Dr. Mehrnaz Jamali

PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT) DATE___/___/___

Email: _____ Social Security #____-___-____

Drivers License #_____

Mr.___ Mrs.___ Ms.___ _____
Last First Middle Initial

Home Address _____
Address City State Zip

Home Phone (___)-___-___ Work Phone (___)-___-___ Birthdate __/__/__ Age___

Marital Status (√) ☐ Single ☐ Divorced ☐ Married ☐ Widower ☐ Minor

Employed By_____

Work Address_____ Occupation_____

Spouse/ Parent_____ Occupation_____
Last First Mid. Init.

Work Address_____ Work Phone ( )_____

Who referred you to this office? _____

Emergency Contact Name & Phone # _____

MEDICAL INSURANCE INFORMATION

How do you intend to pay? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Medicare

Name of Insurance Company_____ Address_____

Policy Number_____ Group Name/ Number_____

IF SOMEONE OTHER THAN PATIENT IS THE INSURED COMPLETE BELOW

Name of responsible party_____ Insured's Date of Birth _____

What is their relationship to the patient_____ Social Security Number____-___-____

I, the undersigned, have insurance coverage with _____ and assign directly to
Name of Insurance Company
_____ all surgical and/or medical benefits if any, otherwise payable to me for services
Name of Doctor
rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date_____ Signed_____

HEALTH QUESTIONAIRE

Name _____ Age _____ Date _____

PAST MEDICAL HISTORY

Anemia.....	NO	YES	Hepatitis.....	NO	YES	Polio.....	NO	YES
Asthma.....	NO	YES	Kidney Disease.....	NO	YES	Rheumatic Fever...	NO	YES
Cancer.....	NO	YES	Liver Disease.....	NO	YES	Scarlet Fever.....	NO	YES
Chicken Pox	NO	YES	Measles.....	NO	YES	Seizure.....	NO	YES
Diabetes.....	NO	YES	Mumps.....	NO	YES	Stroke.....	NO	YES
Gout.....	NO	YES	Peptic Ulcer.....	NO	YES	Thyroid Disease...	NO	YES
Heart Disease.....	NO	YES	Phlebitis/Blood Clot...	NO	YES	Tuberculosis.....	NO	YES
Hypertension.....	NO	YES	Pneumonia.....	NO	YES	Venereal Disease..	NO	YES

PAST SURGICAL HISTORY:

Any other significant illnesses, injuries or hospitalizations:

Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____
Year _____	Illness _____	Year _____	Surgery _____

ALLERGIES: (Medications and Foods)

1. _____ Reaction _____
2. _____ Reaction _____
3. _____ Reaction _____
4. _____ Reaction _____

LIST OF CURRENT MEDICATIONS

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

IMMUNIZATIONS:

Year
Influenza
Tetanus
Pneumococcol
Others:

SOCIAL HISTORY:

Marital Status:	S	M	Sep	D	W	# Children
Occupation:						Hrs / Wk:
Job Satisfaction:	☐ Yes	☐ No				
Smoker:	☐ Yes	☐ No	Pack / Day: #			Years:
Caffeine:	☐ Yes	☐ No	Cups / Drinks / Day: #			
Alcohol: (Kinds, Amounts, Frequency)						
Recreational Drugs:						
Advanced Directive / Living Will:	☐ Yes	☐ No				

Family History	If Living: Age	If Living: Health	If Deceased: Age (at death) & Cause	
Father				
Mother				
Sibling				
Spouse				
Children				

Has any blood relative ever had:		
Cancer	No	Yes
Tuberculosis	No	Yes
Diabetes	No	Yes
Heart Trouble	No	Yes
High Blood Pressure	No	Yes
Stroke	No	Yes
Convulsions	No	Yes
Suicide	No	Yes
Mental Illness	No	Yes
Bleeding Tendencies	No	Yes
Arthritis or Gout	No	Yes
Hereditary Defects	No	Yes

SYSTEM REVIEW

GENITOURINARY

Do you eat a well balanced diet?	NO	YES
Approx Weight: Now _____ 1 year ago: _____		
Maximum weight: _____		
Exercise? Frequency / wk: _____	NO	YES
Activities: _____		
Any Sexual Concerns? _____	NO	YES
Year of Last Complete Physical: _____		
Headaches	NO	YES
Glasses / Contacts	NO	YES
Double Vision	NO	YES
Eye Disease or Injury	NO	YES
Year Last Checked For Glaucoma: _____		
Itchy Eyes or Nose / Hay Fever	NO	YES
Septal Deviation / Polyps (Circle Which)	NO	YES
Nosebleeds	NO	YES
Sinus Problems	NO	YES
Ear Disease	NO	YES
Impaired Hearing	NO	YES
Ringing in the Ears (Tinnitus)	NO	YES
Hoarseness	NO	YES

NECK

Softness	NO	YES
Enlarged Glands	NO	YES
Injury	NO	YES

RESPIRATORY

Coughing Blood	NO	YES
Chronic Cough (Includes Smoker's Cough)	NO	YES
Wheezing	NO	YES
Shortness of Breath	NO	YES
How many blocks can you walk without having to stop and catch your breath? _____		
Night Sweats	NO	YES
Skin Test for Tuberculosis	NO	YES
If YES, Year of Test and Results: _____		
Year of Last X-Ray:		

CARDIOVASCULAR

Chest Pain or Angina Pectoris	NO	YES
Shortness of Breath (when lying flat)	NO	YES
Pain in legs on walking, relieved by rest	NO	YES
Varicose Veins	NO	YES
Ankles often badly swollen	NO	YES
Heart Murmur	NO	YES
Rapid, hard or skipped heart beats	NO	YES
Year of Last EKG? _____		
Have had a stress treadmill? Year	NO	YES

GASTROINTESTINAL

Change in Appetite	NO	YES
Heartburn or Indigestion	NO	YES
Sour Taste in your throat or mouth	NO	YES
Intolerance to spicy foods, coffee or alcohol	NO	YES
Have you ever vomited blood?	NO	YES
Do foods stick in your throat?	NO	YES
Gallbladder trouble / intol. to greasy foods	NO	YES
Intolerance to milk products	NO	YES
Hiatal Hernia	NO	YES
Pancreatitis	NO	YES
Do you vomit often?	NO	YES
Crampy Abdominal Pain	NO	YES
Chronic Constipation	NO	YES
Frequent Diarrhea	NO	YES
Change in Bowel Habits	NO	YES
Bloody or Black Bowel Movements	NO	YES
Hemorrhoids or Piles	NO	YES

GENITOURINARY

Loss of Urine when coughing or sneezing?	NO	YES
Kidney or Bladder Infections (Circle which)	NO	YES
Burning or Frequent Urination (Circle which)	NO	YES
Feeling that you must go immediately?	NO	YES
Do you get up at night to urinate? # _____	NO	YES
Blood in Urine	NO	YES
Kidney Stones	NO	YES
Swelling of the hands and feet	NO	YES
Difficulty starting Urination	NO	YES
Decrease in Strength of Stream	NO	YES
Penile Discharge	NO	YES
Date of last Prostate Exam:		

MUSCULOSKELETAL

Significant Arthritis / Joint Pain	NO	YES
Lower Back Pain	NO	YES
Muscle Weakness or Tenderness	NO	YES
Difficulty Walking	NO	YES
Fractures (list)	NO	YES

SKIN

Skin Disorders (list)	NO	YES

NEUROLOGICAL / PSYCHIATRIC

Numbness / Paralysis (Circle which)	NO	YES
Fainting Spells	NO	YES
Memory Loss	NO	YES
Dizziness	NO	YES
Do you have trouble sleeping?	NO	YES
Are you often depressed?	NO	YES
Are you often anxious or nervous?	NO	YES
Do you ever wish you were dead and away from it all?	NO	YES
Do you often worry?	NO	YES
Have you ever been under psychiatric care?	NO	YES

HEMATOLOGICAL

Excessive Bleeding or Abnormal Bruising	NO	YES

ENDOCRINE

Crave large amounts of fluids	NO	YES
Intolerance to slightly warm rooms	NO	YES
Intolerance to slightly cool rooms	NO	YES
Change in textures of hair or skin	NO	YES
Darkening of Skin	NO	YES

GYNECOLOGICAL (This Section For Women Only)

Age when period began: _____ years old		
Frequency: every _____ days. Last Period: _____		
Are they abnormal or irregular?	NO	YES
Menopausal? If so at what age? _____	NO	YES
Number of Pregnancies: _____ C-Sections: _____		
Term Deliveries: _____ Premature: _____		
Miscarriages: _____ Abortions: _____		
Pelvic Inflammatory Disease	NO	YES
Pain with Intercourse	NO	YES
Date of Last Cancer Smear: _____ Normal?	NO	YES
Breast Masses, Lumps or Cysts (Circle which)	NO	YES
Nipple Discharge	NO	YES
Skin Discoloration / Dimpling (Circle which)	NO	YES
Family History or Breast Cancer	NO	YES
Date of Last Mammogram: _____		
Did someone other than the patient help fill this out?	NO	YES

Patient Signature: _____

Reviewing Physician: _____

Date of Birth_____ Sex M F

Phone _____ E-mail_____

Pharmacy_____ Phone #_____

Code Status_____ Allergies_____

Diagnoses	Date	Diagnoses	Date
1		10	
2		11	
3		12	
4		13	
5		14	
6		15	
7		16	
8		17	
9		18	

Surgical History	Date	Vaccines	Date	Date	Date	Date
1		Pneumovax				
2		Influenza				
3		TB				
4		Hep B				
5						

Health Maintenance	Date	Date	Date	Date	Date	Date	Date
Pap							
Mammogram							
Bone Density							
Cholesterol / HDL							
PSA							
Colonoscopy / Flex Sig							
A1C							
Urine Microalbumin							
Foot Exam / Ophthy							

Medications	Date	Date	Date	Date	Date	Date	Date	Date	Date

Dr. Mehrnaz Nicole Jamali
26671 Aliso Creek Road, Suite 205
Aliso Viejo, CA. 92656
Ph (949) 831-0300
Fax (949) 831-0339

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I herby authorize **MEHRNAZ NICOLE JAMALI, M.D.** to obtain any and all medical records concerning my care from any physician, hospital or other health care professionals that have provided care to me at any time. Additionally, I authorize Dr. Mehrnaz Nicole Jamali to release any and all medical records concerning my care to Medicare, Medicaid and any insurance company, third party.

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

Please fax records to our office at (949) 831-0339

HEALTHCARE ELIGIBILITY WAIVER

Patient Name _____ Health Plan _____

Mehrnaz Nicole Jamali, M.D.

The Patient or Patient`s Legal Representative hereby certifies that he / she is eligible for health benefits coverage, and has chosen the above stated physician as the provider of his / her healthcare.

Furthermore, the Patient or Patient's Legal Representative understands that if he/ she is found ineligible for coverage of plan benefits, he / she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

Patient Signature _____ Date _____

Witness _____ Date _____

DOCTOR'S OFFICE

26671 ALISO CREEK RD #205
ALISO VIEJO, CA 92656

To All of Our Patients:

Due to the high volume of patients in our practice, we ask that you give 24-hour notice if your appointment needs to be changed or canceled. This policy enables us to accommodate as many patients as possible, in a timely manner, and will help our office to handle your needs more efficiently.

You will be billed $50.00 for any appointments that you miss without giving 24 hour prior notice

We ask that you arrive promptly for you appointment time. Once it is 15 minutes past your scheduled appointment, our staff will be happy to reschedule another appointment for you.

You will be given three notices if there is a balance on your account, before being sent to collections. Your account will incur a 33.5% collections/processing fee once your account is turned over to our collection agency.

Thank you for your cooperation,

Printed Name: _____

Signature:_____

Mehrnaz Nicole Jamali, M.D.

Dear Patients of Mehrnaz Nicole Jamali, M.D.

Please be advised that with the insurance information provided in the office we will bill as accordingly. Once insurance pays you are then responsible for any balance left on your account. If payment is not received within 10 days of your statement there will be a 30% late fee charge added to your balance.

Financial Agreement: I accept financial responsibility for all services during any episodes of care done in the office. I understand that I can expect to receive separate bills from **physicians, labs, and specialty services.** I agree to promptly pay all bills, in accordance with the regular rates and terms of the office. Should the account be referred to an attorney or agency for collections, I will pay actual attorney's fees and collection expenses. All delinquent accounts are subject to interest at the legal rate.

Assignment of Insurance Benefits: I assign and authorize direct payment to the office of all insurance and plan benefits that are payable for this episode of care. With this authorization, all parties agree that the insurance company's obligations related to this episode of care. I further understand that I am financially responsible for charges not paid according to this assignment.

Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer including payment under Title XVII of the Social Security Act is correct. I request that payment of authorization benefits be made on my behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part A and Medicare Part B, including but not limited to the effective date of such coverage. I also authorize the office and my physician(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim(s).

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of financial Agreement and Assignment of Insurance Benefits.

Patient Name _____ Patient Signature _____

Witness _____ Date _____