SOLOMON FOROUZESH, M.D.
F.A.C.P., F.A.C.R.
INTERNAL MEDICINE RHEUMATOLOGY

PATIENT DEMOGRAPHICS

Last Name: ________________________ **First Name:** ______________________ **MI:** ________________

DOB: ___ ___/___ ___/___ ___ ___ ___ **Sex:** _______ **SSN:** ______________ **Marital Status:** Single/Married/Other

Cell Phone: (____)-_____-________ **Home Phone:** (____)-_____-________ **Email:** ______________________________

Address: _____________________________**City:** __________________ **State:** ________ **Zip Code:** ___________

Reason for this Visit: ____**Illness** ____ **Injury** _____ **Job Related Injury** _____ **Auto Accident** _____ **Personal Injury**

Allergies: ____

Smoking: Yes/No **Frequency:** Heavy/Light **Race:** _____ American Indian or Alaska Native
_____ Asian: Chinese/ Japanese/Korean/Vietnamese
_____ Black or African American
_____ Declined to Disclose
_____ Pacific Islander
_____ White

EMERGENCY CONTACT:
Contact Name: ____________________________ **Relationship to Patient:** ____________________________
Address: _________________ City: _________________ State: _____ Zip Code: _______ Phone: _______________

EMPLOYMENT INFORMATION:
Professional Title: _________________ **Employment Status:** Employed/Unemployed Full/Part **Employer Name:**______________
Address: ____________________**City:** _______________ **State:** _____ **Zip Code:** _______ **Phone:** _____________

MEDICAL INSURANCE INFORMATION

How do you intend to pay: _____ Cash _____ Check _____Medicare ____Medicaid or Medi/Cal
Primary Care Provider: _______________**Referring Provider:** _____________ **Subscriber ID:** _______________
Group No: ____________ **Plan Name:** __________ **Deductible:** __________ **Visit Co-payment:** ________________

If someone other than patient is responsible for payment, please complete this section:
Name of responsible party: ______________________ Phone: __________________
Address: ______________ City: ____________ State: ________ Zip Code: _______

PLEASE SIGN AND RETURN

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

Sign: ____ **Date:** ____________________________________

MEDICAL HISTORY

Please check the conditions that NOW or HAVE EVER applied to you:

YES	NO		YES	NO	
___	___	Heart Murmur or Congenital Heart Disease	___	___	Glaucoma
___	___	Mitral Valve Prolapse	___	___	Arthritis
___	___	Heart Attack or Angina	___	___	Joint Replacement
___	___	Heart Surgery or Heart Disease	___	___	Organ Transplant
___	___	Rheumatic Fever	___	___	Cancer
___	___	Heart Pacemaker/Artificial Heart Valve	___	___	Radiation Treatment
___	___	Abnormal Blood Pressure (High/Low)	___	___	Immunosuppression
___	___	Stroke	___	___	Convulsions or Epilepsy
___	___	Diabetes	___	___	Dizziness or Fainting Spells
___	___	Bleeding Problems or Hemophilia	___	___	Depression, Psychiatric
___	___	Lung problem (COPD, emphysema, bronchitis)	___	___	Venereal Disease
___	___	Asthma or shortness of breath	___	___	AIDS/HIV positive
___	___	Tuberculosis	___	___	Herpes
___	___	Jaundice or Liver Disease	___	___	Headaches
___	___	Hepatitis	___	___	Sinus Trouble
___	___	Kidney Diseases	___	___	Recent Weight Loss
___	___	Ulcers, stomach or intestinal problems	___	___	Pregnant or Planning to be
___	___	Thyroid Disease	___	___	Other: ___________

MEDICATION LIST

Date	Medication	Dosage	Number