Dr. Gholam R. Mohammadzadeh, M.D. 77 Rolling Oaks Drive Suite 202 Thousand Oaks, CA 91361
Phone (805) 379-6717 Fax (805) 379-6719

PATIENT REGISTRATION INFORMATION

NAME: ____DATE OF BIRTH: _________________

ADDRESS: ____

CITY: _______________________________________ STATE: __________ ZIP: _______________

CELL PHONE: ____

HOME PHONE: ____

EMERGENCY CONTACT: __________________________________PHONE: _________________

EMAIL: ____

PRIMARY CARE PHYSICIAN: ____

HOW DID YOU HEAR ABOUT US?

- ☐ Referral by Dr. _____________________________________
- ☐ Google
- ☐ Yelp
- ☐ Friend

PHARMACY NAME:_________________________________ PHONE #_____________________

PHARMACY ADDRESS: ____

ALLERGIES: NONE ☐____

CURRENT MEDICATIONS AND DOSAGE (INCLUDE STRENGTH): NONE ☐

- __________________________________ ____________________________________
- __________________________________ ____________________________________
- __________________________________ ____________________________________
- __________________________________ ____________________________________

Patient Name: ____

DO YOU HAVE AN ARTIFICIAL DEVICE? ☐ NO ☐ YES _________________________________

DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS:

If yes, please explain:

____

____

- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Blood Clots/DVT
- ☐ Bowel Disease
- ☐ Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack/Stroke
- ☐ High Cholesterol
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurologic Disorder
- ☐ Osteoporosis
- ☐ Seizures/Epilepsy
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Other

PAST SURGERIES:

1. ____ When: ____________________
2. ____ When: ____________________
3. ____ When: ____________________
4. ____ When: ____________________

Patient Name: ____

PLEASE LIST FAMILY HISTORY OF ANY MEDICAL PROBLEMS:

____

____

ARE YOU CURRENTLY WORKING? YES ____ NO ____ IF YES, HOW MANY HOURS/WEEK? ______

IF NOT, ARE YOU RETIRED ____ DISABLED ____ SICK LEAVE ____ STAY AT HOME ____

OCCUPATION: ____

HOW MUCH EXERCISE PER WEEK? _________ WHAT KIND OF EXERCISE? ___________________

SMOKER?

- ☐ YES IF YES, HOW MANY PACKS PER DAY? _________________________
- ☐ FORMER SMOKER WHEN DID YOU QUIT? ____________________________________
- ☐ NO

DO YOU DRINK ALCOHOL?

- ☐ YES If yes, how often? ____
- ☐ NO

MARITAL STATUS:

- ☐ NOT MARRIED
- ☐ SINGLE
- ☐ MARRIED
- ☐ DIVORCED
- ☐ WIDOWED

DO YOU HAVE CHILDREN?

- ☐ YES, HOW MANY? _______ Do your children live with you? _______
- ☐ NO

Patient Name: ____

You will receive a confirmation call from our office the day before each appointment. Appointments without confirmation are subject to cancellation. It is our policy that we require a return call from the patient to confirm all appointments. Please make sure to provide accurate contact information and report any changes as soon as possible. Please provide our office with at least 24-hour notice should you need to cancel or reschedule your appointment. If you cancel an appointment without giving advanced notice, you will be charged a $50 missed appointment fee. We require 5 days' notice for cancellations of medical procedures.

If you have an insurance policy that requires an authorization or referral from your Primary Care Physician, it is your responsibility to obtain one. Please make sure you have a valid referral. I hereby authorize Dr. Mohammadzadeh and staff to release any information in my chart to any practitioner, doctor, or hospital to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, or medical institution to assist in my care.

Our provider will not be able to provide care for any patient who declines to sign the Privacy Practices Financial and HIPAA consent forms.

All requests for medical records made by another healthcare provider will be faxed to the requesting provider at no charge. Patient requests for medical records will incur a $25 charge for a copy.

By signing this form, I agree to be contacted by phone, text, or email as needed for patient correspondence and appointment reminders. I am allowing a staff member to take photos of my treatment and or treated areas for the purpose of monitoring my progress.

☐ I give permission for photographs and/or video to be used anonymously for advertising purposes.

For all billing related questions please call our billing office at 805-980-3040. We accept cash (please have exact change), check, Debit, Visa, Mastercard and American Express. Payments may be made over the phone by calling the office.

I certify that all information above is true and correct to the best of my knowledge.

SIGNATURE: ____Date: ____________________

PRINT NAME OF PATIENT OR LEGAL REPRESENTATIVE: ___________________________________

Patient Name: ____

Gholam R. Mohammadzadeh, M.D. Inc.

77 Rolling Oaks Drive Suite 202 Thousand Oaks, CA 91361

Phone (805) 379-6717 Fax (805) 379-6719

I, ____ authorize the release of my protected health information including results of my laboratory tests, x-rays, appointments and/or other test results to the following designated representative(s).

Patient Initials

______ My Spouse (Name) ____________________________________

______ My Child (Name) _____________________________________

______ Other (Name) ____

______ ____

______ May not be given to anyone other than myself

PRINT Patient's Name: ____

Signature: ____ Date: _________________

This authorization shall be valid for one year from the date of signature above unless revoked in writing by the patient prior to that expiration. As a patient, you have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. All revocation must be given in writing.