treatment by Dr. Elbendary or his designee, for myself or for the patient for whom I am the parent or legally authorized representative. I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures or examinations.

_____
Signature of Patient (or legal guardian/representative)

_____
Date

_____
Relationship to patient

_____ _____
Witness Date

MAIN OFFICE 11652 Studt Road St. Louis, MO 63141 TEL 314.991.5445 FAX 314.991.5447
SATELLITE OFFICE 330 First Capitol Dr., Ste. 240 St. Charles, MO 63301

FINANCIAL RELEASE WAIVER

AL ELBENDARY MD

Patient Name: _____

I have an appointment today , with **Elbendary MD, Alaa A/Kate Burch**.

Should my insurance plan fail to cover today's services, I understand I am fully responsible for the full amount of the services incurred.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Witness **Date**

Al Elbendary MD

Patient Name:_____

Patient DOB:_____

I have received or have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared. I acknowledge that Al Elbendary MD, the physicians, the nurses and other Al Elbendary MD staff may use and share my confidential health confidential health information with others in order to treat me, in order to arrange for payment of my bill, and for issues that concern Al Elbendary MD operations and responsibilities.

Patient/Guardian Signature_____

Date signed_____

Due to the federal privacy regulations, we cannot leave messages with protected health information on home answering machines or with family members without written permission.

I give **Al Elbendary MD** permission to leave detailed messages:

_____ On my home answering machine/voice mail # _____

_____On my work answering machine/voice mail # _____

_____On my cell phone # _____

_____With the person listed below (names and relationship to patient)

_____

_____

_____

_____

_____ _____

Signature of patient Date

____**I do not want any medical information released except to myself.**

_____ _____

Signature of patient **Date**

PATIENT DEMOGRAPHIC FORM

In order to better serve our patients, and to update our records, please complete this basic information form:

Name: _____

Date of Birth: _____/ _____/ _____

Email address: _____

Home Phone Number ( ) _____

Alternate Number ( )_____

Primary dental provider (Dentist) and phone # _____

Race:

____Alaskan Native
____Asian
____Asian/Pacific
____Black/African (not Hispanic)
____ Unknown
____Hispanic
____Native American
____Other
____Pacific Islander
____Spanish American
____White/Caucasian (Not Hispanic)

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino ___Unknown

Preferred Spoken Language:

__Arabic
__Bulgarian
__Central Khmer
__Chinese
__English
__French
__German
__Haitian/Haitian Creole
__Hebrew
__Hindi
__Italian
__Other (please specify)_____
__Japanese
__Korean
__Polish
__Portuguese
__Russian
__Somali
__Spanish/Castllian
__Swahili
__Thai
__Urdu
__Vietnamese