



Office use only:



### PATIENT INFORMATION

PLEASE PRINT

\_\_\_ MR. \_\_\_ MRS. \_\_\_ MS. \_\_\_ MISS \_\_\_ DR.

\_\_\_ MALE \_\_\_ FEMALE

Are you interested in aesthetic services /massage therapy with our licensed esthetician? **Y / N**

↓Name: Last First Middle

Street Address

City State Zip

Home Phone Work Phone Cell Phone

↓E-mail Address May we email you regarding special events/promotions/etc? (Please Circle): YES NO

Birth date Age Social Security #

(Please circle one) Single Married (Spouse: ) Divorced Widowed

Employer

↓Referred By

Responsible Party/Parent or Guardian (If other than Patient)

Relationship

Address

City State Zip

Phone

#### PERSON TO NOTIFY IN CASE OF EMERGENCY

Name Relationship Phone

#### LAST MEDICAL EXAMINATION

Date Reason

Last Hospitalization

Reasons

#### REASON FOR TODAYS VISIT



## MEDICAL INFORMATION

**DO YOU HAVE OR HAVE EVER HAD:**

- | Y N   | Y N  | Y N  |
|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Anemia                  | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes                | <input type="checkbox"/> <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> <input type="checkbox"/> Arthritis/Joint Pain |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia (Reflux)   | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Peptic Ulcer (Stomach)   | <input type="checkbox"/> <input type="checkbox"/> Anxiety/Depression   |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> <input type="checkbox"/> Bowel Disease            | <input type="checkbox"/> <input type="checkbox"/> Sleep Problems       |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> <input type="checkbox"/> Mental Illness       |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> <input type="checkbox"/> Urinary Incontinence     | <input type="checkbox"/> <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> <input type="checkbox"/> Weight Loss/Gain        | <input type="checkbox"/> <input type="checkbox"/> Urinary Infection        | <input type="checkbox"/> <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion(s)     | <input type="checkbox"/> <input type="checkbox"/> Heart Palpitations   |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> <input type="checkbox"/> Varicose Veins/Phlebitis | <input type="checkbox"/> <input type="checkbox"/> Blood Disorder       |
| <input type="checkbox"/> <input type="checkbox"/> Vascular Disease        | <input type="checkbox"/> <input type="checkbox"/> Skin Disease             | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Disease    |

**PREVIOUS MEDICAL HISTORY:**

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**PREVIOUS SURGICAL HISTORY (include dates):**

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**MEDICATIONS:**

**SOCIAL HISTORY:**

Smoking \_\_\_\_\_ Cig./Day for #Years \_\_\_\_\_ Alcohol \_\_\_\_\_ Oz/Wk  
 Coffee \_\_\_\_\_ Cups/Day Drugs \_\_\_\_\_

**ALLERGIES (medications, anesthetics, latex, etc.)**

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Are there any physical conditions we should know about?

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Name of your Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

May we request your medical records, if needed?  Yes  No

**WOMEN** Are you pregnant?  Yes  No

**NOT ALL SERVICES RENDERED BY DR. FAZILAT ARE COVERED BY INSURANCE COMPANIES.**

It is the patient's responsibility to secure the necessary preauthorization that his/her insurance company may require for treatment. Dr. Fazilat's staff will assist by answering inquiries received. Since insurance companies have various restrictions for medical treatment, it is the patients' obligation to make sure that all requirements have been satisfied and accept the liability for any losses if this is not accomplished.

I authorize Shahin Fazilat, M.D. to furnish any medical information necessary to process my insurance claims, including photographs. I authorize that insurance payments be made directly to Dr. Fazilat unless the services were paid in advance. I realize that my insurance carrier may not pay 100% of expenses incurred and I accept full responsibility for any balance due. I further agree to send full payment within 30 days after having received a statement.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_  
 (If not signed by patient)

SHAHIN FAZILAT, M.D.  
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(650) 964-2200 Fax (650) 964-2205

**Acknowledgement of receipt of “Notice of Privacy Practices”**

In this notice “you(r)” means you, and/or your minor dependent that is being treated.

As required via the federal HIPAA regulations (Health Insurance Portability and Accountability Act) the providers at our medical practice, along with its nursing and administrative staff, under the guidance of the Physician(s), may share you(r) health information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be used for the purposes of treatment, payment, and health care operations such as (but not limited to):

- A. Sharing my health information among providers (within and outside our medical practice), on a need to know basis, in order to medically treat me.
- B. Using my health information for medical billing purposes, including providing referrals to medical specialists, when necessary and appropriate.
- C. Sharing my health information with health insurance firms, government agencies, or other claim payers that request information related to benefits determinations, medical claims filed for visits, treatments, admissions, and other billing matters.
- D. Using my health care information for health care operations, including monitoring the quality of care, audits, surveys, and carrying out other medicals procedures as may be deemed advisable by members of this Medical Center.

I understand that all reasonable efforts will be made to protect the privacy of my health information whether maintained as a paper file or electronic file, and regardless of how it is communicated (verbally, or via fax, paper or electronically).

I have been given the opportunity to read the “Notice of Privacy Practices” which outlines in more detail how my health care information is used and shared with others. The “Notice of Privacy Practices” explains when I need to give my further approval for the providers to use my health information or share it outside of the medical practice, and when my permission is not needed for the providers to use my health information or share it outside of the medical practice (such as: required by law, public health activities, and so forth).

I understand that this medical practice has reserved the right to change the “Notice of Privacy Practices” at any time. I may obtain a current copy of the “Notice of Privacy Practices” by contacting the Privacy Officer of this medical practice.

My signature below constitutes my acknowledgement that I have been provided the opportunity to read and obtain a copy of the “Notice of Privacy Practices”.

Signature of adult patient or a minor patient’s parent or legal guardian

Date

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