Patient Information Sheet:

Patients Name:_____Social Security No:_____

Date of Birth:_____ Sex: M / F (Circle One) Married /Single /Divorced /Widow

Address: _____
(Street) (City/State/Zip)

Home:( ) _____ E-mail Address: _____

Preferred Language: _____ Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino

Race: [ ] White [ ] Black [ ] Asian [ ] Middle Eastern [ ] Other: _____

_____
(Patients Employer Name) (Address) (City/State/Zip) (Telephone)

Person Responsible for Patient (Complete ONLY if Different from Patient):

Guarantor Name: _____ Social Security Number: _____

Relationship to Patient: (please check): [ ]Self [ ] Spouse [ ] Parent Date of Birth: _____

Address: _____ Phone Number: ( ) _____

_____
(Employers Name) (Address) (City/State/Zip) (Telephone)

Emergency Contact:

_____
(Last Name, First Name) (Relationship) (Telephone Number)

Insurance Information:

Primary Insurance Comp: _____ Policy Number: _____

Group Number:_____Plan Code: _____

Subscriber Name:_____ DOB:_____SS No._____

Secondary Insurance Comp:_____ Policy Number:_____

Group Number:_____Plan Code: _____

Subscriber Name:_____ DOB:_____SS No. _____

How did you hear about our clinic: (Please check to indicate which method?)

[ ] Newspaper [ ] Radio [ ] Media [ ]TV [ ] Employer [ ] Family/Friend [ ] Other: _____

My signature below hereby authorizes the absolved name, insurance company to pay for all medical service rendered. I, understand that I am financially responsible for all changes not covered by my insurance company. I authorized release of medical information to said insurance company. Additionally, my signature provides willing consent to procedures which may be performed including emergency treatment and services, and which may include but not to laboratory procedure, x-ray exams, medical or surgical treatment or procedures, anesthesia, or services rendered to the patient under the general and special instruction of the patient's physician or designate.

Signature: **(If not Patient, Relationship)** **Date:**

_____

Medication List:

Please list every prescription and over-the-counter drug you are currently taking. Be sure to include the strength and dosage of each medication, and how often it taken.

Medication Name and Strength	Direction, How Taking Medication
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	
22.	
23.	

Medical History:

Are you currently under another physician's care or specialist? [ ] YES [ ] NO If No, please explain: _____

Have you ever been hospitalized or has major operation? [ ] YES [ ] NO If Yes, please explain: _____

Have you ever had any surgeries? [ ] YES [ ] NO If Yes, please explain: _____

Have you ever had a serious head and neck injury? [ ] YES [ ] NO If Yes, please explain: _____

Are you on a special diet? [ ] YES [ ] NO If Yes, please explain: _____

Do you use controlled substance? [ ] YES [ ]NO _____

Do you use tobacco and/or smoke? [ ] YES [ ] NO If Yes, please explain: _____

Do you drink? [ ] YES [ ] NO If Yes, please explain (how much and how often): _____

Are you currently in any pain: (1-10 with 10 being the worst pain) _____

WOMEN: [ ] Pregnant/trying to get pregnant? [ ] Nursing? [ ] Taking any type of contraceptives?

LAST PAP SMEAR? _____ LAST MAMMOGRAM? _____

LAST TENANUS VACCINATION? _____ **LAST INFLUENZA VACCINATION?** _____

Are You Allergic to Any of The Following?

[ ] Aspirin [ ] Penicillin [ ]Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics [ ] other If Yes, please explain: _____

[ ] Any food allergy? If Yes, please explain: _____

FAMILY HISTORY:

	Living status	Diabetes	High Blood Pressure	Heart Disease	Mental Disorder	Cancer (specify)
Mother						
Father						
Siblings						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

Do you have, or have you had, any of the following?

☐ AIDS/HIV POSITIVE	☐ ALZHEIMERS DISEASE	☐ ANAPHYLACTIC	☐ ANEMIA
☐ ANGINA	☐ ARTHRITIS/GOUT	☐ ARTIFICIAL HEART-VALVE	☐ ARTIFICIAL JOINT
☐ ASTHMA	☐ BLOOD DISEASE	☐ BLOOD TRANSFUSION	☐ BREATHING PROBLEM
☐ CANCER	☐ CHEMOTHERAPY	☐ COLD SORES/FEVER BLISTERS	☐ CHEST PAIN
☐ CONTENGINAL HEART DISEASE	☐ CONVULSION	☐ DIABETES	☐ DRUG ADDICTION
☐ EASILY WINDED	☐ EPILEPSY OR SEIZURE	☐ EXCESSIVE BLEEDING	☐ EXCESSIVE THIRST
☐ FAINTING SPELLS/ DIZZINESS	☐ FREQUENT COUGH	☐ FREQUENT DIARRHEA	☐ FREQUENT HEADACHE
☐ GENITAL HERPES	☐ GLUCEMIA	☐ HAY FEVER	☐ HEART ATTACK/FAILURE
☐ HEART MURMUR	☐ HEART PACE MAKER	☐ HEART TROUBLE/DISEASE	☐ HEMOPHILIA
☐ HEPATITIS A	☐ HEPATITIS B OR C	☐ HERPES	☐ HIGH BLOOD PRESSURE
☐ HIVES/RASH	☐ IRREGULAR HEARTBEAT	☐ KIDNEY PROBLEM	☐ LEUKEMIA
☐ LIVER DISEASE	☐ LOW BLOOD PRESSURE	☐ LUNG DISEASE	☐ PAIN IN JAW JOINTS
☐ PARAMECIUM DISEASE	☐ RADIATION TREATMENT	☐ RECENT WEIGHT LOSS	☐ RENAL DIALYSIS
☐ RHEUMATIC FEVER	☐ SCARLET FEVER	☐ RHEUMATISM	☐ SHINGLES
☐ SICKLE CELL DISEASE	☐ SPINA BIFIDA	☐ SINUS TROUBLE	☐ STROKE
☐ SWELLING OF LIMBS	☐ THYROID DISEASE	☐ TONSILITIS	☐ TUBERCULOSIS
☐ ULCERS	☐ VENEREAL DISEASE	☐ YELLOW JAUNDICE	☐ HIGH CHOLESTEROL

Patient Responsibility Form

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITIES
   a. *I understand that I am financially responsible for my health insurance deductibles, co-insurance or non-covered services. Co-payments are due at time of service.*
   b. *If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all service provided.*
   c. *If I am uninsured, I agree to pay for the medical services rendered to me at the time of services.*
2. *INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENIEFITS*
   a. *I hereby authorize and direct payment of my medical benefits to Shima Hadidchi, MD on my behalf of any services furnished to me by the provider(s).*
3. *AUTHORIZATION TO RELEASE RECORDS*
   a. *I hereby authorize Shima Hadidchi, MD to release to my insurer, governmental agencies, or any other financially responsible for my medical care, all information, including diagnosis(s) and the records of any medical care, all rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referrals to other medical provider(s)*
4. *MEDICAL REQUEST FOR PAYMENT*
   a. *I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Shima Hadidchi, MD*
   b. *I authorize any holder of medical or other information about me renewed to Medicare and its agents any information needed to determine these benefits for related services.*

(Signature of patient, authorized representative or responsible party) **(Date)**

(print name)

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to attribute it is understood that any dispute as a medical malpractice, that is asked to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, Will be determined by submission to attribution as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review for attribution proceeding. Parties to this contract by entering into an argument of the constitutional rights to have any such dispute decided in a court of law before a jury, and instead are excepting to use of arbitrated Article 2: All claims must be attributed it is in intention of the parties the disagreement bind all parties who claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient any children whether born or unborn at the time of the occurrence given rise to any claim in the case of any pregnant mother the term "Patient" herein show me what and the mothers expected child or children. All claims for monetary damage exceeding the judicial limit the small claims court against the physician in the physicians partner associates, association, corporation or partnership, and the employees, agents and a state of any of them, must be attribute included, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fees from the patient shall wave right to compel attribution of any malpractice claim Article 3: procedures and Application law: a demand for retribution must be communicated in writing to all parties. Each party shall select an arbitrator "party attribution" within 30 days any third arbitrator (neutral arbitrator) shall be selected by the attribute yours appointed by the party within 30 days of a demand for a neutral attribution by either parties. Each party to the arbitrator shall pay such party's pro rata share the expenses and fees of the neutral arbitrator, together with other expenses of attribution incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the attribute or has the immunity of a judicial office from civil liability when acting in the capacity of attribution under this contract. This immunity shall supplement, not supplant, any other applicable statuary or common-law. Either party shall have the absolute right to attribute separately the issues of liability and damages upon writing request to the neutral arbitrator. The parties consent to the intervention and joinder in this attribution of any person or entity in which what otherwise be a proper additional party in a court action, and up on such intervention and joinder any existing court action against heredity shall be stayed pending arbitration. The parties agree that provision of California law applicable to health care provides shall apply to dispute within this activation agreement, including, but not limited to, code of Civil Procedure section 340.5 and 667.7 in civil court section 3333.1 and 3333.2. Any party may bring before arbitrators a motion for summary judgment or summary arbitration in accordance with the code of civil procedures. Discovery shall be conducted pursuit to code of civil procedure section 1283.05, however the position may be taken without prior approval of the neutral arbitrator. Article 4: General provision: all claims based upon the same incident, the transaction or related circumstance shall be attribute it in one proceeding. A clean shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if assorted in a civil action, would be buried by the applicable California statute of limitations, or(2) the claimant feels to pursue that attribution claim in accordance with the procedure prescribed hearin with reasonable diligence. With respect to any matter not herein express provided for, the arbitrator shall be governed by the California code of civil procedures provision relating to arbitration. Article 5:Revocation: this agreement maybe revoked permit notice delivered to the physician within 30 days of signature. It is intended of this agreement to apply to all medical services rendered anytime for any condition. Article 6 Retroactive Effect: a patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of the first medical service:_____Patients or patient representatives and initial:_____

If any provision of this arch vision agreement is held invalid running forcible, the remaining provisions shall remain in full force and should not be affected by the invalidating of any other provision. I understand that I have the right to receive a copy of this attribution agreement. By my signature below I acknowledge that I have received the copy.

Notice: By signing this contract you're agreed to have any issue of medical malpractice decided by the neutral attribution that you're giving up your right to jury core trail the article (1) of this contract

By:

_____

Patient or Patient Representative Signature Date

By:

_____

Positions or authorized representative signature Date

By:

_____

Patients Name Printed

MD Shima Hadidchi

_____

Print or step name a physician dr. Shima Hadidchi

By:

_____

Is representative print name and relationship to patient

It signed copy of this documentation Is to be given to the patient. Originals to be filed in patient's medical record

SHIMA HADIDCHI MD, A PROFESSIONAL GROUP
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