Danésh

NEW PATIENT REGISTRATION FORM

NAME____
FIRST **MI** **LAST**

ADDRESS____ **APT#**__________

CITY______________________________ **STATE**__________ **ZIP**___________________

DATE OF BIRTH ______ /______ /______ ☐ **MALE** ☐ **FEMALE**

PRIMARY LANGUAGE ___________________

ETHNICITY _______________________

HOME NUMBER ( ) ________-__________ **CELL NUMBER** ( ) ______-_________

WORK NUMBER ( ) ________-__________ **PHARMACY** ( ) ________-__________

EMAIL____

PRIMARY PHYSICIAN:

DOCTOR'S NAME _________________________ **PHONE NUMBER** ( ) _______-_________

REFERRED BY: ____

EMERGENCY CONTACT:

NAME _______________________ **RELATIONSHIP** ___________________

PHONE NUMBER ( ) ________-__________

I hereby authorize Sid Danesh M.D. to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to Sid Danesh M.D all payments for medical services rendered and all major medical benefits. I authorize Sid Danesh M.D to inquire and receive any information pertaining to my insurance company as a courtesy to me.

___________________________________ ______________________
Patient/Guardian Signature Date

SID DANESH M.D. | GINA DANESH D.O.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, the office of Sid Danesh, MD and Gina Danesh, DO (office) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Sid Danesh's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of privacy practices prior to signing this consent. The office reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at 240 S. La Cienega Dr. Suite 400, Beverly Hills, CA 90210 or 316 E. Las Tunas Dr. Suite 103, San Gabriel, CA 91776.

With my consent, the office may call or text my home or other designated location and leave me a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, the office may mail, email, or text to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, photos and patient statements.

With my consent, the office may fax, mail, text, or email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment cards, photos, and patient statements. I have the right to request that the office restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The physicians in this office are licensed by the state of California and regulated by the Medical Board of California, 800-633-2322 www.mbc.ca.gov.

By signing this form, I am consenting to the office's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don't sign this consent, Sid Danesh, MD or Gina Danesh, DO may decline to provide treatment to me.

I have read the Notice of Privacy Practice prior to signing this consent.

____
Patient/Legal Guardian Signature

____
Patient Name (and Legal Guardian)

PATIENT HISTORY

Name ___________________________ Date _______________________

Occupation_______________________ Marital Status _______________

Social History: **Tobacco:** ☐ Yes ☐ No
Alcohol: ☐ Yes ☐ No ☐ Socially

Medical History:

______AIDS / HIV
______Anemia
______Bleeding Disorders
______Cancer
______Diabetes
______Dizziness
______Eczema
______Heart Conditions
______Heart Murmur
______**Hepatitis**
______High Blood Pressure
______High Cholesterol
______**Blood Clots**
______Glaucoma

Medical History:

______Anxiety / Depression
______Colitis
______**Heart Valve Disease**
______History of Fainting
______Hives
______Keloids
______Rheumatic Fever
______Tuberculosis
______Peptic Ulcer
______Psoriasis
______**Pregnant** / Nursing
______**Pacemaker**
______Osteoporosis
Any Other Conditions: __________________

Family History: Any of the above in your family:_______________________________________

Review of Systems:

Skin: ☐ Rashes ☐ Itching ☐ Dryness ☐ Lumps ☐ Hair/Nail changes

Constitutional: ☐ Weight changes ☐ Fever or chills ☐ Fatigue/weakness

Medication Allergies: ☐ No ☐ Yes: ________________________________

Medications: Please list any medications that you currently take.

___________________________________ ______________________________________

___________________________________ ______________________________________

___________________________________ ______________________________________

Office Staff Initials ______ **Patient Initials**______