PRESTIGE MEDICAL GROUP

Patient Registration

Patient Information

Last Name:	First Name:	MI:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Email Address:	Sex: ☐ Male ☐ Female	
Marital Status: ☐ M ☐ S ☐ D ☐ W	Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled	
Preferred Language:	Race:	Ethnicity:
If employed, please complete the following information:		
Employer Name:	Employer Phone:	
Employer Address:		
City:	State:	ZIP Code:

Spouse or Insured Parent Information

Last Name:	First Name:	MI:
Current address:		
City:	State:	Zip Code:
Primary Phone:	Date of Birth:	SSN:
Sex: ☐ Male ☐ Female		
If employed, please complete the following information:		
Employer Name:	Employer Phone:	
Employer Address:		
City:	State:	ZIP Code:

Primary Care Physician

Name:			
Address:			
City:	State:	ZIP Code:	Referral Phone:

Primary Insurance

Name:			
Address:			
City:	State:	ZIP Code:	Primary Phone:
Insured's Name:	ID#:	Group#	

Secondary Insurance

Name:			
Address:			
City:	State:	ZIP Code:	Primary Phone:
Insured's Name:	ID#:	Group#:	

Emergency Contact – Not at Same Address

Name:	Relationship:		
Address:			
City:	State:	Zip:	Primary Phone:

Preferred Pharmacy

Name:	Address:		
City:	State:	ZIP Code:	Pharmacy Phone:

I hereby authorize and request my insurance company to pay any and all medical benefits directly to: Lamia Gabal, M.D. I understand that I am financially responsible for any charges not paid by my insurance carrier, and hereby authorize Dr. Gabal's office to release any information necessary to process my claim.

Patient's/Authorized Person's Signature:	Date:

PRESTIGE MEDICAL GROUP

Patient History

Name *(Last, First, M.I.):*	**Date:**
How did you hear about us: ☐ **Referring Physicians** ☐ **Friend** ☐ **Insurance Company** ☐ **Facebook** ☐ **Google** ☐ **Yelp** ☐ **WebMD** ☐ **Healthgrades**	
Why are you seeing the doctor today?	

REVIEW OF SYSTEMS

Please CHECK if you have or have had any of the following diseases or conditions:

Constitutional	*Throat/Neck*	☐ Diarrhea	☐ Tremors	☐ Retention
☐ Chills	☐ Frequent Sore Throats	☐ Hepatitis	☐ Headaches	☐ Stones
☐ Fever	☐ Lumps	☐ Rectal Bleeding	☐ Numbness	☐ Bed-Wetting
☐ Weakness	**Respiratory**	**Musculoskeletal**	☐ Strokes	☐ Difficulty Starting Stream
☐ Easy Bruising	☐ Asthma	☐ Arthritis	☐ Unsteady Gait	☐ Flank Pain
☐ Insomnia	☐ Coughing Blood	☐ Joint Pain	**Endocrine**	☐ Incontinence
☐ Weight Gain	☐ Short of Breath	☐ Back Problems	☐ Cold Intolerance	☐ Kidney Stones
☐ Fatigue	☐ Bronchitis	☐ Muscle Cramps	☐ Fatigue	☐ Sexual Arousal Disorder
☐ Sleep Apnea	☐ Emphysema	☐ Gout	☐ Sweats	☐ Urgency
☐ Weight Loss	☐ Tuberculosis	☐ Weakness	☐ Diabetes	*Male Genitalia*
Head	☐ Cough	**Psychiatric**	☐ Heat Intolerance	☐ Discharge
☐ Fainting	☐ Pneumonia	☐ Anxiety	☐ Thyroid Trouble	☐ Impotence
☐ Headaches	☐ Wheezing	☐ Nervousness	☐ Excessive Urination	☐ Painful Ejaculation
Eyes	**Cardiovascular**	☐ Depression	☐ Increased Thirst	☐ Scrotal Masses
☐ Blurry Vision	☐ Chest Pain	☐ Psychiatric Disorders	☐ Weight Gain	☐ Fertility Problems
☐ Glaucoma	☐ High Blood Pressure	☐ Generally Satisfied	**Hematologic/Lymph**	☐ Lesions
☐ Vision Loss	☐ Mitral Valve Prolapse	**Breasts**	☐ Anemia	☐ Peyronies Disease
☐ Cataracts	☐ Swelling of Legs	☐ Discharge	☐ HIV	☐ Sexual Problems
☐ Infections	☐ Heart Failure	☐ Self-Examination	☐ Bleeding Easily	☐ Hernias
☐ Eyeglass Use	☐ History of Heart Attack	☐ Lumps	☐ Swollen Glands	☐ Pain
☐ Redness	☐ Palpitations	☐ Tenderness	☐ Blood Clotting Problems	☐ Prostate Problems
ENT	☐ Thrombophlebitis	☐ Pain	**Allergic/Immunologic**	☐ STD
Nose	☐ Heart Murmur	**Skin**	☐ Drug Allergies	*Female Genitalia*
☐ Frequent Colds	☐ Irregular Heart Beat	☐ Eczema	☐ Hives	☐ Bladder Prolapse
☐ Nose Bleeds	☐ Shortness of Breath	☐ Mole Increased Size	☐ Environmental Allergies	☐ Menopause
☐ Hay Fever	☐ Varicose Veins	☐ Hives	☐ Wheezing	☐ Recurrent Urinary Tract Infections
☐ Sinus Infections	**Gastrointestinal**	☐ Persistent Itching	☐ Food Allergies	☐ Bleeding Between Periods
☐ Nasal Obstruction	☐ Abdominal Pain	☐ Lumps	**Genitourinary**	☐ Pain on Intercourse
Mouth	☐ Constipation	☐ Rashes	*Urinary*	☐ Sexual Problems
☐ Bleeding Gums	☐ Gallbladder Disease	**Neurological**	☐ Awakening to Urinate	☐ Lesions
☐ Voice Changes	☐ Jaundice	☐ Burning	☐ Blood in Urine	☐ Recent Pregnancy
☐ Change in Dentition	☐ Vomiting	☐ Loss of Consciousness	☐ Dribbling	☐ Venereal Disease
☐ Hoarseness	☐ Acid Reflux	☐ Paralysis	☐ Frequency	
Ears	☐ Decreased Appetite	☐ Tingling	☐ Infections	
☐ Hearing Impairment	☐ Hemorrhoids	☐ Dizziness	☐ Pain on Urination	
☐ Infections	☐ Nausea	☐ Memory Loss	☐ Hesitancy	
☐ Ringing in Ears	☐ Black Tarry Stools	☐ Speech Disorders	☐ Kidney Failure	

FAMILY HISTORY

Please CHECK and indicate which family member has/had any of the following (Father, Mother, Son, Daughter, Sister, Brother, Maternal Grandmother, Paternal Grandfather, Maternal Aunt, Paternal Aunt, Maternal Uncle, Paternal Uncle, First Degree Relative):

Condition / Disease	Family Member(s)
☐ Thyroid Dysfunction	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Breast Cancer	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Diabetes	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ MI	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Arthritis	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ CAD	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ HIV	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Prostate Cancer	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ BPH	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Cancer	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Hypertension	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Renal Stone	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Bladder Cancer	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Cholesterol High	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)
☐ Kidney Cancer	_____ (☐ Alive / ☐ Deceased), _____ (☐ Alive / ☐ Deceased)

MEDICAL HISTORY

Please CHECK if you have or have had any of the following diseases or conditions:

☐ Lower Urinary Tract Infections	☐ Prostate Cancer	☐ Migraine	☐ Kidney Stone	☐ Hepatitis
☐ Arthritis	☐ Hx of Non-Hodgkin's Lymphoma	☐ Retention	☐ Mixed Incontinence	☐ Low Testosterone
☐ Bladder Cancer	☐ Asthma	☐ Allergy to any Drugs	☐ Stroke	☐ Overactive Bladder
☐ Cancer	☐ Blood in Urine	☐ BPH	☐ Anemia	☐ TB
☐ Coronary Artery Disease	☐ Cholesterol High	☐ Breast Cancer	☐ Back Problem	
☐ Glaucoma	☐ Depression	☐ Chronic Kidney Disease	☐ COPD	
☐ Hypertension	☐ Gout	☐ Diabetes	☐ Congestive Heart Failure	
☐ MI	☐ Kidney Cancer	☐ HIV	☐ Erectile Dysfunction	

SOCIAL HISTORY

Please provide the following information:

Tobacco

Cigarettes	☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Former Smoker	☐ Never Smoked
	If Smoker: ☐ Heavy Tobacco Smoker (Greater than 10 daily)	☐ Light Tobacco Smoker (less than 10 daily)		
Cigars	☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Former Smoker	☐ Never Smoked
	If Smoker: ☐ Heavy Tobacco Smoker (Greater than 10 daily)	☐ Light Tobacco Smoker (less than 10 daily)		
Pipe	☐ Current Every Day Smoker	☐ Current Some Day Smoker	☐ Former Smoker	☐ Never Smoked
	If Smoker: ☐ Heavy Tobacco Smoker (Greater than 10 daily)	☐ Light Tobacco Smoker (less than 10 daily)		
Chewing Tobacco	☐ Current Every Day User	☐ Current Some Day User	☐ Former User	☐ Never Used
	If Smoker: ☐ Heavy Tobacco User (Greater than 10 daily)	☐ Light Tobacco User (less than 10 daily)		
Dipping Tobacco	☐ Current Every Day User	☐ Current Some Day User	☐ Former User	☐ Never Used
	If Smoker: ☐ Heavy Tobacco User (Greater than 10 daily)	☐ Light Tobacco User (less than 10 daily)		

Alcohol Consumption

Beer	☐ Social	☐ Occasional	☐ Light	☐ Heavy
Wine	☐ Social	☐ Occasional	☐ Light	☐ Heavy
Hard Liquor	☐ Social	☐ Occasional	☐ Light	☐ Heavy

Name *(Last, First, M.I.):*	**Date:**

SURGICAL HISTORY				
Please CHECK if you have had any of the following surgeries and date of surgery:				
Common Surgeries	☐ Prostatectomy Retro	☐ Prior Surgery	☐ TURBT – Resection of Bladder Tumor	☐ Major Orthopedic Surgery
☐ Torsion of Spermatic Cord	☐ Total Nephrectomy	☐ Spermatocele Repair	☐ Urinary Stone	☐ Rotator Cuff Repair
☐ Ablation for Atrial Fibrillation	☐ TURBT	☐ Vasectomy	☐ Bladder Excision Total	☐ Spinal Surgery
☐ CABG	☐ Appendectomy	**Other Surgeries**	☐ Hydrocelectomy	*OB/GYN*
☐ Colectomy	☐ Carotid Endarterectomy	*Circulatory*	☐ Prostatectomy Retropubic	☐ Hysterectomy Benign Disease
☐ Fracture	☐ Defibrillator Pacemaker	☐ Major Vascular Surgery	☐ Ureter Stent	☐ Oophorectomy R
☐ Hysterectomy	☐ Hernia Abdominal	☐ Mitral Valve Repair	☐ Calculus Kidney	☐ Hysterectomy Total
☐ Prostate Biopsy	☐ Pacemaker	*Digestive*	☐ Kidney Donation	☐ Oophorectomy L
☐ TURP	☐ Sling for Stress Incontinence	☐ Hernia Inguinal	☐ Renal Transplant	☐ Normal Delivery
☐ Cholecystectomy	☐ Tubal Ligation	☐ Resection Colon Partial	☐ Ureteric Calculus Laser TX	☐ Sterilization-Female
☐ Aortic Aneurysm	☐ AAA Repair	☐ Hernia Umbilical	☐ Circumcision	☐ Oophorectomy BL
☐ Cardiac Stent	☐ Breast Augmen	☐ Major Abdominal Surgery	☐ Nephrectomy Partial	*Other*
☐ Cystoscopy	☐ Cesarean Section	*Genitourinary*	☐ Stress Incontinence	☐ Laparoscopy
☐ Heart Valve	☐ ESWL	☐ Urinary Bladder Stone	☐ Urethral Stricture	
☐ Insertion of Penile Prosthesis	☐ Hip Surgery	☐ Genital Prolapse	*Musculoskeletal*	
☐ Basal Cell Carcinoma	☐ Tonsillectomy	☐ Orchidopexy	☐ Artificial Joint	

Current Medications – Please list ALL medications you are currently taking including over the counter meds (attach list if necessary)		
Drug Name:	Strength:	Directions/How you take it:
Allergies – Please list ALL types (Drug, seasonal, pets, environmental, foods)		

Name *(Last, First, M.I.):*	**Date:**

Prestige Medical Group
720 N Tustin Avenue Suite #104 Santa Ana, CA
92705 P: 949-825-7650 Fax: 949-825-7648

Financial and Office Policies

	Please initial next to each section to acknowledge:
	All co-pays, co-insurance, deductibles and cash payments are due at check-in on the day services are rendered. Should you have any remaining balance on your account, you will receive a billing statement in the mail due immediately upon receipt.
	For your convenience we accept cash, check, money order, Mastercard, Visa, Discover, American Express and Care Credit.
	A fee of $50.00 will be charged to your account for any returned check.
	"No Show for New Patient Appointment" – failure to keep a scheduled appointment fee. $100.00
	"No Show for Est pt OV" – Failure to keep a scheduled office visit appointment fee. $50.00
	"Cancellation"- Appointment Cancellation with less than 24 hours' notice fee. $50.00
	"Procedure Cancellation/Procedure No Show" – Procedure cancelled with less than 24 hours' notice fee. $100.00
	Surgery Deposits must be paid prior to your scheduled surgery day, usually at the time of your pre-operative appointment
	Dr. Gabal requires a 5 BUSINESS day notice for canceling surgical cases. If you do not cancel your surgery 5 business days in advance, you will be charged $200.00.
	Completion of disability forms, FMLA, Social Security or insurance forms will be assessed at $40.00 fee per form to cover the administrative overhead involved in completing these forms. This fee is not covered by insurance.
	Prior Authorizations for medications that are not covered by your insurance company- $30.00. We will notify you in advance if we believe your insurance company won't cover your medication. If you wish for us to appeal the decision, the fee will cover the manpower required to attempt the appeal. **THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL APPROVE ANY APPEAL.**
	Peer to Peer Review- $100.00. If your insurance company denies a procedure, test or medication and requests a peer to peer review, this fee will cover the time required for Dr. Gabal to go through this process**. THERE IS NO GUARANTEE THAT YOUR INSURANCE COMPANY WILL GRANT APPROVAL.**
	Charges for copies of medical records –Forty cents per page plus postage per California law. This is to cover the manpower and supply costs of copying and mailing these records. You may access and print your records free of charge from the patient portal.
	Delinquent accounts will be turned over to a collection agency if balances due are not received within 90 days. If your account is turned over to a collection agency, you will be responsible for all collection and legal fees (small claims court).

We appreciate your trust in us and the opportunity to serve your healthcare needs.

Patient's Signature_____ Date_____

Prestige Medical Group

CREDIT CARD AUTHORIZATION / POLICY

We ask that you provide an updated credit card number to have on file upon scheduling your next appointment. Rest assured that all cards on file are added to the system via a secure electronic process that ensures the information is encrypted and remains protected. By signing below, the patient is authorizing Lamia Gabal, MD Inc., to charge the cardholder for no-show fees, unpaid medical services pursuant to the above policies. The no-show fees will be charged to the credit card on the date of the appointment.

Effective Date: April 5th, 2022

Credit Card Information Credit Card Type:

☐ **MasterCard** ☐ **Visa** ☐ **American Express** ☐ **Discover Card**

Number: _____ Expiration Month: _____

CVV: _____ Expiration Year: _____

Cardholder Signature: _____

Date ____/____/____

_____
Patient's Name (PRINTED)

_____
Signature

_____
Date

Prestige Medical Group
720 N, Rustin Avenue Suite #104 Santa Ana, CA 92705
949-825-7650 Fax: 949-825-7648

RESPONSIBILITY FORM

PLEASE INITIAL BESIDES EACH SECTION TO ACKNOWLEDGE

_____ 1. I acknowledge that my physician is my partner in health. As an adult, it is my responsibility to keep track of my medical conditions, medications, and all other physicians that are involved in my medical care. It is my responsibility to inform every physician or other health care provider that I encounter about any changes in my medications, medication dosages, any medical conditions or any evaluations in progress

_____ 2. I acknowledge that to help protect me from identity theft – this medical office participates in the federal regulation program titled the "Red Flags Rule." As a result, I acknowledge that I will be REQUIRED to present my photo ID and ALL insurance cards at EVERY office visit. Copies of these will be part of my medical record.

_____ 3. I acknowledge that if I fail to keep an advised follow-up appointment to go over test results, monitor treatment, or evaluate symptoms, then I am responsible if this results in harm to myself, delay in diagnosis, or failure to treat or cure.

_____ 4. I acknowledge that I am responsible for scheduling my own appointments. As a courtesy – the physician's office will attempt to contact me one or two days prior to remind me of the appointment, however I may not receive this message for various reasons.

_____ 5. I acknowledge the importance of making sure the physician's office has my current address and all phone number contacts. If my information on file is not current, then I acknowledge that my physician's office will not be able to notify me about abnormal test results, medication recalls, changes in appointment or surgery scheduling, etc.

_____ 6. I acknowledge that I am responsible to know the insurance benefits provided by my insurance carrier(s). Any questions I have regarding my insurance benefits will be directed to my Insurance carrier or Human Resources department by my guarantor or myself.

Name Signature Date

PRESTIGE MEDICAL GROUP

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Patient Signature / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship_____ Phone_____

Name: _____ Relationship: _____ Phone_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation Phone_____
☐ Work Phone Confirmation ☐ **Any of the Above** Cell Phone_____

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation
☐ Email Confirmation ☐ Work Phone Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ Clinical Research ☐ **Opt Out**
☐ Email ☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

PRESTIGE MEDICAL GROUP

Possible or Probable Denial of Coverage of Treatment of Diagnostic Test

Some insurance carriers or providers will only pay for tests and services that are covered under the terms of your contract. Each contract is different. Many insurance companies will not pay for certain tests that are excluded by your contract. **Insurance companies may deny payment for the following tests:**

- Urine Culture and Sensitivity
- Urine Analysis Complete
- Free and Total Testosterone
- Semen Analysis
- PSA
- PCA3
- Urine Cytology
- Prostate Biopsy
- Stone Analysis
- STD Tests/Culture
- Penile Doppler
- PTNS

Patient Agreement:

My physician has notified me that my insurance carrier may deny payment for the tests and services identified above. **If my insurance carrier denies payment, I agree to be personally and fully responsible for the payment of these services.**

Patient Signature: _____Date:_____

Printed Name: _____

PRESTIGE MEDICAL GROUP

RECORDS RELEASE FORM

From:

Address_____

I Hereby authorize and request the
Release of copies of the following information:

☐ Complete ☐ Medical Records ☐ X-Rays

☐ Laboratory Records ☐ Procedure Reports ☐ Other Records_____

INCLUDING CURRENT AND PREVIOUS MEDICAL RECORDS FROM OTHER PRACTICES AND PRACTICIONERS, HOSPITALS, AND/OR CLINIC WHICH ARE A PART OF MY MEDICAL RECORDS.

To: Lamia L. Gabal, MD or Vera Trofimenko, MD
720 N. Tustin Ave., Ste 104, Santa Ana, CA 92705

Phone: 949-825-7650 Fax: 877-473-1042

This information has been released to you specifically with the consent of the patient of his/her authorized representative. It is strictly confidential, and no further release or use of the information is authorized without the consent of the patient or authorized representative. I hereby release the facility from any Liability which may arise as a result of the use of the information contained in the records released.

Patient Name:_____ Date of Birth_____

Social Security#:_____ Phone #:_____

Signature:_____Date:_____

☐ Signature Disclosure ☐ Continuing disclosure for 90 days ☐ Expiration Date_____

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