S. RADI SHAMSI, M.D.
GASTROENTEROLOGY • DISEASES OF THE LIVER • DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY

PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION

Legal Name ______________________ Preferred Name ______________

Home Address ______________________ No. ________

City ______________________ State ______ Zip Code ____________

Home No. (   ) ______________________ Work No. (   ) ______________________

Cell No. (   ) ______________________ Fax No. (   ) ______________________

E-mail: ______________________ SEX: ☐ Male ☐ Female

Date of Birth ______________ Social Security No. ______________ Driver's License No. ______________

Employer ______________________ Occupation ______________

Marital Status ____________ Spouse's Name ______________________

PRIMARY
Insurance Co. ______________________ Name of Insured ______________
Relationship to Patient ______________________ Insured's Date of Birth ______________
Insured's Soc. Sec. No. ______________________ Insured's Employer ______________

SECONDARY
Insurance Co. ______________________ Insured ______________
Relationship to Patient ______________________ Insured's Date of Birth ______________
Insured's Soc. Sec. No. ______________________ Insured's Employer ______________

IS MEDICARE THE PRIMARY COVERAGE? ☐ **YES** ☐ **NO**

2021 SANTA MONICA BLVD. SUITE 325-E. SANTA MONICA, CA 90404 TEL: 310.453.0504 FAX: 310.453.0520
E-MAIL: DRSHAMSO@LAGIDOC.COM

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EMERGENCY CONTACTS: Please identify three (3) people with whom the physicians or staff can speak to regarding your medical care, i.e., family member, friend, assistant:

Name________________________________ No. (   ) ____________________________

Name________________________________ No. (   ) ____________________________

Name________________________________ No. (   ) ____________________________

Referring Physician: ____

Referring Physician's Phone Number: No. (   ) ____________________________________

Please list below physicians you see on a regular or annual basis:

Name________________________________ No. (   ) ____________________________

I give permission to share my medical information with above physician: ☐ **YES**☐ **NO**

Name________________________________ No. (   ) ____________________________

I give permission to share my medical information with above physician: ☐ **YES**☐ **NO**

Name________________________________ No. (   ) ____________________________

I give permission to share my medical information with above physician: ☐ **YES**☐ **NO**

DO WE HAVE YOUR PERMISSION TO LEAVE RESULTS AND/OR A DETAILED MESSAGE ON YOUR HOME ANSWERING MACHINE OR WITH ANYONE WHO ANSWERS YOUR HOME PHONE? ☐ **YES** ☐ **NO**

I HEREBY AUTHORIZE ____, M.D., TO FURNISH INFORMATION TO MY INSURANCE CARRIER AND HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF.

I AUTHORIZE YOU TO GIVE ME A REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS

PATIENT'S SIGNATURE____________________________________ **DATE**_____________

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MEDICAL HISTORY

NAME______________________________ AGE_____ DATE_______________

What gastrointestinal problems are you currently having? ______________________

Are you experiencing?

- Indigestion or ulcer pain: ______
- Abdominal pain: ______
- Nausea, vomiting: ______
- Heartburn: ______
- Difficulty swallowing: ______
- Change in bowel habits, constipation or diarrhea: ______
- Blood in the stool: ______
- Change in stool caliber: ______
- Rectal pain or discharge: ______
- Hemorrhoids: ______
- Gas, belching or bloating: ______
- Jaundice: ______
- Food or milk product intolerance: ______

Have you ever had?

- An Ulcer: ______
- Gallstones: ______
- Liver disease or hepatitis: ______
- Blood transfusions: ______
- Pancreatitis: ______
- Ulcerative colitis or Crohns disease: ______
- Colon polyps: ______
- Rectal problems: ______

Have you traveled in the past two years? ______________ Where? ______________

Have you had any antibiotics in the past year: ______________?

Have you had any recent weight loss? ______________

- Weight now: ______
- Weight one month ago: ______
- Weight six months ago: ______
- If yes, any change in appetite: ______

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Please list any past medical problems for which you have been under treatment.

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Please list any medication allergies.

1.____________________ 3.____________________
2.____________________ 4.____________________

Please list any prior hospitalizations or surgeries.

	Year	Problem	Operations	Hospital
1.				
2.				
3.				
4.				

Please list all medications or pills that you take. List everything even if you only take it occasionally.

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

What medications are you allergic to? ______________________________

____

Do you have any other allergies? ______________________________

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Do you have any eye trouble? _____________ Do you have Glaucoma? ___________
Do you have any mouth or throat trouble? ______________________________________
Do you have any trouble with your heart, lungs, or blood vessels? ________________

Heart Murmur: ____
Rapid or irregular heartbeat: ______________________________________
Shortness of breath or trouble breathing: ____________________________
Swelling of ankles or feet: ____
Persistent cough, or coughed up blood: _______________________________
Pain or pressure in chest: ____
Lung disease: ____

Do you have any skin problems? ____
Do you have any fevers or chills? ____
Do you have any trouble with urinary system?_________________________________

Pain, burning, or infection: ____
Blood (red or brown) in urine: ______________________________________
Difficulty passing urine: ____
Difficulty holding urine: ____

Do you have any trouble with bones, joints? _______Bursitis ________ Gout _________
Arthritis _____________Backache ____________________Stiff Neck ____________
Do you have any neurological or muscular trouble? ____________________________

Dizziness, fainting, loss of balance: ___________________________________
Tremor, paralysis, loss of strength: ____________________________________
Headaches: ____
Psychiatric problems: ____

Is there a family history of?

Colon cancer or polyps: ____
Stomach cancer: ____
Other cancers: ____
Gallstones: ____
Ulcer disease: ____
Ulcerative colitis or Chrohn's disease: __________________________________
Other gastrointestinal disorders: ______________________________________

Do you have children? _________ How many? ______ Do they have any medical problems? ____
Do you smoke? ________If yes, How much? _________________ How long? _______
Have you ever smoked? ____________________________ Year quit? ____________
How many alcoholic beverages do you consume per week? _______________________
How many caffeinated beverages do you consume per day? ______________________

NOTICE TO ALL PATIENTS

We feel privileged to care for you and in order to maintain an excellent relationship, we feel that you should be aware of our policies.

As a courtesy to you, our office will submit your claims to your insurance company. If payment for services rendered is not received within sixty (60) days, you will be responsible for payment in full at that time. It will then become your responsibility to follow up with your insurance company.

If the insurance covers only a portion of the charges, you will be responsible for the balance. If you claim is denied, you will be billed for the entire account.

Prior to your procedure date, our office will contact your insurance company to determine eligibility and to request pre-certification if this is required. However, even though eligibility has been established and pre-certification received, it is **not guaranteed that the insurance will pay**. For this reason, **we suggest that you also contact your insurance company and make certain that benefits are available for your planned procedure/test.**

______________________________ ____________________

Signature **Date**

____

Printed name of patient

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OWNERSHIP INTEREST

We hereby inform you that S. Radi Shamsi, M.D. has ownership interest in the 20th Street Surgery Center and Path MD laboratories.

____

Print Name

____

Signature

____

Date

2021 Santa Monica Blvd. Suite 325-E Santa Monica, CA 90404 TEL: 310-453-0504 FAX: 310-453-0520
EMAIL: DRSHAMSI@LAGIDOC.COM

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