PATIENT INFORMATION SHEET

Date:______________________________ E-Mail Address:__________________________________

First Name:________________________ M.I.________ Last Name:_________________________

Address:____
(please include: street, apt #, city, state, zip)

Social Security #______-______-_______ DOB_____(m)_____(d)_____(y)

Emergency Contact:_____________________ Relationship:______________ Phone #_________

Employer Company:_________________________ Employer Phone #:______________________

Occupation:___________________ Race:___________________ Ethnicity:____________________

Sex:_____ Marital Status:_________ Home #__________________ Mobile #________________

*Who can we thank for referring you?*______________________________________

Do you have an advance directive or power of attorney?__________________________________
If so, please supply our office with a copy.

Please check off all the services that are of interest to you

- [ ] Botox
- [ ] Anti-Aging
- [ ] Body Sculpting
- [ ] Weight Management
- [ ] Stop Smoking
- [ ] Allergy Testing
- [ ] Filler
- [ ] Cellulite Reduction
- [ ] Hair Regeneration
- [ ] Lip Augmentation
- [ ] Double Chin
- [ ] Laser Hair Removal
- [ ] Micro-Needling
- [ ] Facial Veins
- [ ] Sunspot Removal
- [ ] Skin Tightening
- [ ] Skin Resurfacing
- [ ] Wrinkle Reduction
- [ ] Scar Removal
- [ ] Skin Care Products
- [ ] PRP(Platelet Rich Plasma)
- [ ] Acne/Rosacea
- [ ] Vaginal Rejuvenation
- [ ] Stretch Mark Removal

PATIENT PRELOAD QUESTIONNAIRE

Do you want the best care?
If so, please fill out the following information carefully. This form only needs to be completed once so we can enter the information in our electronic medical records. If you have already completed this form, you do not need to fill it out again.

Date:____________________

Name:_______________________________ DOB_____(m)_____(d)_____(y)

Emergency Contact Name and Phone #:____

Pharmacy:
Preferred Pharmacy:________________________________ Pharmacy Phone#:_________________

Pharmacy Address: ____

Immunizations:
Do you know when you received your last vaccine?

Flu:_________________________ Tetanus:_____________________ Pneumonia:_______________

We will need a copy of your immunization card for your chart

Chronic Illness/Medical Conditions:
List any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, etc?

____

____

____

____

Past Surgeries and/or Hospitalizations:
List any surgeries and/or hospitalizations and dates if known.

____

____

____

____

Medications and Supplements:

Are you currently taking any medications or supplements? ☐YES or ☐NO
Please list ALL medications and/or supplements OR bring a copy to your visit.
If YES, please list all medications and dosage, if known. If more space is needed please continue on the back of this page.

Medication Name	Dose	Directions

Allergies:

Are you allergic to any medications? ☐YES or ☐NO

Allergy	Reaction

Family History:

2840 E Los Angeles Avenue, Simi Valley CA 93065
Office: 805.526.8360 Fax: 805.526.1438
SimiDoctor.com Incoming Paperwork: forms@simidoctor.com
@simidoctor @simidoctors @simidoctor

Has anyone in your immediate family (biological mother, father, brother, sister) had any major illness? List parents or siblings next to each diagnosis.

Family Member	Diagnosis	Family Member	Diagnosis
	ADD/ADHD		High Blood Pressure
	Alcoholism		Mental Illness
	Alzheimer's Disease		High Cholesterol
	Anxiety		Obesity
	Heart attack		Osteoporosis
	Cancer Type:		Kidney Disease
	Depression		Seizure Disorder
	Diabetes		Stroke
	Blood Disease		Sleep Apnea

Any additional Family History:

____

____

____

____

Social History:

Employer:_________________________________ Occupation:__________________________

Do you use Tobacco (ie. cigarettes, cigar, vape, chew): ☐YES or ☐NO
What type of Tobacco? (Be honest, no judgement) _____________________________________
How many times a day do you use tobacco? (Be honest, no judgement) ____________________

Do you drink alcohol: ☐YES or ☐NO
What type of Alcohol? (Be honest, no judgement) ______________________________________
How many times day/week? (Be honest, no judgement) _________________________________

Do you use any illicit drugs: ☐YES or ☐NO
What type of drugs? (Be honest, no judgement) _______________________________________
How often are you using? (Be honest, no judgement) ___________________________________
***This is ALSO to notify you that if one of our employees is exposed to your blood you are giving us permission to test your blood for HIV, Hep B and Hep C.

Do you use Marijuana: ☐YES or ☐NO
What type of Marijuana (i.e. flower, edibles, tincture)? __________________________________
How often are you using? (Be honest, no judgement) ___________________________________
Is it during the day or night?____

Health Maintenance:

Date of last physical exam?____

When was your last blood test?____

When was your last colonoscopy?____

When was your last bone density/osteoporosis test?____________________________________

Women only:

When was your last pap smear?____

When was your last mammogram?_______________________________________

RESPONSIBLE PARTY INFORMATION

Insured Name:______________________________

Address:____
(please include: street, apt #, city, state, zip)

Insured DOB:_____(m)_____(d)_____(y) Insured Sex:________

Insured Social Security #______-______-_______

Insured Employer:_______________________ Group #_________________ Plan:___________

Name of Insurance:______________________________

Address:____
(please include: street, apt #, city, state, zip)

WE WILL NEED A COPY OF ALL YOUR INSURANCE CARDS FOR YOUR CHART.
PAYMENT OF CO-PAYS AND CO-INSURANCE ARE DUE AT THE TIME OF SERVICE

ASSIGNMENT OF BENEFITS

I hereby assign to Simi Doctors Medical, aka Daniel Ghiyam, M.D. all payments for medical services rendered.

I understand that all checks will be made payable to the Simi Doctors Medical or Dr. Daniel Ghiyam.

A photographic copy of this authorization shall be as valid as the original.

Date Signed:______________________________

Patient Signature:__________________________

Print Name:______________________________

Relationship to Patient:____________________

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A NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- "The open payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice* of *Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice* of *Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Date Signed:_____________________________

Patient Signature:_________________________

Print Name:______________________________

Relationship to Patient:____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

MEDICAL COMMUNICATION RELEASE

Date:___________________________

I, ________________________________ hereby authorize ________________________________

who is my ____, to have access to my medical

information should the need arise.

This notice is giving my medical providers at Simi Doctors Medical permission to speak either via phone or in person about my medical treatment including medications and test results. I do understand that this is not a power of attorney or medical directive, this is only allowing the above named patient information to be released.

This notice will remain in effect until I, in writing, stop this authorization.

Date Signed:____________________________

Patient Signature:_________________________

Print Name:_____________________________

Relationship to Patient:___________________

Witness Name:___________________________

Witness Signature:________________________

Date Signed:____________________________

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