

EASTERN LONG ISLAND SURGERY, PC
Medhat E. Allam, M.D.
365 County Rd 39A, Ste 11
Southampton NY 11968

Office Use Only
HT _____
WT _____
BMI _____

Date _____ Last Name _____ First Name _____

Mailing address _____ City _____ St _____ Zip _____

Street Address (if different) _____ City _____ St _____ Zip _____

Tel # _____ Cell # _____ Date of Birth _____ Age _____

SS# _____ Sex: M or F Marital Status: S M W D Sep.

Employer Name _____ Tel # _____

Address _____ Occupation _____

Emergency Contact _____ Tel # _____ Relationship _____

Primary Ins Co _____ ID# _____ Copay \$ _____

Policy Holder Name _____ Date of Birth _____

SS# _____ Relationship to Patient Self Spouse Child Other _____

Secondary Ins Co _____ ID# _____ Copay \$ _____

Policy Holder Name _____ Date of Birth _____

SS# _____ Relationship to Patient Self Spouse Child Other _____

Primary Care Physician _____ Tel # _____

Address _____ City _____ St _____ Zip _____

Referring Physician _____ Tel # _____

Pharmacy: _____ **Telephone number:** _____

Reason for Your Visit Today?

Do YOU: Smoke? NO

IF YES- HOW MANY PER DAY _____ HOW MANY YEARS _____

DRINK? NO

IF YES- SOCIALLY OR EXCESSIVELY

Do YOU have: (circle) Sleep Apnea Arthritis/Joint Pain Deep Vein Thrombosis
Leg Edema Kidney Problems Chronic Back Pain Psychiatric Disorders
Asthma High Cholesterol Varicose Veins Bleeding Disorders
Heart Burn Difficulty Walking Diabetes Headaches
Heart Disease High Blood Pressure

Family History of: (circle) Diabetes Cancer Heart Disease High Blood Pressure

List any Drug Allergies: _____

Previous Surgeries (Type, Year, Hospital)

1. _____ 2. _____
3. _____ 4. _____

List current Medications you are taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

I authorize the release of any information needed to process my medical claims for benefits and to coordinate my care. I authorize payment of benefits to Dr. Allam for the services rendered. I acknowledge that all information provided above is accurate. I also understand that false information may increase my peri-operative risks.

Patient (or authorized) Signature _____ **Date** _____

