LAST NAME ____________________ FIRST NAME __________________ NICKNAME ________________________

MIDDLE INITIAL

❐ MALE DATE OF BIRTH ______________ AGE_____ SS# __________________________________

❐ FEMALE

ADDRESS ____

CITY STATE ZIP CODE

HOME PHONE ______________________ WORK PHONE ____________________ CELL PHONE ________________

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE CO.____

NAME CLAIMS ADDRESS CITY STATE ZIP

POLICY/ID NO. ________________________________ GROUP NO. __________________________________

PLEASE SUPPLY THE FOLLOWING *ONLY* IF THE PATIENT IS *NOT* THE *PRIMARY POLICY HOLDER:*

PRIMARY POLICY HOLDER ______________________________________ DATE OF BIRTH ______________________

ADDRESS ____

❐ SAME AS PATIENT CITY STATE ZIP

SECONDARY INSURANCE:

INSURANCE CO.____

NAME CLAIMS ADDRESS CITY STATE ZIP

POLICY/ID NO. ________________________________ GROUP NO. _________________________________

PLEASE SUPPLY THE FOLLOWING *ONLY* IF THE PATIENT IS *NOT* THE *PRIMARY POLICY HOLDER:*

PRIMARY POLICY HOLDER ______________________________________ DATE OF BIRTH_____________________

ADDRESS ____

❐ SAME AS PATIENT CITY STATE ZIP

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INS., OR ANY OTHER HEALTH/AUTO INSURANCE PLANS TO *PCCC/IDC OF VOLUSIA*. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY (INCLUDING PHOTOCOPIES OF MEDICAL RECORDS) TO SECURE PAYMENT (SEE NOTICE OF PRIVACY PRACTICES.) ALSO, BY SIGNING BELOW, I AM ATTESTING THAT I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES FOR THIS OFFICE (AVAILBLE FROM RECEPTIONIST).

SIGNATURE OF PATIENT ____ DATE _________________

OR, GUARDIAN IF PATIENT UNDER THE AGE OF 18

NEXT PAGE →

IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF INDIVIDUAL PLANS, POLICIES AND BENEFITS. THE FILING OF CLAIMS FOR YOU DOES NOT GUARANTEE PAYMENT FROM YOUR INSURANCE COMPANY, NOR SHOULD IT BE CONSIDERED A BINDING AGREEMENT OF PAYMENT AND/OR BENEFITS FROM YOU INSURANCE COMPANY. AS A PATIENT OF PCCC/IDC OF VOULSIA, YOU ARE RESPONSIBLE FOR THE ENTIRE BILL OF SERVICES SHOULD YOUR INSURANCE COMPANY DENY PAYMENT FOR ANY REASON. BY SIGING THIS STATEMENT AS A GUARANTOR, YOU AGREE TO PAY FOR ALL SERVICES AND/OR SUPPLIES THAT ARE DEEMED PATIENT RESPONSIBILITY BY EITHER PCCC/IDC OF VOLUSIA OR YOUR INSURANCE COMPANY.

Rajesh K. Ailani, M.D.
Reba K. Ailani, M.D.
Theodossis Zacharis, M.D.
Dany A. Obeid, M.D.
Anil Gopinath, M.D.

PERSONAL HEALTHCARE CONFIDANT

I, ___________________________, elect the following person/people, listed below, as my Personal Healthcare Confidant(s). ***I give permission to the above named physicians and their office staff to release any& all information regarding my medical treatment to my elected Personal Healthcare Confidant.*** I understand that should I choose to change or remove an elected person, I must do so in writing in the presence of the staff, or by sending my notarized request in the mail.

ELECTED PERSON **RELATIONSHIP**

____

____

____

____

MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE OR VOICE MAIL REGARDING YOUR HEALTH (*INCLUDING BUT NOT LIMITED TO: LABS, RADIOLOGY STUDIES, APPOINTMENTS*)

□YES □NO

PATIENT SIGNATURE ___________________________

DATE SIGNED ____________________

*****NOTARY _________________________ DATE_________**

***** ONLY NEED NOTARY IF PATIENT IS NOT SIGNING IN FRONT OF A MEMBER OF THE OFFICE STAFF*****

NEXT PAGE

Rajesh K. Ailani, M.D.
Reba K. Ailani, M.D.
Theodossis Zacharis, M.D.
Dany A. Obeid, M.D.
Anil Gopinath, M.D.

NAME ____________________________ DOB _________________

PHARMACY OF CHOICE ____

LOCATION ____

PHONE ____

MEDICATION	**STRENGTH**	**FREQUENCY**

****PLESE BE SURE TO LIST VITAMANS AND SUPPLEMENTS AS WELL****

NEXT PAGE →

RAJESH AILANI, M.D.
THEODOSSIS ZACHARIS, M.D.
REBA AILANI, M.D.
DANY A. OBEID, M.D.
ANIL GOPINATH, M.D.

Name:________________________ DOB:________________________

PAST MEDICAL HISTORY: _____Diabetes _____High Blood Pressure
_____Coronary Artery Disease _____Lung Disease (__________________)
_____Kidney Disease _____Liver Disease _____Thyroid Disease
_____Vascular Disease _____Bleeding Problems _____Heart Attack
_____Angina _____Stroke _____Seizures _____Ulcer _____Asthma
_____Heart Murmur _____Emphysema _____Back Injury
_____Rheumatic Fever _____Cancer (Type)________________________
_____Other Medical Problems____________________________________

ALLERGIES:

____

____

____

SOCIAL HISTORY: _____Cigarettes: _____Years _____Packs per day
_____Quit Smoking :__________________________
_____Alcohol (Type and Amount)______________

Occupation:__________________________________

SURGICAL HISTORY:

Procedure	Date
____	__________________________
____	__________________________
____	__________________________
____	__________________________
____	__________________________
____	__________________________
____	__________________________

FAMILY HISTORY: _____Heart Disease (_______________________)
_____Diabetes (_______________________) _____High Blood Pressure (____________)
_____Cancer (_______________________) _____Stroke (_______________________)
_____Lung Disease (__________________) _____Kidney Disease (_________________)

CHILDREN: How many? Ages:
____

General Office Policies

MISSED APPOINTMENTS

If you need to cancel your appointment, we require 24 hours notice so we may be able to offer your appointment to someone else. Please call our main number 423-0505, option 2. Missed appointments are billed at $20* and are not covered by insurance.

RETURNED CHECK FEES

There will be a $20 fee on all returned checks, in addition to any bank fees assessed.

WALK-INS

We ask that when you are sick, please call and speak with the nurse (423-0505, option 3) and we will do our best to get you in to see the physician. We might recommend that you see your primary care physician or possibly the Emergency Room instead.

PRESCRIPTION REFILL POLICY

Please call your pharmacy directly for any prescription refills written by Dr. Reba Ailani, Dr. Rajesh Ailani, Dr. Theodossis Zacharias & Dr. Dany Obeid, Anil Gopinath *even if the prescription has expired*. The pharmacy will contact us for refills. (This applies to all insurances except Florida HealthCare Plans.)

Prescriptions *not written* by Dr. Reba Ailani, Dr. Rajesh Ailani, Dany A. Obeid, Anil Gopinath, & Dr. Theodossis Zacharias will not be filled. These will need to be filled by the prescribing doctor.

Please allow two days for refill request.

Prescriptions will only be filled during working hours.

No prescriptions will be filled after 12PM on Friday, or on the weekends.

We appreciate your cooperation.

*Unless otherwise stated by your insurance company.

01/03/2006