ABIDEEN O. YEKINNI, M.D.
PATIENT REGISTRATION
(Complete All Information)

PATIENT INFORMATION ***Date Completed***

Patient's Last Name:	Social Security No.:
First Name and Middle Initial:	Occupation:
Address:	Employer:
City: State: Zip Code:	Work Phone:
Home Phone:	Date of Birth: Age: Sex: M F
Cell Phone:	E-Mail Address:
Family Doctor:	
Address: City/State/Zip Code: Phone Number:	Ethnicity: (Circle the appropriate one) Alaska Native, American Indian, Asian, African American/Black, Hispanic, Latino, Native Hawaiian, Other Pacific Islander, White/Caucasian, Other

RESPONSIBLE PARTY, IF OTHER THAN PATIENT (For minors, complete for parent or legal guardian)

Name:	Alternate Phone:
Address:	Social Security No.:
City: State: Zip Code:	Employer:
Home Phone:	Relationship to Patient:

NEAREST RELATIVE NOT LIVING WITH PATIENT:

Name:	Phone No.: Relationship:
Address:	City/State/Zip Code:

PRIMARY INSURANCE: ***SECONDARY INSURANCE:***

Insurance Co. Name:	Insurance Co. Name:
Policy No.	Policy No.
Group No.	Group No.

AUTHORIZATION AND ASSIGNMENT:

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid or any other insurance company with my/my dependent's care is covered any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance Company benefits be made on my behalf directly to Abideen O. Yekinni, M.D. for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, non-covered services, and services obtained without prior authorization from my insurance when required. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees. I authorize my physician to provide and perform medical/surgical care, tests, procedures, drugs and other services considered necessary or beneficial for my health and well being. I acknowledge that no guarantees have been made to me as to the results or cures due to treatments performed by my physician. A fee of $25 will be accessed and charged to me if I fail to keep a scheduled appointment without a 24 hour notice or cancellation or reschedule.

Patient/Legal Representative

*Signature:*_____ *Date:*_____

Abideen O. Yekinni, M.D.
Patient Medical Information
(Complete all information)

PATIENT'S NAME_____
DATE:_____

CURRENT MEDICAL HISTORY/CONDITIONS
(CHECK EACH ONE THAT APPLIES)

☐ AIDS	☐ Dementia/Alzheimer	☐ Insulin Pump	☐ Shortness of Breath
☐ Alcoholism	☐ Depression	☐ Kidney disease	☐ Sinus Congestion
☐ Acid Reflux	☐ Diabetes	☐ Liver disease	☐ Sinus Infections Chronic
☐ Anemia	☐ Difficulty Swallowing	☐ Metal in Body	☐ Sleep Apnea
☐ Anxiety	☐ Ear Infections	☐ MRSA	☐ Stroke
☐ Arthritis	☐ Ear Pressure	☐ Migraines	☐ Thyroid Disorder
☐ Asthma	☐ Gout	☐ Noise in ears	☐ Tonsillitis
☐ A trial Fib/Flutter	☐ Headaches	☐ Nose Bleeds	☐ Tuberculosis
☐ Autism	☐ Heart Arrhythmia	☐ Osteoporosis	☐ Weight Loss
☐ Bleeding Disorders	☐ Heart Failure	☐ Pace Maker	☐ Weight Gain
☐ Balance/Dizziness	☐ Hearing Loss	☐ Pneumonia	☐ Wheezing
☐ Cancer (Type_____)	☐ Hepatitis (A B C)	☐ Popping/Cracking in Ear	
☐ COPD	☐ High/Low Cholesterol	☐ Psychiatric Disorder	
☐ Coronary Artery Disease	☐ Hypertension	☐ Pulmonary Embolism	
☐ Cough	☐ Insomnia	☐ Rheumatic Fever	
	☐ Irregular Heart Beat	☐ Seizure Disorder	

Any Hospitalizations/Surgeries	**Year**	**DRUG ALLERGIES (IF YES, LIST)**
_____	_____	_____
_____	_____	_____
_____	_____	
_____	_____	

MEDICATIONS
(List all medications)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Caffeine Use	Yes	No	Number of drinks per day_____
Alcohol Use	Yes	No	Number of drinks per week_____
Tobacco Use	Yes	No	Number of years_____ Number of packs per day_____
Illicit Drug use	Yes	No	
Exercise	Yes	No	Number of times per week_____
Special Diet	Yes	No	Type_____
Marital Status	_____		
Height	_____		
Weight	_____		