**PATIENT REGISTRATION**
**HENRY C. ZIZZI, Ill, M.D. APMC**
**(318) 387-1812- PHONE**
**(318) 387-7529- FAX**

**Date:**_____ **Social Security Number:**_____

**Referring Doctor:**_____ **Insured SS Number:**_____

**Patient's Name:**_____ _____ _____
**First** **Middle** **Last**

**Date of Birth:**_____/_____/_____ **Sex:**_____**M** _____**F** **Phone:**_____
**Home**

**Cell Phone:**_____

**Mailing Address:**_____ _____ _____
**Street** **Street** **City** **State** **Zip**

**Patient's Employer:**_____ _____ _____
**Name** **City** **Phone**

**Spouse:**_____ **Date of Birth:**_____

**Employer:**_____ **Phone:**_____**SS Number**_____

**Emergency Contact:**_____ _____ _____
**Name** **Phone** **Relationship**

**INSURANCE INFORMATION (PLEASE PROVIDE A CARD TO RECEPTIONIST FOR COPYING**

**Authorization for Treatment**

**I hereby consent to treatment necessary for the care of the patient indicated on this form. This authorization is hereby granted to release medical information to any physician or entities I may be referred to for care.**

**Signature:**_____**Date:**_____

**Authorization for Benefits**

**I understand that I am responsible for payment of services rendered by Dr. Henry C. Zizzi, III. I understand the payment ploicy of this practice to pay for services at the time of service. I authorize the medical payment of my health insurance filed by this practice to be paid directly to the provider of services rendered. There will be a $25.00 service charge on all insufficient checks.**

**Signature:**_____**Date:**_____

# AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

1. I, _____, hereby authorize _____, to Disclose the following protected health informationto: **Henry C. Zizzi, III, M.D. 102 Thomas Road, Suite 203 West Monroe, LA 71291 318-387-1812 Phone) 318-387-7529 (Fax).**

2. The specific information subject ot this authorization is:
   Receive for release records from other doctors, hospitals, etc.: Insurance infrmation and payments.

3. This protected health information is being used or disclosed for Medical treatmen; insurance purposes and payments.

4. This authorization shall be in force and effect until _____ at which time this authorization to disclose this protected health information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to this Health Care Provider. I understand that a revocation is not effective:

   A. To the extent that this Health Care Provider has relied on the use or disclosure of the protected health information; or
   B. If the authorization is obtained as a condition of obtaining insurance coverage, if some other policy provides the insurer with the right to contest a claim under the policy.

6. I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

7. I understand that this Health Care Provider may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide this authorization for the requested use or disclosure.

8. I understand that I have the right to:

   A. Inspect a copy of the protected health information to be used or disclosed as permitted under the federal law, or state law to the extent the state law provides greater access rights; and
   B. Refuse to sign this authorization

9. I authorize verbal communication.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Name of Patient or Representative | Description of Representative's Authority

# NOTICE OF PRIVACY PRACTICES

**Dr. Henry C. Zizzi**

We are required to provide you with our "Notice of Privacy Practices."

**Please Provide the Information Below**

Your Name (Patient) please print:_____

Date of Birth:_____

_____
Your Signature (Patient or Personal Representative)

If a personal representative, please give description of personal representative's authority:

_____ Date:_____

May we leave medical information on your "home" answering machine? _____Yes _____No
May we leave appointment information on your "home" answering machine? _____Yes _____No

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers) that we may discuss your medical or financial information with.

Name Relationship Phone Number

1_____

2_____

3_____

_____ _____
Signature of Patient/Parent/Legal Guardian Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign below.

_____
Signature of Patient/Parent/Legal Guardian

**THE ABOVE INFORMATION IS PRIVATE AND CONFIDENTIAL AND WILL BE PLACED IN YOUR CHART**

**PATIENT NAME:** _____ **DOB:** _____

**Date:** _____

**ALLERGIES TO ANY MEDICATIONS:**

_____

_____

_____

**LIST OF CURRENT MEDICATIONS**

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**PATIENT NAME:** _____ **DOB:** _____

**Date:** _____

**Have you ever had any of the following illness?**

___High Blood Pressure
___Chest Pain
___Heart Blockage
___Heart Attack
___Heart Failure
___Heart Rhythm Problem
___Heart Valve Problem
___Kidney Failure
___Kidney Stone
___Kidney Infections
___Colon Polyps
___Diverticulitis
___Ulcerative Colitis
___Irritable Bowel
___Crohn's Disease
___Arthritis
___Osteoporosis
___Seizures
___Migraine Headache
___Aneurysm in Brain
___Tuberculosis
___Asthma
___Emphysema
___COPD
___Acid Reflux
___Ulcers
___Hepatitis
___Pancreas Disease
___Diabetic
___Cataracts
___Glaucoma
___Enlarged Thyroid
___Underactive Thyroid
___Overactive Thyroid
___Thyroid Nodule
___Anemia
___Stroke
___Cancer-What Kind
_____

**Gynecologic History**

___Do you have regular periods?
___Are you in menopause?
___Any abnormal pap smears?
___Date of last mammogram?
___Have you had an abnormal mammogram?
___Date:_____
___Breast pain or tenderness?
___Nipple discharge?

**Family Medical History**

Check all that apply to any of your blood relitives:
(Grandparents, Parents, Siblings, Children)

____Heart Disease
____Stroke
____Asthma
____Kidney Disease
____Cancer - Type of Cancer:_____
____High Blood Pressure
____Arthritis
____Diabetes
____Tuberculosis

**PSYCHIATRIC**

| | | |
|---|---|---|
| Memory Loss | No | Yes |
| Nervousness | No | Yes |
| Depression | No | Yes |
| Sleeping Problems | No | Yes |
| Eating Disorder | No | Yes |

**Have you had any of the following surgeries?**

___Cataract Rt___Lt___
___Eye SX Rt___Lt___
___Ear SX Rt___Lt___
___Sinus Surgery
___Tonsils
___Breast Implants
___Breast Biopsy
___Lumpectomy Rt___Lt___
___Mastectomy Rt___Lt___
___Gallbladder
___Appendix
___Hysterectomy P___C___
___Ovaries Rt___ Lt___
___Tubes Tied
___Skin Cancers
___Fatty Tumors
___Kidney
___Vasectomy
___Bladder
___Prostate
___Hemorrhoids
___Spine/Back
___Bone_____
___Joint_____
___Heart
___Stomach
___Stomach Stapling
___Colon, Bowel
___Hernia
___Brain
___Pituitary Gland

OTHER_____

**Social History**

Do you smoke?_____ Have you ever smoked?_____
How many packs a day?_____ How long?_____
Use of beer, whiskey or wine:_____
Never_____ Rarely_____ Occasionally_____ Often_____
Retired?_____

Who referred you to our office?_____

Have you ever been treated for a psychiatric illness?_____ If yes, please explain:_____
Who is your family or primary care physician?_____

REVIEWED BY PHYSICIAN_____DATE:_____

**PATIENT NAME:**_____ **DOB:**_____

**Date:**_____

**CONSTITUTIONAL SYMPTOMS**

| | | |
|---|---|---|
| Recent Weight Change | No | Yes |
| Fever | No | Yes |
| Fatigue | No | Yes |
| Headaches | No | Yes |

**EYES**

| | | |
|---|---|---|
| Eye Disease or Injury | No | Yes |
| Blurred or Double Vision | No | Yes |
| Glaucoma | No | Yes |

**EARS/NOSE/MOUTH/THROAT**

| | | |
|---|---|---|
| Hearing Loss or Ringing | No | Yes |
| Mouth Sores | No | Yes |
| Sore Throat or Voice Changes | No | Yes |
| Swollen Glands in Neck | No | Yes |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| Heart Trouble | No | Yes |
| Chest Pain | No | Yes |
| Shortness of Breath | No | Yes |
| Swelling of Feet/Ankles/Hands | No | Yes |

**RESPIRATORY**

| | | |
|---|---|---|
| Chronic or Frequent Coughs | No | Yes |
| Spitting Up Blood | No | Yes |
| Asthma or Wheezing | No | Yes |

**GASTROINTESTIONAL**

| | | |
|---|---|---|
| Loss of Appetite | No | Yes |
| Change in Bowel Habits | No | Yes |
| Nausea/Vomiting | No | Yes |
| Frequent Diarrhea | No | Yes |
| Painful Bowel/Constipation | No | Yes |
| Rectal Bleeding/Blood in Stool | No | Yes |
| Abdominal Pain | No | Yes |
| Peptic Ulcer | No | Yes |

**GENITOURINARY**

| | | |
|---|---|---|
| Hernia/Umbilical/Inguinal | No | Yes |
| Kidney Stones | No | Yes |
| Burning/Painful Urination | No | Yes |
| Male-Testicle Pain | No | Yes |
| Female Pain | No | Yes |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Joint Stiffness/Swelling | No | Yes |
| Weakness of Muscle/Joint | No | Yes |
| Muscle Pain or Cramps | No | Yes |
| Back Pain | No | Yes |
| Coldness of Limbs | No | Yes |
| Difficulty in Walking | No | Yes |

**INTEGEMENTAY (SKIN/BREAST)**

| | | |
|---|---|---|
| Rash or Itching | No | Yes |
| Change in Skin Color | No | Yes |
| Change in Hair/Nails | No | Yes |
| Varicose Veins | No | Yes |
| Breast Pain | No | Yes |
| Breast Lump | No | Yes |
| Breast Discharge | No | Yes |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Frequent Headaches | No | Yes |
| Light Headed or Dizzy | No | Yes |
| Convulsions/Seizures | No | Yes |
| Numbness/Tingling | No | Yes |
| Tremors | No | Yes |
| Paralysis | No | Yes |
| Stroke | No | Yes |
| Head Injury | No | Yes |

**ENDOCRINE**

| | | |
|---|---|---|
| Hormone Problems | No | Yes |
| Thyroid Disease | No | Yes |
| Diabetes/Insulin | No | Yes |
| Excessive Thirst/Urine | No | Yes |
| Heat or Cold Intolerance | No | Yes |
| Skin Becoming Dry | No | Yes |

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Slow to Heal After Cuts | No | Yes |
| Bleeding/Bruise Easily | No | Yes |
| Anemia | No | Yes |
| Phlebitis | No | Yes |
| Enlarged Glands | No | Yes |

**REVIEWED BY PHYSICIAN**_____ **DATE:**_____