PATIENT REGISTRATION

TODAYS DATE_____ HOME PHONE_____

NAME_____ DATE OF BIRTH_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

WORK PHONE_____ CELLULAR/PGR_____

Email Address:_____

SOCIAL SECURITY NUMBER_____ DRIVERS LICENSE NUMBER _____

EMPLOYED BY_____OCCUPATION_____

EMERGENCY CONTACT
INFORMATION_____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE?_____

ADDRESS_____PHONE NUMBER_____

AUTHORIZATIONS

I hereby consent to and authorize the administration of all emergency, diagnostic and therapeutic treatment for me and/or my minor child that may be necessary in the judgment of Dr Nikravesh. I hereby authorize Dr. Nikravesh and any laboratories used by Dr. Nikravesh for me, to furnish information (irregardless of sensitivity) to insurance carriers and I authorize and instruct these same insurance carriers to make payments directly to Dr. Nikravesh and laboratory for the medical expenses benefits. A Copy of this assignment and authorization shall be considered as effective and valid as the original. This lien is irrevocable.

I also understand that I am financially responsible to Dr. Nikravesh and laboratory for charges not covered and/or paid by my insurance carrier. If I do not pay said fees I will be responsible for all fees related to its collection. I understand **any balance over 30 days will be subject to a 10% APR interest. All charges related to its collection i.e. attorney fees, court costs, collection fees**. will be your responsibility (parent(s) if minor)

H.M.O. Patients: ONLY services authorized in writing by your HMO will per paid for, anything not authorized will be YOUR responsibility if services rendered are denied due to an IPA change or non-covered services, you are responsible for the balance.

Date:_____ Signature_____(parent if minor)

MEDICAL HISTORY

TO AVOID ANY DELAY PLEASE FILL OUT **ALL** INFORMATION ☺

Name_____ Date_____

Height_____ Weight_____ Age_____ Sex_____ Shoe size_____

PRIMARY CARE PHYSICIAN

Name _____ Date of last exam _____

Address_____ Telephone _____

PAST INJURIES/SURGERIES please include APPROXIMATE DATE, PHYSICIAN/ HOSPITAL (sport & others i.e.; sprains, fractures, MVA etc.) (**THIS INFORMATION IS COMPLETELY CONFIDENTIAL**!!)
+ None

_____

_____

_____

Please list all **Medications** you are currently taking + None

_____

_____

FOR **WOMEN** ONLY Are you pregnant?_____ If so, how many months?_____

ALLERGIES Please check all that apply + None

☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Tape ☐ Sulfa ☐ Keflex ☐ Food(shellfish)
☐ Local anesthetics (xylocaine/marcaine/novacaine) ☐ Betadine/iodine ☐ buprofen (Advil/Motrin)
☐ other/explain_____

PAST MEDICAL HISTORY If you have or had any of these problems please check all that apply ☐ None

☐ heart disease ☐ rheumatoid arthritis ☐ osteoarthritis ☐ bleeding disorder ☐ stroke
☐ heart attack(MI) ☐ neurological disorder ☐ seizure disorders ☐ hypertension(high blood pressure)
☐ diabetes (insulin/pill/diet) ☐ fainting ☐ anemia ☐ kidney disease ☐ hepatitis ☐ HIV
☐ ulcers/stomach ☐ circulatory disorders ☐ high cholesterol ☐ other/explain _____

FAMILY HISTORY (blood relative) Please check all that apply ☐ None

☐ Diabetes ☐ bleeding disorders ☐ genetic abnormalities ☐ neurological disorders ☐ other_____

☐ Mother ☐ Father ☐ Brother ☐ Sister is Deceased Cause of death_____

☐ Mother ☐ Father ☐ Brother ☐ Sister is Deceased Cause of death_____

Name_____ Date_____

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes Number of packs per day _____ Number of years smoking _____

Do you drink? ☐ No ☐ Yes Drinks per day _____ Per week _____ Number of years drinking _____

Activity level ☐ sedentary light walking ☐ moderate light running/walking ☐ very active athlete

REVIEW OF SYSTEMS Please check all that apply

LUNG/RESPIRATORY + None
+ wheezing + coughing up blood + difficulty breathing + frequent coughing + shortness of breath
+ painful breathing + bronchitis+ pneumonia

CARDIOVASCULAR + None
+ rapid/skipped beats + high/low blood pressure + fainting + chest pains + swollen ankles

GASTROINTESTINAL/DIGESTION + None
+loose bowels +constipation + bloating +gas + abdominal pain + Denies nausea + blood in stools
+frequent belching+ hemorrhoids +heart burn +vomiting

URINARY + None
+frequent urination +pain on urination+ brown/black +bloody urine + bladder infections
+ unable to hold urine or a constant urge to urinate

MUSCULOSKELETAL + None
+muscle spasms or cramps +weakness in arms/legs + numbness + joint stiffness

SKIN + None
+ hair loss +rashes+hives +dryness +itching +bruise easily + growth or ulcerations

NEUROLOGICAL/ HEAD + None
+ headaches/migraines + ringing in ears + contact lenses + wears glasses + glaucoma
+ blurry vision+ seeing halos or lights+ night blindness + dizziness +head injury +eye pain + cataracts

Sinus/Ear/Nose/Throat + None
+ frequent colds + sore throats + sore or bleeding gums + impaired hearing + nosebleeds + hoarse voice
+ sinus problems + earaches + sores on lips or tongue + difficulty swallowing + stuffiness

Endocrine + None
+ cold hands and feet + gain weight easily + heat or cold intolerance + excessive thirst + excessive
+ hot flashes + chronic fatigue + have lost a lot of weight recently

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

Signature: _____ Date: _____