

26800 Crown Valley Pkwy Suite 150 22 Odyssey Suite 115

Mission Viejo, CA 92691 Irvine, CA 92618

PATIENTS’ INFORMATION

Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Legal Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? Y/N

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Leave a message? Y/N

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: Single/ Married/ Divorced/ Widowed/ Domestic Partnership

I give permission to speak or leave a message with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This will be in effect until revoked in writing.

DOB: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ M / F (circle one)

SS#: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN/PRIMAY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy & Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE (PLEASE CIRCLE ALL THAT APPLY)

I have provided my cards at my initial appointment to be scanned into my chart. \_\_\_\_\_\_\_Initial

MEDICARE/ PPO/ WORK COMP/HMO/ SELF-PAY/ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT NAMED ABOVE INCLUDING BUT NOT RESTRICTED TO DRUGS, MEDICINE, PERFORMANCE OF OPERATION AND CONDUCT OF LABORATORY, X-RAYS, OR OTHER STUDIES THAT MAY BE USED BY DR.GLAZER AND DR. NOSRATI, THEIR ASSISTANTS OR ANY OTHER QUALIFIED DESIGNANTE. I AGREE TO ARBITRATOR MEDIATION IN THE CASE OF DEBATE IN REGARDS TO TREAMENT. I CONSENT TO THE TAKING AND PUBLICATION OF ANY PHOTOGRAPHS DURING THE COURSE OF THIS TREAMENT FOR THE PURPOSE OF ADVANCING MEDICAL EDUCATION. I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

SUBSCRIBER/INSURED SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT HEALTH HISTORY**

Your Health History is **IMPORTANT**. Please answer all questions thoroughly.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_ Shoe size:\_\_\_\_\_\_\_

**Chief Complaint**

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­

Pain Level of Injury ( 0-10 where 0=none, 10=extreme): \_\_\_\_\_\_\_\_\_\_

Current problem is the result of a(n): Check all that apply Car Accident\_\_\_\_\_\_ Work Accident\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

 **Medication**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Reason** |
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**Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle all that apply**

 Diabetes High Blood Pressure Heart Disease Lung Disorders High Cholesterol Kidney Problems Prostate Problems Thyroid

 Anemia Arthritis Gout Liver Disease Psychiatric Stroke TB Hepatitis Seizure Bleeding Disorders Polio Multiple Sclerosis Eating Disorder STD's AIDS/HIV Low Blood Pressure

 Cancer Type & Current Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**

**Surgeries/Hospitalizations:**

|  |  |  |
| --- | --- | --- |
| **Surgery** | **Year** | **Outcome/Complications** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever had general anesthesia? No Yes

Have you ever had any problems with anesthesia? No Yes

 Please Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have sleep apnea? If yes are you using CPAP?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

Are you currently having or have you had problems with your:

**Circle/Describe all “Yes” Responses:**

Eyes No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Ears, Nose,Throat No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lungs, breathing No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Irregular Heart Beat No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Digestion No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Bowel Movement No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bladder Problem No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding Problems No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Balance Problem No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Numbness/Tingling No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blackout/Fainting No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Headaches No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psych No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Fevers/Chills No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_ Skin Issues No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back Pain No Yes\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancies No Yes Number of Pregnancies:\_\_\_\_\_\_\_\_ Complications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity Level**

How often do you exercise? What do you do for exercise?

Daily Weekly Monthly Rarely Never

**Social Habits**

Do you have a history of substance abuse? No Yes What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Alcohol? No Daily 1-2 x/week 1-2 x/month 1-2 x/year

Currently Smoking? No Yes \_\_\_\_\_\_\_ Packs per day \_\_\_\_\_ for \_\_\_\_\_\_ years

Quit Smoking? \_\_\_\_\_\_\_ previously smoked \_\_\_\_\_\_\_\_ packs per day for \_\_\_\_\_\_\_ years.

Have you used other tobacco products? No Yes What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to tobacco in your household? No Yes

**Family History**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Age** | **Deceased/Alive** | **Medical Condition** |
| **Father** |  |  |  |
| **Mother** |  |  |  |
| **Brother** |  |  |  |
|  |  |  |
| **Sister** |  |  |  |
|  |  |  |  |
|  |  |  |

**I certify that the above information is correct to the best of my knowledge, I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_