DATE_____ RESP. PARTY ACC #_____ ACCT NO._____

PATIENT INFORMATION

NOOSHA SHAHEEDY M.D
SHAHEEDY MEDICAL CORPORATION
2080 CENTURY PARK EAST, STE 1101
LOS ANGELES, CA 90067

PATIENT'S NAME:_____ **DATE OF BIRTH:**____/____/____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____ PHONE (___)_____-_____

MOTHER'S NAME:_____ **DATE OF BIRTH:**___/____/____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____ PHONE: (___)_____-_____

HOME FAX: (____)_____-_____ CELL PHONE: (___)_____-_____

SOCIAL SECURITY NUMBER:_____ EMAIL ADDRESS:_____

OCCUPATION:_____ WORK NUMBER: (____)_____-_____

PLACE OF EMPLOYMENT:_____ WORK FAX: (___)_____-_____

FATHER'S / PARTNER'S NAME:_____ **DATE OF BIRTH:**___/____/____

ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____ PHONE NUMBER: (___)___-_____

HOME FAX:_____ CELL PHONE: (___)_____-_____

SOCIAL SECURITY NUMBER:_____ EMAIL ADDRESS:_____

OCCUPATION:_____ WORK NUMBER: (___)_____-_____

PLACE OF EMPLOYEMENT:_____ WORK FAX (____)_____-_____

IN CASE OF EMERGENCY (OTHER THEN PARENT OR GAURDIAN)_____

RELATIONSHIP:_____ PHONE NUMBER: (___)_____-_____

ADDRESS:_____

INSURANCE COMPANY:_____
PHARMACY NUMBER: (____)_____-_____
REFERRED TO OUR OFFICE BY:_____
ALLERGIES:_____

SHAHEEDY MEDICAL CORP.
NOOSHA SHAHEEDY, M.D. F.A.A.P.
2080 CENTURY PARK EAST, STE 1101
LOS ANGELES, CA 90067
310-358-9484 PHONE 310-358-3485 FAX

FINANCIAL INFORMATION AND AUTHORIZATION

PATIENT'S NAME _____ DATE OF BIRTH___/___/_____

The doctor is contracted with PPO insurance plans. If you are covered under an HMO plan that does not have an out-of-network option there will be no coverage at all. If you are covered under an HMO plan that does have an out-of-network option (POS or Point- Of- Service) or a PPO that your doctor does not contract with then your benefits will be reduced. If you have any questions regarding the type of coverage you have please contact your insurance company or ask a member of our front office staff.

Personal checks that are returned for any reason will result in an additional $25.00 fee due to bank fees billed to your account.

I have reviewed the above information and understand that I am financially responsible for any balance in addition to my copay, not covered by my insurance carrier, or any umpaid balance within 30 days of my visit.

Signature_____ Date_____

Relationship_____

I authorize release of any medical information to my insurance carrier necessary for processing of claims.

Signature_____ Date_____

Relationship_____

I authorize payment of medical benefits directly from my insurance carrier to the treating physician for services provided.

Signature_____ Date_____

Relationship_____

NOOSHA SHAHEEDY, M.D.

SHAHEEDY MEDICAL CORP.

2080 CENTURY PARK EAST, STE. 1101, LOS ANGELES, CA 90067
PHONE 310-358-9484 FAX 310-358-9485

CONSENT OF TREATMENT

(PLEASE SIGN ONLY ONE OF THE FOLLOWING TWO STATEMENTS.)

PATIENT'S NAME:_____
DATE OF BIRTH:_____/_____/_____

I AUTHORIZE DR. SHAHEEDY OR A COVERING PHYSICIAN (IF THEY ARE NOT AVAILABLE) TO RENDER ANY MEDICAL TREATMENT NECESSARY TO MY CHILD. IF I AM NOT AVAILABLE AND NO OTHER LEGAL GAURDAIN IS AVAILABLE AT THE TIME MY CHILD IS BROUGHT TO THE OFFICE, I AUTHORIZE IN ADVANCE THAT CARE MAY BE RENDERED IN MY ABSENCE.

ANY RESTRICTIONS TO THE ABOVE STATEMENT:_____
_____
_____

SIGNATURE:_____ **DATE:**_____/_____/_____
PRINT NAME:_____
RELATIONSHIP:_____

OR

I AUTHORIZE DR. SHAHEEDY OR COVERING PHYSICIAN, (IF THEY ARE NOT AVAILABLE) TO RENDER ANY MEDICAL CARE NECESSARY TO MY CHILD. IF I AM NOT AVAILABLE AND NO OTHER LEGAL GAURDIAN IS AVAILABLE AT THE TIME MY CHILD IS BROUGHT TO THE OFFICE I DO NOT AUTHORIZE IN ADVANCE THAT CARE MAY BE RENDERED IN MY ABSENCE. I UNDERSTAND THAT BY SIGNING BELOW THE DOCTORS WILL NOT SEE MY CHILD UNLESS A PARENT OR GAURDIAN IS PRESENT.

SIGNATURE:_____ **DATE:**_____
PRINT NAME:_____
RELATIONSHIP:_____