Name:______________________________ SS#______________

Street Address:______________________ Date of Birth:________ Marital Status: **S M W Sep D**

City:______________________________ State:__________ Zip:__________

Telephone: Home:____________________ Office:____________________

Referred by:____

Spouse's name:____

Spouse's employer / address:______________________________

Emergency contact:____________________ Tel#:__________ Relationship:__________

PATIENT EMPLOYER INFORMATION

Employer name:______________________________ Tel#:______________

Employer street address:__________________ City / State______________ Zip________

Patient Occupation:______________________________________

INSURED PERSON (If not Patient)

Name:______________________________ Tel#:______________

Street address:______________________ City / State______________ Zip________

Relationship to Patient:__________________________________

INSURANCE

Medicaid # (if applicable):__________________ Medicare # (if applicable):______________

Primary Insurance Company Name:__________________________

IID #__________________ Group #______________ Tel#______________

Secondary Insurance Company Name:________________________

IID #__________________ Group #______________ Tel#______________

Street address:______________________ City / State______________ Zip________

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date:__________________ Signature______________________________

I authorize Dr. Saied Jamshidi to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Saied Jamshidi (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my company at any time in writing.

Date:__________________ Signature______________________________

(Patient, parent, or guardian)

Name:______________________ SS#______________

GENERAL MEDICAL INFORMATION

Describe the current medical problem / reason for today's visit:______________________

____

Present medications:______________________

Allergies to medications:______________________

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent:______________________

Other physicians currently treating you:______________________

Previous or other medical problems:______________________

List all previous surgeries or hospitalizations (include number of miscarriages and live births):______________________

____

Do you smoke? ☐ No ☐ Yes ☐ Cigarettes ☐ Pipe ☐ Cigars No. of years_________ How much per day?____________

Interested in stopping Yes ☐ No ☐

Do you regularly drink alcohol? Yes ☐ No ☐ How many ounces/beers per day?______________________

Do you regularly drink coffee? Yes ☐ No ☐ How many cups per day?______________________

Are you under a lot of pressure at work? Yes ☐ No ☐ Please describe:______________________

PERSONAL MEDICAL INFORMATION

☐ Chest pain/pressure/tightening______	☐ Asthma______	☐ Kidney disease______
☐ Hypertension______	☐ Dizzy spells______	☐ Shortness of breath______
☐ Heart attack______	☐ Cancer______	☐ TB/Lung disorder______
☐ Stroke______	☐ Diabetes______	☐ Ulcers______
☐ Headaches______	☐ Arthritis______	☐ Skin disorders______
☐ Glaucoma______	☐ Difficulty hearing______	☐ Hepatitis______
☐ Allergies or Eczema______	☐ Cataracts______	☐ Depression______
☐ Memory loss______	☐ Digestive problems______	☐ Blood in stool______
☐ Hemorrhoids______	☐ Urinary infections______	☐ Others______

IMMUNIZATIONS

(Year last received, if known)

Smallpox______________________

Tetanus______________________

Typhoid______________________

Polio______________________

IInfluenza______________________

Pneumonia______________________

Rubella______________________

Hepatitis______________________

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐
Heart Attack / Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐	☐	☐