Southern California Multi-Specialty Center

REGISTRATION FORM: Please Print
Complete All Sections.
Missing information may result in charges billed directly to the patient. PATIENT INFORMATION

Last Name: First Name: M.I.
Also known as or maiden name:
Marital Status: □ Single □ Married □ Other Date of Birth: Age:
Sex: □ M □ Female □ Prefer not to specify Social Security #:
Race: □ Black/ African American □ White/Caucasian □ Native Hawaiian / Other Pacific Islander □ American Indian/ Alaska Native □ Asian □ Unknown □ Other or Prefer not to specify
Ethnicity: □ Hispanic □ Non-Hispanic □ Prefer not to specify
Preferred Language: □ English □ Spanish □ Hmong □ Lao □ Punjabi □ Hearing □ Impaired/Sign □ Vietnamese □ Other □ Prefer not to specify
Preferred Phone #: □ Home □ Cell □ Work
Secondary Phone #: □ Home □ Cell □ Work
Street Address: P.O. Box / Apt. #:
City: State: Zip Code:
E-mail Address:
Employer: Phone #:
Primary Care Physician: Phone #:
Did a Physician refer you or did you choose this office yourself ? □ Physician □ Self
If a Physician, please state who:
Preferred Pharmacy: Phone #:
Pharmacy Location / Cross Streets:

Injury Information- Date of Injury:

Non-Work Related Injury: □ Yes □ No Work Related Injury: □ Yes □ No

IN CASE OF AN EMERGENCY

Emergency Contact: Relationship to Patient:
Home Phone #: Work Phone #:

Southern California Multi-Specialty Center

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Last Name: First Name: M.I.

Insurance Information- Please give your insurance card to the receptionist.

Guarantor information: □ Check here if same as patient
Responsible Party: Date of Birth:

Address *(if different from patient)*: Home Phone #:

Occupation: Employer:

Employer Address:

Primary Insurance-Insurance Company Name:

Subscriber's Name: Subscriber's SS#:

Date of Birth: Group #: Policy #:

Co-Pay: $ Patients relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other:

SECONDARY INSURANCE (IF APPLICABLE)- Insurance Company Name

Subscriber's Name: Subscriber's SS#:

Date of Birth: Group #: Policy #:

Co-Pay: $ Patients relationship to subscriber: ☐ Self-01 ☐ Spouse-02 ☐ Child-03 ☐ Other:

Is this a worker's compensation claim: ☐ Yes ☐ No

Medicare Secondary Reason Code (Must check one if Medicare is Secondary)

- □ 12 Working Aged Beneficiary or Spouse with Employer Group Health Plan
- □ 13 End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
- □ 14 No-fault Insurance including Auto is Primary
- □ 15 Worker's Compensation
- □ 16 Public Health Service (PHS) or Other Federal Agency (Government Research Program)
- □ 41 Black Lung
- □ 42 Veteran's Administration
- □ 43 Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGH-Employers with 50+ Employees)
- □ 47 Other Liability Insurance is Primary (Homeowners)

What is your preferred method of communication for appointment reminders ?

☐ Phone ☐ Regular Mail ☐ Web Portal ☐ Text Message ☐ Do Not Contact

PRIVACY CLAUSE: A person is liable for constructive invasion of privacy when they attempt to capture, any type of visual image, sound recording, or other physical impression of another individual engaging in a personal or familial activity under circumstances in which that individual had a reasonable expectation of privacy. A person who violates these provisions would be subject to a civil fine of not less than $5,000 and not more than $50,000 [California Civil Code, Section 1708.8] Southern California Multi-Specialty Center complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

Patient / Guardian Signature Date

Southern California Multi-Specialty Center

PATIENT MEDICAL HISTORY

Medical History

Date: _____

Patient Name: _____

DOB: _____

Primary Care Physician: _____

Health Problems – Check all that apply

Yes	No		Yes	No	
□	□	Stroke	□	□	Allergies
□	□	Heart Disease	□	□	Kidney Disease
□	□	Heart Attack	□	□	Jaundice/ Hepatitis
□	□	Rheumatic Fever	□	□	High Blood Pressure
□	□	Emphysema	□	□	Cancer
□	□	Tuberculosis	□	□	Back Problems
□	□	Pneumonia	□	□	Arthritis
□	□	Bleeding/ Clotting Problems	□	□	Stomach / Ulcer Problem
□	□	Speech / Hearing Problems	□	□	Diabetes
□	□	Other			
□	□	Blood Transfusions Dates:_____			

Previous Surgeries – Check all that apply

	Date		Date
□ Ear/Nose / Throat	_____	□ Hysterectomy	_____
□ Appendectomy	_____	□ Hernia	_____
□ Eye	_____	□ Hemorrhoid	_____
□ Breast	_____	□ Back / Neck	_____
□ Gallbladder	_____	□ Joints (Hip/Knee)	_____
□ Heart	_____	□ Carotid Surgery	_____
□ Bypass	_____	□ Baloons or stents in blood vessels	_____
If yes, where? _____		If yes, where? _____	

□ Aneurysm Surgery _____

Open □ Yes □ No If yes, where?_____

□ Other Hospitalizations: _____

Family History

□ Heart Disease	□ Cancer
□ Diabetes	□ Stroke
□ High Blood Pressure	□ Other _____

Southern California Multi-Specialty Center

PATIENT MEDICAL HISTORY

Name: _____
Date: _____
DOB: _____

Social History

Do you or have you ever smoked? □No □ Yes If yes how much? _____How long? _____

Do you consume alcohol? □No □ Yes If yes how much? _____How long? _____

Do you use illegal drugs? □No □ Yes If yes how much? _____How long? _____

Do you have piercings? _____

Do you have tattoos? _____

Allergies to Medications: _____

Other Allergies (i.e. Latex, Dye, Food): _____

Current Medications /Prescription or Over the Counter

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy

Name: _____

Address: _____

Phone Number: _____

Southern California Multi-Specialty Center

PATIENT MEDICAL HISTORY

Name: _____

Date: _____

DOB: _____

Are you currently experiencing any of the following?

Constitutional Symptoms

Good general health lately	□ Yes □ No
Recent weight gain	□ Yes □ No
Recent weight loss	□ Yes □ No
Fever	□ Yes □ No
Fatigue	□ Yes □ No

Eyes

Eye disease or injury	□ Yes □ No
Wear glasses / contact lens	□ Yes □ No
Blurred or double vision	□ Yes □ No
Glaucoma	□ Yes □ No

Ears / Nose / Throat / Mouth

Hearing loss or ringing	□ Yes □ No
Earaches or drainage	□ Yes □ No
Chronic sinus problems or rhinitis	□ Yes □ No
Nose bleeds	□ Yes □ No
Mouth sores	□ Yes □ No
Bleeding gums	□ Yes □ No
Bad breath or bad taste	□ Yes □ No
Sore throat	□ Yes □ No
Voice change	□ Yes □ No
Swollen glands in neck	□ Yes □ No

Cardiovascular

Heart trouble	□ Yes □ No
Chest pain or angina pectoris	□ Yes □ No
Palpitation	□ Yes □ No
Shortness of breath with walking	□ Yes □ No
Shortness of breath while lying flat	□ Yes □ No
Swelling of feet, ankles or hands	□ Yes □ No

Respiratory

Chronic or frequent cough	□ Yes □ No
Spitting up blood	□ Yes □ No
Shortness of breath	□ Yes □ No
Difficulty breathing	□ Yes □ No
Wheezing	□ Yes □ No

Psychiatric

Memory loss or confusion	□ Yes □ No
Nervousness	□ Yes □ No
Depression	□ Yes □ No
Insomnia	□ Yes □ No

Gastrointestinal

Loss of appetite	□ Yes □ No
Change in bowel movements	□ Yes □ No
Nausea or vomiting	□ Yes □ No
Frequent diarrhea	□ Yes □ No
Painful bowel movements	□ Yes □ No
Constipation	□ Yes □ No
Rectal bleeding or blood in stool	□ Yes □ No
Abdominal pain or heartburn	□ Yes □ No
Peptic ulcer (stomach or duodenal)	□ Yes □ No

Genitourinary

Frequent urination	□ Yes □ No
Burning or painful urination	□ Yes □ No
Blood in urine	□ Yes □ No
Change in force or strain when urinating	□ Yes □ No
Incontinence or dribbling	□ Yes □ No
Kidney stones	□ Yes □ No
Sexual difficulty	□ Yes □ No
Male - testicle pain	□ Yes □ No
Female -- pain with periods	□ Yes □ No
Female – irregular periods	□ Yes □ No
Female – vaginal discharge	□ Yes □ No

Musculoskeletal

Joint pain	□ Yes □ No
Joint stiffness or swelling	□ Yes □ No
Weakness of muscles / joints	□ Yes □ No
Muscle pain or cramps	□ Yes □ No
Back pain	□ Yes □ No
Cold extremities	□ Yes □ No
Difficulty in walking	□ Yes □ No

Southern California Multi-Specialty Center

PATIENT MEDICAL HISTORY

Name: _____
Date: _____
DOB: _____

Integumentary (skin, breast)

Rash or itching	□ Yes □ No
Change in skin color	□ Yes □ No
Change in hair or nails	□ Yes □ No
Varicose veins	□ Yes □ No
Breast pain	□ Yes □ No
Breast lump	□ Yes □ No
Breast discharge	□ Yes □ No

Neurological

Frequent or recurring headaches	□ Yes □ No
Light headed or dizzy	□ Yes □ No
Convulsions or seizures	□ Yes □ No
Numbness or tingling sensation	□ Yes □ No
Tremors	□ Yes □ No
Paralysis	□ Yes □ No
Stroke	□ Yes □ No
Head injury	□ Yes □ No

Endocrine

Glandular or hormone problem	□ Yes □ No
Thyroid disease	□ Yes □ No
Diabetes	□ Yes □ No
Excessive thirst or urination	□ Yes □ No
Heat or cold intolerance	□ Yes □ No
Skin becoming dryer	□ Yes □ No
Change in hat or glove size	□ Yes □ No
History of dialysis	□ Yes □ No

Hematologic / Lymphatic

Slow to heal after cuts	□ Yes □ No
Bleeding or bruising tendency	□ Yes □ No
Anemia	□ Yes □ No
Phlebitis	□ Yes □ No
Enlarged glands	□ Yes □ No
History of DVT	□ Yes □ No
History of pulmonary embolism	□ Yes □ No
Fam history of clotting/bleeding disorders	□ Yes □ No

Allergic / Immunologic

Skin reaction or other adverse reaction to:

Penicillin or other antibiotics	□ Yes □ No
Morphine, Demerol or other narcotics	□ Yes □ No
Novocain or other anesthetics	□ Yes □ No
Aspirin or other pain remedies	□ Yes □ No
Tetanus antitoxin or other serum	□ Yes □ No
Iodine, Methiolate, or other antiseptic	□ Yes □ No
CT / MRI Contrast	□ Yes □ No

SMOKE FREE ENVIRONMENT

To protect the health, safety, and comfort of patients, employees, and visitors of Southern California Multi-Specialty Center, smoking is not permitted at any owned or leased property of SCMSC.

This policy covers the smoking of any tobacco product, including smokeless tobacco products and electronic cigarettes (regardless of tobacco content), and it applies to both employees and non-employee visitor.

WEAPON FREE ENVIRONMENT

Southern California Multi-Specialty Center strives to maintain an environment free from violence and intimidation. Weapons of any kind are prohibited on all SCMSC owned or leased property. (The only exception is for authorized law enforcement officers.). For this policy, weapons are defined as any implement or tool whose primary function is to cause bodily harm to the person against whom it is used.

NO SHOW /APPOINTMENT CANCELLATION POLICY

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least **24 hours** in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "NO SHOW" and a $35.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand and agree to the above policies.

_____ _____

Patient Signature (Guarantor if patient is a minor) Date

_____

Print Name

PATIENT CONSENT TO PHOTOGRAPHY

The Department of Health and Human Services has established a "Privacy Rule". The Privacy Rule was created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your healthcare information and information about treatment, payment, or healthcare operations, to provide healthcare that is in your best interest. Part of your treatment may include photographs and/or video of your face and other body parts. We may desire to use the photographs and/or video taken of you by our office for treatment, educational, and/or advertising purposes. However, prior to using any photographs and/or video for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

INFORMED CONSENT TO PHOTOGRAPH

I, _____, due hereby give consent to Southern California Multi-Specialty Center
(Legal Guardian / Patient)
to take and/or display photographs and/or video of the face and other body parts. The photographs will be used as part of medical information, educational and/or advertising purposes by Southern California Multi-Specialty Center and may be displayed within the office and/or the office's webpage. The doctors and office staff will protect my personal data, such as name, age and date of birth, from being displayed.

I further understand that if the photograph(s) and/or video are used I do not expect compensation, financial or otherwise, of the use of these photographs and/or video.

_____ _____
Print Name Signature

_____ _____
Witness (Relationship to patient) Date

Southern California Multi-Specialty Center

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and authorize _____ to release healthcare information of the patient named above to:

□ **Dr. Babak Eghbalieh**
□ **Dr. Sammy Eghbalieh**

19950 Rinaldi St. Ste. 101D
Porter Ranch, CA 91326
Fax. (818) 900-6489

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

_____
_____
_____

○ All healthcare information ○ Other

_____
_____
_____

Patient Signature: _____ Date signed: _____