PATIENT REGISTRATION

Raad Taki, M.D.
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Tucson, AZ 85712
(520)881-3232

☐ **Please Provide Photo ID**

Patient's Last Name | First Name | Middle

Preferred Gender Pronouns (Optional) | Date of birth | Email Address

Address - Street, Apt # | City / State | Zip Code

Primary Phone Number | Mobile Phone Number | Work Phone Number

Employed By | Occupation | Employer's Address

Emergency Contact Name | Relationship to Patient | Phone Number for Emergency

Reason for Consultation:

Referred By:

Health Information:

Height_____ Present Weight _____ Marital Status: ☐ Married ☐ Single

Substance Use: Please disclose current or past substance abuse to the anesthesiologist prior to any procedure

Do you use Tobacco? ☐ Yes ☐ No If yes, how much and how often?_____

Do you use Marijuana? ☐ Yes ☐ No If yes, how much and how often?_____

Do you Vape? ☐ Yes ☐ No If yes, how much and how often?_____

Are you allergic to any medications? ☐ Yes ☐ No

Name of medication and type of reaction:_____

LATEX ALLERGY? ☐ Yes ☐ No Seasonal allergies? ☐ Yes ☐ No

Are you allergic to any foods or other substances? ☐ Yes ☐ No _____

Please list all medications and supplements you are now taking [including birth control pills, diuretics (water pills), blood pressure medication or ASPIRIN, IBUPROFEN(ADVIL), NAPROXEN (ALEVE)] Please Include Implanted devices here (IUD, Pacemaker).

_____

_____

PATIENT REGISTRATION

PREVIOUS SURGERY (please list)

Operation	Year	Complications, if any

Have you ever had a REACTION to a GENERAL anesthetic? (Being put to sleep) ☐ Yes ☐ No

Have you ever had a REACTION to a LOCAL anesthetic? (Ex: Novocaine, etc.) ☐ Yes ☐ No

SPECIFIC MEDICAL HISTORY:

Have you ever had a problem with your heart? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

Do you have fast or irregular heartbeats? ☐ Yes ☐ No

Do you have dizziness or fainting spells? ☐ Yes ☐ No

Have you ever had a problem with your lungs? ☐ Yes ☐ No

Asthma / Emphysema? ☐ Yes ☐ No

Sleep Apnea? ☐ Yes ☐ No

CPAP Machine? ☐ Yes ☐ No

Do you have stomach acid problems like Reflux (GERD/Heartburn)? ☐ Yes ☐ No

Do you take reflux medicine or use antacids (Please list above) ☐ Yes ☐ No

Have you ever had any excessive bleeding problems? ☐ Yes ☐ No

Have you ever been diagnosed with or treated for blood clots? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No

Have you ever had psychiatric care? ☐ Yes ☐ No

Have you ever had a stroke, paralysis, vision loss, meningitis, or polio? ☐ Yes ☐ No

Do you form heavy scars? ☐ Yes ☐ No

Do you have a personal or family history of breast cancer? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Could you be pregnant now? ☐ Yes ☐ No

How many children do you have? _____

Do you have an advance directive / a living will? ☐ Yes ☐ No

Do you have any other medical condition you have been treated for in the past? ☐ Yes ☐ No _____

_____

THE ABOVE MEDICAL HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature: _____ Date:_____/_____/_____

Acknowledgement of Receipt of Privacy Health Information Practices

I have been presented with a copy of RAAD M. TAKI, M.D., P.C. **Notice of Privacy Health Information Practices** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medication information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

SIGNED: _____ **DATE:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnessed by:** _____

_____

Internal Use Only:
If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time it was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____