

MEDICAL HISTORY

Today's Date ___/___/___

Patient Name: _____

Reason for today's visit: _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>		YES	NO
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
			Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion/ Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO
 Has anyone in your family had skin cancer? YES NO
 Do you have a history of any specific skin diseases? YES NO
 Do you have problems with healing? YES NO
 Do you develop keloids (scars) after surgery? YES NO
 Do you bleed easily? YES NO
 Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
Other _____

Social History:
 Do you drink alcohol? YES NO If YES _____ drinks per day / _____ per week
 Do you use IV drugs? YES NO If YES, what? _____ How often? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO

(Women) Are you pregnant? YES NO Due Date: ___/___/___

Hobbies? _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ___/___/___

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. **In the event that your account must be turned over to collections, you will at that time be considered a cash patient for the duration of your patient/doctor relationship – payment in full will be due at the time each service is rendered.** Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ___/___/___

Completed by: Patient Signed by Patient _____ Date ___/___/___

Medical Assistant Doctors Signature: _____ Date: ___/___/___

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date of Birth: ____/____/____
(Please Print LAST, FIRST)

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. Patients are responsible for meeting their annual \$110.00 deductible and paying for the 20% co-payment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed. If you have Medi-cal or a HMO as a secondary, the balance after Medicare pays is your responsibility.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you that you will be a cash patient.

PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered, cosmetic services.

MEDI-CAL & HMO's: Dr. Said will not accept any kind of an HMO or Medi-cal insurance as a primary or secondary plan. You will be considered a cash patient and the entire balance is due at the time of service or after your primary insurance has paid.

Commercial Patients: Patients who are covered by private, commercial plans in which the physician they are seeing is not a provider will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ Date ____/____/____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ Date ____/____/____

Patient Name: _____ Date of Birth: ____/____/____
(Please Print LAST, FIRST)

AUTHORIZATION TO LEAVE MESSAGES

I give my permission for the staff of Dr. Said's office to leave messages on my telephone answering machine regarding my health care, test results, or my appointments.

Patient or Guardian Signature: _____ Date: ____/____/____

CONSENT TO MEDICAL CARE & TREATMENT OF MINOR CHILDREN

I, _____, the natural parent/legal guardian
(LAST, FIRST NAME)

of _____
(PATIENT'S NAME LAST, FIRST) (PATIENT'S DATE OF BIRTH)

authorize and consent to medical and surgical care, treatment and procedures to be performed for my child by a licensed physician/provider. In the sole discretion of the attending physician/provider, such care, treatment and procedures are necessary or advisable in the interest of my child's health and well-being. This consent is valid until I have notified Dr. Said's office that this policy has been revoked.

SIGNATURE OF PARENT/GUARDIAN DATE

PATIENTS RESPONSIBILITY FOR CALLING RE. LABORATORY RESULTS

Dr. Said feels it is very important that you receive all laboratory results including blood work, cultures and pathology results. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedures for notification of our patients may not take place. We therefore ask our patients to share in the responsibility of obtaining their laboratory results by calling for results if not notified after a reasonable time period, i.e., three to four weeks for biopsy results, seven days for culture results and two weeks for routine blood work. Your physician or nurse will let you know during your visit what test will be done so you are aware of what results are pending. Your health care is our number one priority. Thank you for partnering with us in your care.

PLEASE NOTE: If a biopsy is done today a separate bill from the pathologist office will be sent to you.

Sincerely,

Samireh Z. Said, M.D.

I will take responsibility for calling for my laboratory results if not notified in a reasonable amount of time

Patient or Guardian Signature: _____ Date: ____/____/____
Samireh Z. Said, M.D., Inc.

AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFO.

By signing this authorization, I authorize Dr. Said's office to use and/or disclose certain protected health information (PHI) about me to ____ . This authorization permits Dr. Said's office to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

_____ If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____ .

Patient Signature: _____ Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____
(Please Print LAST, FIRST)

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Samireh Z. Said, M.D., Inc.

Patient Name: _____ Date of Birth: ____/____/____
(Please Print LAST, FIRST)

PAYMENT POLICY

This policy is perfectly compatible with all the insurance contracts, as no usual payments are asked for at the time of the visit.

When the explanation of benefits comes in from your insurance(s) we will then bill you for the balance deemed owed by you the patient. If no payment is received on your account after 60 days, we will then apply your balance to your credit card. This will avoid any collection actions or fees to apply to your account.

This information will be in a secure location and will not be in your chart. Our office will only use this information for collection purposes.

We appreciate your understanding and cooperation.

Sincerely,

Samireh Z. Said, M.D.

MASTERCARD

VISA

Credit Card Number: _____ - _____ - _____ - _____ Exp. Date: ____/____/____

Name as it appears on the credit card: __

Signature: _____ Date: ____/____/____