

# 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:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relation** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relation** \_\_\_\_\_

## **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 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.

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**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.")*

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

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

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**Previous Surgeries:**  No previous surgeries When?

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**Patient 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.

<u>Condition</u>	<u>Relationship</u>	<u>Condition</u>	<u>Relationship</u>
Alcoholism	_____	Heart disease	_____
Asthma	_____	High blood pressure	_____
Cancer, type _____	_____	High cholesterol	_____
Cancer, type _____	_____	Stroke	_____
Depression	_____	Thyroid disease	_____
Diabetes	_____	Other, _____	_____