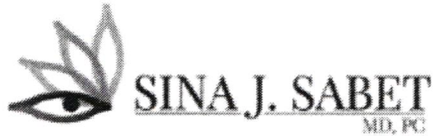

New Patient Registration

Name: ______________________________ **DOB:** ____________________

1. Who referred you to Dr. Sina Sabet? ____

2. What condition are you being referred for? __________________________________

3. When did your symptoms begin? ____

4. Have you had any imaging related to this problem? Yes / No

If yes, specify imaging type and where it was done. ____________________________

5. Please list any other physicians you have seen for this. _______________________

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