The Office of Dr. Mazhari
8100 Boone Blvd, Suite 300, Vienna, VA 22182
Phone: 703-716-2866

Patient Information

Date: _____/____/_____Whom may we thank for referring you? ___________________________

Patient Name: ____Date of Birth: _____/_____/______

Address: ____ Apt/Unit:________________________

City: ____ST: ____________Zip: _______________

Cell Phone #: ________________________________

Home Phone#: ______________________________

Work Phone#: ______________________________

Sex: Male ____Female____

Email: ____@______________________________. com

Occupation: ________________________________Marital Status: ____________________________

Emergency Contact: ____

Emergency contact #: ____

Relationship to Patient: ____

Pharmacy Name and Phone Number: ____

Appointment cancellation policy:

Patient agrees to call the office at least 24 hours in advance to avoid cancellation charges. If patient does not give 24 hours' notice or no call, or misses his/her his appointment, there will be a $35 fee for office visits and $50 for annual physical visits.

X____Date: ____/____/________
Signature of patient, insured or beneficiary

Print Name: ____

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Concerning Insurance:

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claims, to my insurance carrier (or, in the case of Medicare part B benefits to the Social Security Administration in Health Care Financing Administration). A copy of the authorization may be used in place of the original. Either my insurance carrier or I may revoke this authorization at any time in writing. *I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. I understand and agree that I am financially responsible for charges not paid by my insurance company.

Patient Consent Form:

The Department of Health and Human Services has established a “privacy rule” to help ensure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain the patient's consent for uses and disclosures of healthcare operations. As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationship with you (such as laboratories that only interact with physicians and not patient's) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to give your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

X____Date: ____/____/________

Signature of patient, insured or beneficiary

Print Name: ____

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I _________________________, hereby authorize Ramin Mazhari LLC and/or his representatives to release any and all information pertaining to my healthcare results, procedures, billing, and or accounting information to the following person(s) or agencies:

________Myself

________Spouse

________Other. Please Specify: ____________________

________Insurance Company

________Parents

________No One

I further authorize a physician, nurse, and representatives to release the results of my medical exams and one or more of the following ways:

May call me (Patient): ________At Home/Cell ________At Work

May leave message(s) to return call to physician's office:

________At Home/Cell on Answering Machine/Voice Mail ________At Work on Voice Mail

I understand that this officer can release any information to those persons who I have determined.

Other physicians may receive this information without separate consent as needed for maintaining my health. I also understand that this relates to all medical, as well as accounting information

IF you wish to make any changes to the status of this form, it will need to be done in writing.

X____Date: ____/____/________

Signature of patient, insured or beneficiary

Print Name ____

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Health Habits:

Smoking Status: ϒ Current Everyday Smoker ϒ Current Some Day Smoker ϒ Heavy Tobacco Smoker ϒ Light Tobacco Smoker ϒ Former Smoker ϒ Never Smoker **Are you a Tobacco User** ϒ Yes ϒ No

No. Of Years: _______ **Pack/Day:** _________**Date of Quit:** ____________________

Alcohol Use: ϒ Every Day ϒ Most Days ϒ Some Days ϒ Rarely ϒ Never

Illicit Drugs: ϒ Yes ϒ No

Blood transfusion: ϒ Yes ϒ No

Exercise Habits: ϒ Regularly ϒ Occasionally ϒ Rarely

Do you drive? ϒ Yes ϒ No

Do you use your Seatbelt? ϒ Yes ϒ No

Do You live alone? ϒ Yes ϒ No

Past Medical History:

ϒ Abnormal Mammogram
ϒ Alcoholism
ϒ Anemia
ϒ Arthritis
ϒ Asthma
ϒ Bleeding Disorder
ϒ Bronchitis
ϒ Cancer _______________
ϒ Hepatitis

ϒ COPD
ϒ Diabetes
ϒ Kidney Disease
ϒ Eating Disorder
ϒ Epilepsy
ϒ Glaucoma
ϒ Gout
ϒ Heart Disease

ϒ High Cholesterol
ϒ HIV/AIDS
ϒ Scarlet Fever
ϒ Liver Disease
ϒ Stroke
ϒ Migraines
ϒ Tuberculosis
ϒ Multiple Sclerosis
ϒ Other: ____________________

ϒ Prostate Disease
ϒ Rheumatic Fever
ϒ Thyroid Disease
ϒ Sexually Transmitted Disease

Family Record:

Mother: ϒ **Alive** ϒ **Deceased - Age at Death** _______ **Cause of Death** ___________________________

Father: ϒ **Alive** ϒ **Deceased - Age at Death** _______ **Cause of Death** ___________________________

(Circle the appropriate letter for Father, Mother, Brother, Sister, and Children)

Arthritis	M	F	S	B	C	Thyroid Dz.	M	F	S	B	C
Asthma	M	F	S	B	C	Kidney Dz.	M	F	S	B	C
Angina	M	F	S	B	C	Heart Dz.	M	F	S	B	C
Hypertension	M	F	S	B	C	Cancer	M	F	S	B	C
Stroke	M	F	S	B	C	Seizures	M	F	S	B	C
Diabetes	M	F	S	B	C	Hepatitis	M	F	S	B	C

Other Diseases or Illnesses in Family: ____

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Name: ____ DOB: ____/____/________

List All Current Medications with Dose & Frequency

____

____

____

____

____

____

____

____

____

List All Previous Surgeries or Hospitalizations w/ Date

____

____

____

____

____

Medications You Are Allergic To:

____

____

____

Symptoms: Check (√) symptoms you currently have or have had in the past year.

General

ϒChills
ϒDepression
ϒDizziness
ϒFainting
ϒFever
ϒForgetfulness
ϒHeadache
ϒLoss of Sleep
ϒNervousness
ϒ Numbness
ϒSweats

Muscle/Joint Bone

Pain, Weakness, Numbness
ϒ Arms ϒ Hips ϒ Back
ϒ Legs ϒ Feet ϒ Neck
ϒ Head ϒ Shoulders

Genito- Urinary
ϒ Blood in Urine
ϒ Frequent Urination
ϒ Lack of Bladder Control
ϒ Painful Urination

Gastrointestinal

ϒ Appetite
ϒBloating
ϒBowel Changes
ϒConstipation
ϒDiarrhea
ϒExcessive Hunger
ϒExcessive Thirst
ϒGas
ϒHemorrhoids
ϒIndigestion
ϒNausea
ϒRectal Bleeding
ϒStomach Pain
ϒVomiting
ϒVomiting Blood

Cardiovascular

ϒChest pain
ϒHigh blood pressure
ϒIrregular heartbeat
ϒLow blood pressure
ϒPoor circulation
ϒRapid heart beat
ϒSwelling of ankle
ϒVaricose veins

Eye, Ear, Nose, Throat

ϒBleeding Gums
ϒBlurred Vision
ϒCrossed Eyes
ϒDifficulty Swallowing
ϒDouble Vision
ϒEarache
ϒEar Discharge
ϒHay Fever
ϒHoarseness
ϒLoss of hearing
ϒNosebleeds
ϒPersistent cough
ϒRinging in ears
ϒSinus problems
ϒVision flashes
ϒVision halos

Skin

ϒBruise easily
ϒHives
ϒItching
ϒChange in malls
ϒRash
ϒScars
ϒSores that won't heal

Men Only

ϒBreast lump
ϒErection difficult
ϒLump in testicles
ϒPenis discharge
ϒSore in penis
ϒProstate disease
ϒPoor urinary

Women Only

ϒAbnormal Pap smear
ϒBleeding btw. Period
ϒBreast lump
ϒExtreme menstrual pain
ϒHot flashes
ϒNipple discharge
ϒPainful Intercourse
ϒVaginal discharge

Date of Last Period
____
Date of Last Pap Smear
____
Have you had a Mammogram?
ϒYes ϒNo
Pregnant? ϒ Yes ϒ No
Number of Children? ___________

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Late Policy:

Patient agrees to reschedule their appointment if the appointment is **20 minutes late.** This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

X____Date: ______/______/________

Signature of patient, insured or beneficiary

Print Name: ______________________________________

Payment Policy:

We are dedicated to providing the best possible care and service to you. To reduce confusion and misunderstanding between our patients and practice, please see our financial policies. You are responsible for payment of all charges, including any balance due following insurance payment. **Full payment is due at the time of service** unless your health insurance carrier has made prior arrangements. This includes co-payments, deductible, and non-covered items. For your convenience we accept cash, checks or credit cards. We do not save payment information.

A balance of $0 is required before being seen by the doctor

X____Date: ______/______/________

Signature of patient, insured or beneficiary

Print Name: ______________________________________

RM