



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**

↓Last Name, **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 # :** (Insurance Patients)

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

Employer

↓Referred By (please check one)

**Groupon**  **Facebook**  **Yelp**  **Living Social**  **Signature Forum**  
 **Current Patient-Name:** \_\_\_\_\_  **Other (please specify):** \_\_\_\_\_

**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

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DO YOU HAVE OR HAVE EVER HAD:

Y N

- Anemia
- Diabetes
- Epilepsy
- Abnormal Bleeding
- Abnormal Blood Pressure
- Hepatitis
- Rheumatic Fever
- Heart Murmur
- Weight Loss/Gain
- Headaches/Migraines
- Heart Disease
- Vascular Disease

Y N

- High Blood Pressure
- High Cholesterol
- Jaundice
- Hiatal Hernia (Reflux)
- Peptic Ulcer (Stomach)
- Bowel Disease
- Kidney Disease
- Urinary Incontinence
- Urinary Infection
- Blood Transfusion(s)
- Varicose Veins/Phlebitis
- Skin Disease

Y N

- Thyroid Disease
  - Cancer
  - Arthritis/Joint Pain
  - Osteoporosis
  - Anxiety/Depression
  - Sleep Problems
  - Mental Illness
  - Stroke
  - Asthma
  - Heart Palpitations
  - Blood Disorder
  - Rheumatic Disease
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PREVIOUS MEDICAL HISTORY:

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PREVIOUS SURGICAL HISTORY (include dates):

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MEDICATIONS:

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SOCIAL HISTORY:

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

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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

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**WOMEN** Are you pregnant?  Yes  No

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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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**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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