Dr. Kalil Al-Nassir, M.D., FACP, FCCP
1215 South Coulter, Suite 204
Amarillo, TX 79106
Phone: 806-677-2030
Fax: 806-356-0045

REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION			
Today's Date:	Primary Care Physician:		
SS#:	Date of Birth:		Gender: ☐Male ☐Female
Last name:	First name:		Middle Initial:
Is this your legal name? ☐Yes ☐ No	If not, what is your legal name?		
Marital Status: ☐ Mr. ☐Miss ☐ Mrs. ☐ Ms. ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow			
Mailing address:			
City:	State:	Zip:	County:
Home phone:		Cell phone:	
Email:			
Would you like to sign up for the patient portal, so you can view your lab results? ☐ Yes ☐ No			
Employer:	Occupation:		Employer phone:
Mailing Address:			
City:	State:		Zip:
Are you a student? ☐ Yes ☐ No	Full Time?		Part Time?
How did you hear about our practice?			
Referring Provider:			

INSURANCE INFORMATION	
Primary Insurance: Policy Holder Information	**Secondary Insurance: Policy Holder Information:**
Policy Holder Name:	Policy Holder Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Insurance Company:	Insurance Company:
Ins. Co. Address:	Ins. Co. Address:
Group # / Contract #:	Group # / Contract #:
Employee/Cert #: Deductible: $	Employee/Cert #: Deductible: $
Financial Responsible Party Complete this section only if the information is different from the Patient Information Section	
Guarantor's Relationship to Patient:	Gender: ☐ Male ☐ Female
Date of Birth:	SS#:
Last Name:	First Name:
Address:	City/State/Zip:
Employer:	Phone:
Address:	City/State/Zip:

EMERGENCY CONTACT INFORMATION	
PARENT/LEGAL GUARDIAN CONTACT INFORMATION (PATIENTS 18 AND YOUNGER)	**EMERGENCY CONTACT INFORMATION (PATIENTS 18 AND OVER)**
Parent/Guardian Name:	Emergency Contact Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Parent Home Phone:	Contact Home Phone:
Parent Cell Phone:	Contact Cell Phone:

PREFERRED PHARMACY CONTACT INFORMATION	
PREFERRED LOCAL PHARMACY:	**MAIL ORDER PHARMACY:**
Name of Pharmacy:	Name of Pharmacy:
Location:	Location:
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

ADDITIONAL INFORMATION
We are not required by CMS to collect information on race and ethnicity.
☐ African American ☐ American Indian or Native Alaskan ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian ☐ Decline to State ☐ Other
Do you have any additional needs or requests?

Patient/Guardian Signature: ______________________________ Date: ____________________

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Notice to all Patients

Effective April 4, 2019

Rules and Expectations

Dr. Al-Nassir does not accept any social media requests or messages sent via social media. Please contact the office for any questions or concerns. 806-677-2030

Non-Emergent medical health calls will be returned as soon as possible during business hours. By deciding to be a patient at this clinic you are acknowledging that after-hours emergency care is not provided by this clinic. Please call 911 if a medical health emergency is occurring.

All patients are expected to give 48-hour notice for any cancellation. Please respect the doctors time and the clinics time by following this rule. If this rule is not followed you will be considered a “No Show”. A $50.00 fee is charged for each “No Show”. As a new patient there will be a $100.00 “No Show” fee if the appointment is not cancelled or rescheduled within 48 hours prior to the appointment.

A $30 fee will be charged for any check return.

Patient/Guardian Signature: ______________________________ Date: ____________________

AFTER HOURS POLICY

This clinic is NOT open after hours.

After hour calls will be directed by the answering service. In case of an Emergency or patient is in crisis, they will be directed to call 911 or go to the nearest emergency room.

You will NOT be able to get any medication refills after hours. If the medication is a Non-Controlled substance the pharmacy will usually bridge over the weekend.

There will be NO Medication changes done over the weekend. The Nurse will return your call within 24-48hrs of the next business day.

If patient wants to be referred to another provider who may take individual calls after hours, Referrals can be made.

HEALTH INFORMATION EXCHANCE (HIE)

It is a database where records are electronically stored. Doctors can sign into this database and see records from other doctor's you have seen in the past.

Only doctors you are currently seeing are allowed to access this database. Emergency rooms in Amarillo are set up on the database.

This database is Health Insurance Portability and Accountability Act (HIPAA) approved.

Printed Name: ____

Signature: ____

Date: ____

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any services being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name: ____ Date of Birth: _________________________

1. Please list the family members and/or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

____
Name Phone Number

____
Name Phone Number

____
Name Phone Number

2. Please list the family members and/or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

____
Name Phone Number

____
Name Phone Number

____
Name Phone Number

3. Please list the telephone number(s) where you want to receive calls about your appointments, lab, x-ray results, and any additional health care information:

____

Please note: while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.

SIGNATURES:

Patient/Legal Representative: _______________________________ Date: _______________________________

If Legal Representative, Relation to Patient: ____

Witness (optional): ____ Date: _______________________________

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: ______________________________

Records requested from:

Primary Care Physician/Clinic/Hospital____

Address: ____

Phone: ____

Fax: ____

to the following person(s):

Kalil Al-Nassir, M.D., FACP, FCCP
Amarillo Medical Specialists
1215 S. Coulter, Ste 204
Amarillo, TX 79106
Phone: (806) 677-2030
Fax: (806) 356-0045

Full Name: ____

Other Name(s) Used: ___________________________________ Date of Birth: _________________

Address: ____

City: ____________________________________ State: ____________ Zip Code: ________

Phone: ___________________________________

Signature: ____

Potter County Texas Venue Agreement for any Health Care Liability Claim

Parties:
The parties to this agreement are:

1. Amarillo Medical Specialists, LLP and all Amarillo Medical Specialists staff Physicians, Nurse Practitioners, and Physician Assistants (collectively referred to as “PHYSICIAN”); and
2. ____ (“PATIENT”),

Definitions:

1. HEALTH CARE LIABILITY CLAIM means a cause of action against a physician or a physician’s employees for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care or safety which proximately results in injury to or death of the patient, whether the patient’s claim or cause of action sounds in tort or contract, whether the claim or cause of action is now known or unknown, and whether the claim or cause of action is a result of past or future medical care;

For Good and Valuable Consideration Including but not limited to the medical care services provided by PHYSICIAN, PHYSICIAN and PATIENT Agree as Follows:

1. Representations: PATIENT warrants and represents the following;

   I. I have read the Agreement;

   II. I fully understand the terms and provisions of the Agreement or, in the event that I do not fully understand the terms and provisions, I will consult an attorney of my choosing to discuss this Agreement and have the terms and provisions fully explained to me to my satisfaction;

2. Venue and Choice of Law: This Agreement and any HEALTH CARE LIABILITY CLAIM will be governed by and construed in accordance with the laws of the State of Texas without giving effect to any choice or conflict of law provision or rule (whether of the State of Texas or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Texas. Any dispute arising out of this agreement and any HEALTH CARE LIABILITY CLAIM shall be heard by a Texas state court of competent jurisdiction located in Potter County, Texas. Accordingly, PATIENT and PHYSICIAN agree that venue for purposes of any dispute arising out of this agreement and HEALTH CARE LIABILITY CLAIM shall be in state court – and not federal court – in and for Potter County, Texas, and that only the laws of the State of Texas will govern such dispute or claim.

3. Severability Clause: If any of the terms, conditions, or provisions of this Agreement are held to be illegal, invalid or unenforceable by any court of competent jurisdiction, the legality, validity, and enforceability of all remaining terms, conditions, or provisions will not be affected thereby. Furthermore, in lieu of such illegal, invalid or unenforceable provision, there will be added automatically as a part of this Agreement, a provision as similar in its terms to such illegal, invalid or unenforceable provision as may be possible and be legal, valid and enforceable.

________________________________ ________________________________
PATIENT NAME DATE

PAST MEDICAL HISTORY

Reason for appointment: ____

SURGICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST SURGICAL HISTORY)*

Appendectomy Cataract Gyn Surgery Gallbladder Tonsillectomy Hernia Heart or Lung Surgery

Pacemaker Other Surgeries: ____

MEDICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST MEDICAL HISTORY)*

High Blood Pressure Diabetes Seizures Heart Disease Migraine Stroke

Thyroid Disease High Cholesterol Asthma COPD Allergic Rhinitis Sleep Apnea

Cancer (Type of Cancer) ____

Other Medical Problems ____

CURRENT MEDICATIONS & DOSAGE please include over the counter medication, herbal supplements, and vitamins and changes (start/stop) to medications in the past 3 months.

☐ If you need more space for medications, please check the box and complete on last page of this packet.

SOCIAL HISTORY

Smoking? Do you currently smoke? Yes No How much?

Age started smoking: Age quit smoking: How much on average you smoked a day: Pack

Have you ever smoked? Yes No

Alcohol? No Yes (If yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used)

_____ Drink(s) per day for _____ year(s). Type(s) of drinks Beer Wine Mixed Drinks

Never used Alcohol Hospitalized for alcohol use

Recreation drug use? Yes No

Patient Name: ____ Date: ______________

Physician Name: ____ Date: ______________

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PAST MEDICAL HISTORY (cont.)

EMPLOYMENT Job Title ____

Exposures: Noise Chemicals Toxins Fumes Gases

EDUCATION Highest level Achieved ____________________________________

FAMILY HISTORY (please list those people in your family with the following illnesses):

High Blood Pressure:____

Heart Disease:____

Diabetes: ____

Cancer:____

Other Conditions:____

ALLERGY HISTORY

Penicillin or other antibiotics: No Yes (list): ______________________________

Morphine, Demerol, or other narcotics: No Yes

Novocain or other anesthetics: No Yes

Aspirin or other pain remedies: No Yes

Iodine, chlorhexidine or other antiseptic: No Yes

Tetanus antitoxin or other serums: No Yes

Other medications:
Food allergies? If yes, please specify:

____

Any seasonal allergies? If yes, please specify:

____

Patient Name: ____ Date: ____________

Physician Name: ____ Date:____________
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PATIENT SYMPTOMS

	No	Yes
Constitutional Symptoms		
Recent weight loss:	No	Yes
Fever:	No	Yes
Fatigue or daytime sleepiness:	No	Yes
Neurological		
Headaches:	No	Yes
Lightheaded or dizzy:	No	Yes
Convulsions or seizures:	No	Yes
Numbness or tingling sensations:	No	Yes
Migraines:	No	Yes
Difficulty walking:	No	Yes
Insomnia:	No	Yes
Psychiatric		
Anxiety:	No	Yes
Nervousness:	No	Yes
Depression:	No	Yes
Eyes		
Eye disease or injury:	No	Yes
Wear glasses / contact lens:	No	Yes
Blurred vision:	No	Yes
Glaucoma:	No	Yes
ENT		
Hearing loss:	No	Yes
Hoarseness:	No	Yes
Ringing in the ears:	No	Yes
Respiratory		
Chronic or frequent cough:	No	Yes
Sputum production:	No	Yes
Coughing up blood:	No	Yes
Shortness of breath:	No	Yes
Wheezing:	No	Yes
Snoring:	No	Yes
Cardiovascular		
Chest Pain:	No	Yes
Palpitation:	No	Yes
Difficulty breathing laying down:	No	Yes
Swelling of feet, ankles or legs:	No	Yes

Patient Name: ____ Date: ____________

Physician Name: ____ Date:____________

PATIENT SYMPTOMS (cont.)

	No	Yes
Gastrointestinal		
Nausea:	No	Yes
Blood in stool:	No	Yes
Heartburn:	No	Yes
Vomiting:	No	Yes
Musculoskeletal		
Joint pain:	No	Yes
Joint stiffness:	No	Yes
Joint swelling:	No	Yes
Muscle cramps:	No	Yes
Leg claudication:	No	Yes
Genitourinary		
Frequent urination:	No	Yes
Burning or painful urination:	No	Yes
Blood in urine:	No	Yes
Integumentary (skin)		
Rash:	No	Yes
Change in skin color:	No	Yes
Itching:	No	Yes
Endocrine		
Excessive thirst:	No	Yes
Heat intolerance:	No	Yes
Cold intolerance:	No	Yes
Hematology		
Bleeding tendency:	No	Yes
Anemia:	No	Yes
Bruising tendency:	No	Yes
Lymph glands swelling:	No	Yes
Nose bleeds:	No	Yes
Allergy		
Seasonal allergies:	No	Yes
Allergic rhinitis:	No	Yes
Nasal congestion:	No	Yes
Postnasal drip:	No	Yes

Patient Name: ____ Date: ____________

Physician Name: ____ Date: ____________
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MEDICATIONS (cont.)

Please continue medication list on this page, if needed.

Epworth Sleepiness Scale

Name: _______________________________________ Today's date:____________

Your age (Yrs): _______________ Your sex (Male = M, Female = F): ________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading ____	_______
Watching TV ____	_______
Sitting, inactive in a public place (e.g. a theatre or a meeting) _________	_______
As a passenger in a car for an hour without a break _________________	_______
Lying down to rest in the afternoon when circumstances permit ________	_______
Sitting and talking to someone ___________________________________	_______
Sitting quietly after a lunch without alcohol _________________________	_______
In a car, while stopped for a few minutes in the traffic ________________	_______

M.W. Johns 1990-97