New Patient Intake Form

Saeed Darbandi, M.D.

Vein and Laser Center, Surgical LTD.

Section 1

Patient Last Name: _____ First:_____ M:_____

Address:_____

City:_____ State: _____ Zip Code: _____

Date Of Birth: _____ Social Security Number: _____

Home Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____

Sex: Male ____ Female ____ **Marital Status:** Single Married Widowed Divorced

Employer:_____

Occupation: _____

Is this a work related injury? No ___ Yes ___ **Result of an auto accident? No___ Yes___**

In Case of an emergency notify: _____

Relationship:_____ Phone Number: _____

INSURANCE POLICY: _____

POLICY HOLDER NAME:_____ D.O.B._____

Authorization to Treat

I hereby authorize my insurance benefits to be paid directly to Dr. Saeed Darbandi, realizing I am responsible to pay non-covered services. I also authorize the release of pertinent medical information to insurance carriers.

Patient Signature: _____ Date: _____

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Section 2

Patient Name: _____ Family Physician: _____

Date Of Birth: _____ Age: _____ Allergies: _____

Who referred you to us? _____

Medical History (Diagnosed Illness, years and dates occurred) _____ _____ _____ _____	**Surgeries and Dates** **(surgery and date)** _____ _____ _____ _____	**Family History** (Please circle **if anyone in your family** has the following) **High Blood Pressure Stroke** **Diabetes Heart Attack Cancer** **Kidney Illness High Cholesterol** **Thyroid Dysfunction**
Medications **(Please include all prescribed, OTC, and herbal medications)** _____ _____ _____ _____ _____ _____ _____ _____	**Preferred Pharmacy and Location** **Pharmacy: _____** **Address: _____** **Phone : _____** **Fax : _____**	**Please Circle The Answer** **Do you drink alcohol?** Yes or No **Do you smoke?** Yes or No If so how many packs/day? _____ How long? _____

Section 3

Please circle if you have any of the following symptoms in the past 6 months or if they are related to your current illness

General	**Head/Eyes/Ears/Nose/Throat**	**Cardiac**	**Digestive**	**Females Only**
Fatigue Fever Chills Night Sweats Jaundice of skin	Headache Dizziness or Fainting Ringing in Ears Change in Vision Nose Bleeds Difficulty Swallowing Hoarseness of Throat	Chest Pain Palpitations Swelling in feet or ankles Discoloration in ankles Pain in Calves or Feet Varicose/Spider Veins	Abdominal Pain Heart Burn Nausea/Vomiting Decreased Appetite Change in Stools Blood or Black Stools Diarrhea Constipation Loss of Appetite Hemorrhoids	Age of first Menstruation: _____ Number Of Pregnancies: _____ Number of Children: _____ Last Mammogram: _____
Skin	**BREASTS**	**Lungs:**	**Urinary**	**Nerves/Muscles**
Rash/ Itching Skin Color Change Ulcer Lumps Bumps Sores	Lumps or Bumps Pain Tenderness Discharge Skin Color Change Skin Texture Change	Shortness of breath Cough Sputum Wheezing Coughing up blood	Painful Urination Frequency Urgency Incontinence Pain/Swelling in Groin	Weakness Numbness Seizures Tingling in extremities

Financial Responsibility:

I understand that I am responsible for the total charges for the services rendered. I further agree that all amounts are due upon request, and are made payable to Saeed Darbandi, M.D. in the event of collection. I will be responsible for any of the charges for the collection of overdue payment. I have read and fully understand this document.

Patient Signature: _____ Date: _____

Saeed Darbandi, M.D

Vein and Laser Center, Surgical LTD

My signature acknowledges that I have provided complete and accurate information and authorize the physician to examine and treat me.

I have received this physician's Notice of Privacy Policies.

Federal privacy rules permits my personal and medical information to be used and disclosed without my permission for billing, medical treatment, and healthcare operations. For other purposes, my information will only be release with my written permission.

I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.

I have no objection to the Doctor and/or his staff discussing my medical treatment with;

Dr. _____ Primary Care Physician

Dr. _____ Specialty:_____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Call Preference: _____Cell Phone _____Home Phone

____ Messages may be left on my answering machine/voice mail.

____ Messages may NOT be left on my answering machine/voicemail.

Saeed Darbandi, M.D.

Vein and Laser Center, Surgical LTD.

EFFECTIVE JANUARY 1ST, 2017

Starting January 1ST, 2017 we will implement a cancellation fee, which is applicable to all patients.

This fee will be a $50.00 charge for cancellations less than 24 hours' notice and no show appointments.

There will be one pardon granted per patient.

THANK YOU!

By signing below, you verify that you understand these policies and will be compliant or will be responsible for the $50.00 charge.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____