PATIENT INFORMATION

NAME____
FIRST MI LAST

ADDRESS________________________APT#________CITY, ST, ZIP___________________________

DATE OF BIRTH _____/_____/_____SS#______________________________ MALE______FEMALE_____

PHONE NUMBER (_____)____________________WORK NUMBER (_____)_________________________

CELL PHONE #(____)_____________FAX # (____)____________E-MAIL

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT____

RELATIONSHIP TO PATIENT__________________________PHONE NUMBER( )____________________

PRIMARY INSURANCE INFORMATION

INSURED'S NAME____DATE OF BIRTH_________________

SS#_________________________________EMPLOYER_______________________________________

INSURANCE CO NAME_________________________________PHONE #___________________________

ID#_______________________________________ GROUP #___________________________

OFFICE VISIT COPAY $___________________________DEDUCTIBLE $_________________________

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE CO NAME_________________________________PHONE#____________________________

ID#_______________________________________ GROUP #___________________________

REFERRED BY:____

EMERGENCY CONTACT NAME:______________________RELATIONSHIP__________PHONE#__________

ASSIGNMENT OF BENEFITS

I hereby authorize Sid Danesh, MD to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to Sid Danesh, MD all payments for medical services rendered and all major medical benefits. I authorize Sid Danesh, MD to inquire and receive any information pertaining to my insurance company as a courtesy to me.

PATIENT/GUARDIAN SIGNATURE_________________________________DATE___________________

Patient History

DATE______________________________

PATIENT NAME____
FIRST MIDDLE LAST

OCCUPATION____

SOCIAL HISTORY: DO YOU SMOKE? YES OR NO DO YOU DRINK? YES OR NO

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE:

DIABETES	______	AIDS	______
HIGH BLOOD PRESSURE	______	PREGNANT	______
BLEEDING DISORDER	______	HEART CONDITIONS	______
HEART MURMUR	______	HAYFEVER	______
HEPATITIS	______	VARICOSE VEINS	______
PEPTIC ULCERS	______	ANEMIA	______
HIVES	______	ECZEMA	______
PSORIASIS	______	KELOIDS	______
PACEMAKER	______	CANCER (_______)	______

ANY OTHER CONDITION NOT SPECIFIED________________________________

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE ABOVE CONDITIONS? YES/NO

IF SO, WHAT MEMBER AND WHICH CONDITION?________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES OR NO

IF SO, WHICH ONES?____

LIST ALL CURRENT MEDICATIONS YOU ARE TAKING?__________________
____
____
____

OFFICE STAFF INITIALS: ____________

SID DANESH, M.D.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, the office of Sid Danesh, MD (office) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Sid Danesh's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office's Privacy Officer at 316 E. Las Tunas Dr. Suite 103, San Gabriel, CA 91776.

With my consent, the office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, the office may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as they are marked Personal and Confidential.

With my consent, the office may fax or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting the office's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don't sign this consent, Sid Danesh, MD may decline to provide treatment to me.

I have read the Notice of Privacy Practices prior to signing this consent

____
Signature of Patient or Legal Guardian

________________________________ ______________________
Patient's Name **Date**

____
Print Name of Patient or Legal Guardian