ELITE MEDICAL CLINIC

PATIENT NAME: _____ **AGE**: _____

Home Address: _____ **Apt/Unit #**:_____

City: _____ **State:** _____**Zip:** _____

Cell Phone: _____ **Home Phone:**_____
(Providing your numbers above will allow use for medical communications and to leave voice messages with results and/or text messages)

Personal E-Mail: (**please print legibly**)_____
*(Providing your email above will allow use for medical communications e.g., test results and billing. **We will not share with any third party**)*

Date of Birth: _____-_____-_____ **Sex**: Male / Female **Marital Status**: Single / Married / Other

Social Security Number: _____-_____-_____ **Driver's License#**: _____
(*Social security number is required to bill insurance*)

Patient Occupation: _____ Employer: _____

Emergency Contact #1: _____ Phone: _____ Relation_____
Permission to disclose your medical information to emergency contact #1? ☐ Yes ☐ No

Emergency Contact #2: _____ Phone: _____ Relation_____
Permission to disclose your medical information to emergency contact #2? ☐ Yes ☐ No

HEALTH INSURANCE INFORMATION *(if applicable)*

Please provide the receptionist with your insurance card(s)

PRIMARY INSURANCE
Blue Cross / Blue Shield / Medicare / Aetna / United Health / Tricare / Oscar / HMO Other:_____
Insurance ID: _____ Group #: _____
Subscriber/Insured: _____ Their date of birth: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

SECONDARY INSURANCE (If applicable):
Blue Cross / Blue Shield / Medicare / Aetna / United Health / Tricare / HealthNet / Oscar / HMO Other:_____
Insurance ID: _____ Group #: _____

Referred By: Yelp / Google / Self / Family / Friend / Physician Name: _____

I hereby consent to medical evaluations, testing, and/or treatment provided to me by the staff of Elite Medical clinic. I am advised that such treatment may include physical examination, laboratory testing and/or other procedures, as required. I understand that Elite Medical Clinic may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits otherwise payable to me directly to Elite Medical Clinic and agree to pay any remaining balance once my insurance plan has processed my claim. Responsibility for payment of all charges, however, rests at all times with the person signing below.

I acknowledge that Elite Medical Clinic's Notice of Privacy Practices has been presented to me. I acknowledge that the Notice is available in the reception area and on the practice website, and by email or paper copy, upon request. I understand that Houman Kashani M.D., APC has a right to change its Notice of Privacy Practices from time to time and that I may contact Houman Kashani, M.D., Inc. at any time to obtain a current copy of the Notice of Privacy Practices.

I am aware that the practice of medicine and surgery is not an exact science. I understand that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the outcome of my care, examination, and for treatment and Elite Medical Clinic. This agreement releases Houman M Kashani MD, Houman M Kashani, MD, A Professional Corp., and Elite Medical Clinic from all liability relating to injuries including, but not limited to slip and falls, that may occur while in the clinic. By signing this agreement, I agree to hold Houman M Kashani MD, Houman M Kashani, MD, A Professional Corp., and Elite Medical Clinic entirely free from liability, including financial responsibility for injuries occurred, regardless of whether the injuries are caused by negligence.

Patient Signature X_____ **Date** _____

Health History

Medications: ☐ Not taking any current medications

List all prescription meds, non prescription meds (Include Birth Control or IUD) with dosage and frequency.

_____

_____

_____

Medication Allergies: ☐ No allergies If Yes, please list: _____

Past Medical History: ☐ No past medical problems

Have you ever had the following: ***(circle if "yes," leave blank if "no.")***

				Pneumonia	yes
AIDS or HIV+	yes	Diabetes	yes	Prostate issues	yes
Alcoholism	yes	Gastritis	yes	Psychiatric issues	yes
Allergy	yes	GERD (reflux)	yes	Rheumatoid Arthritis	yes
Anemia	yes	Glaucoma	yes	Rheumatic Fever	yes
Anxiety	yes	Heart Disease	yes	Scarlet Fever	yes
Arthritis	yes	Hepatitis	yes	Seizure	Yes
Asthma	yes	Herniated Disk	yes	Stroke	yes
Bleeding disorders	yes	High Blood Pressure	yes	Thyroid disease	yes
Blood transfusions	yes	High Cholesterol	yes	Tuberculosis	yes
Bulimia	yes	Hives/ Eczema	yes	Stomach ulcers	yes
Cancer	yes	Migraine Headaches	yes	Urine infections	yes
Drug abuse	yes	Osteoporosis	yes	Venereal disease	yes
Depression	yes	Pacemaker	yes		

Please explain any of the above "yes" answers or other medical illnesses not listed When?

_____ _____

_____ _____

_____ _____

Previous Surgeries: ☐ No previous surgeries When?

_____ _____

_____ _____

_____ _____

Social History:

Use of Tobacco: No:_____ Current packs/day:_____Previously, but Quit:_____

Use of Alcohol: No:_____ Occasional:_____ 1-2 Drinks/day:_____ >2 Drinks/day:_____

Use of Drugs: No:_____ Type/Frequency_____

Marital Status: Single / Married / Divorced / Widowed / Separated / Other

Family Medical History: ☐ No major diseases or illnesses run in my family

Please list if any blood relatives have or have had any of the conditions listed below. List all that apply.

Condition	***Relationship***	***Condition***	***Relationship***
Alcoholism	_____	Heart disease	_____
Asthma	_____	High blood pressure	_____
Cancer, type _____	_____	High cholesterol	_____
Cancer, type _____	_____	Stroke	_____
Depression	_____	Thyroid disease	_____
Diabetes	_____	Other, _____	_____