# *ABDUL S. THANNOUN, M.D., P.A.*
# Registration Information

**Date: _____ Cell Phone:_____ Home Phone:_____**

**Patient Name:_____**
**Last Name First Name Middle Initial**
**Mailing Address:_____**

**City:_____ State: _____Zip:_____**

**Date of Birth:_____Driver's License #:_____Social Security # _____**

**Marital Status M / D / S / W Sex: M / F Race:_____ Ethnicity:_____**

**Primary Care Physician:_____ Referring Physician:_____**

**Patient's Employer:_____Title:_____ Work Phone:_____**

**Spouse Name:_____Employer:_____ Work Phone:_____**

**Spouse SSN #:_____ Spouse Date of Birth:_____ Cell:_____**

**Do you have medical insurance? Y / N If yes, name of insurance?**
*(If you do not have medical insurance, payment is due on the date of service.)*

**Policyholder's Name:_____**
**DOB:_____SS#_____EMPLOYER_____**
**Employer's Phone #:_____**

**Name of Secondary Insurance (if any):_____Policy #_____**

**In case of an emergency, who should be notified?**

_____
**Name Relationship Phone Number/Work Number/Cell Phone**

***AUTHORIZATION AND RELEASE OF MEDICAL RECORDS***

I authorize the release of any information including the diagnosis and/or records of any treatments/examinations rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to my doctor, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payments of all services rendered on my behalf or my dependents.

I acknowledge I have received a copy of this office's Notice of Privacy Practice's.

_____

Signature of Patient, Parent, Legal Guardian, Attorney ad Litem or Personal Representative* Date:

**Legal Guardian, Attorney ad Litem, or Personal Representative must produce legal document of authority.*

Many insurance companies do require a referral to see a specialist which must be in the insurance company's system prior to your office visit. Since most office's will no longer fax referrals, the patient is responsible to make sure this process is completed PRIOR to your office visit with us. If this process is not complete, full payment will be expected at the time of service.

During your office visit with Dr. Thannoun, you may be scheduled for endoscopy procedures, laboratory testing, radiology examinations, and in some cases a referral to another specialist. Although we try and follow your insurance guidelines, it remains the patient's responsibility to ensure that a PPO/HMO facility or provider is used. We encourage you to call your insurance carrier or use your insurance provider manual to access this information. Failure to do so will result in a reduction of benefits or a denial of payment by your insurance carrier.

Pre-Certification is required for hospital admissions, surgical procedures, diagnostic services, and out patient procedures as specified in your insurance manual. (This means that your insurance company must be notified if any testing has been scheduled.) Although we make every effort to obtain this, it is the patient's responsibility to make sure this process has been completed. Failure to obtain pre-certification will result in the reduction of benefits.

I have read the above information and understand that I am responsible for any penalties, reduction in benefits, or if a denial of payment is incurred.

_____ _____

Signature of Patient, Parent, Legal Guardian, Attorney ad Litem or Personal Representative* Date:

**Legal Guardian, Attorney ad Litem, or Personal Representative must produce legal document of authority*

# Abdul S. Thannoun, M.D., P.A.
# 3501 Soncy Road, Suite 107
# Amarillo, Texas 79119
# (806) 354-2400

Our office participates with Follow My Health, which allows our patients to access their medical records online. Please provide us with your email address so that we may send you an invitation to register. Once we send you your invitation, you will just need to follow the links to get signed up.

( ) Yes, please register me.
My email address is:_____.

( ) No, I do not wish to participate and am aware if I need a copy of my medical records, there will be a charge. I also understand that Dr. Thannoun may charge a fee for phone calls strictly relating to my medical record file.

( ) No, I am already a registered Follow My Health user.

Appointments that are missed, canceled and or rescheduled with less than 24 hour notice can and may be subject to a ***$25 charge***. If you need to reschedule for any reason, please call us so we can accommodate you and make your spot available to another patient.

_____

Patient Signature Date

# Medication List

**Name:**_____

**ALLERGIES:**_____

**Local Pharmacy:**_____**Mail Order Pharmacy**_____

| MEDICATION & DOSE | DIRECTIONS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |