DR. AZAM SHAMANI

PATIENT REGISTRATION FORM

5555 Reservoir Dr. Ste. 312
San Diego, CA, 92120

PATIENT INFORMATION:		
Name:	DOB:	Age:
Primary Phone Number: Secondary Phone Number:	Email Address: SSN:	
Address: ZIP:	City:	State:

INSURANCE INFORMATION:			
Primary Insurance:	ID Number:		
Secondary Insurance:	ID Number:		
POLICY/ SPONSOR First & Last NAME:	**DOB:**	**SSN(TRICARE HOLDERS):**	**Relationship:**

EMERGENCY CONTACT :			
Name of local friend or relative:	Relationship to patient:	Home Phone Number: ( )	Work/Cell phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I also authorize Dr. Azam Shamani or Insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

Do you Smoke? (Circle) Yes No

Quantity of Cig/Day: Length of time you have been smoking: Former Smoker? Date of last Cigarette (year):

Alcohol History:
Preferred Language:
Advance Directive:

SURGERIES

Pharmacy Information
Pharmacy Name:
Pharmacy Zip Code:

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Personal History	
Conditions that you currently have, or Symptoms you have been experiencing frequently in the past year. Such as Back Pain, Joint Pain, Digestive Complications.	
Condition or Symptom:	**Frequency and Concern of Condition or Symptom:**
Allergies IE: Seasonal, Peanuts, Shellfish	

Last Menstrual Cycle: _____

Are you Sexually Active? (Circle) Yes No How many Partners in the last 12 months:

Marital Status: **Occupation:**

Family Environment (e.g. live with spouse, caregiver etc.):

Family History:

Do any **family members** have any of the following Conditions?

Diabetes Yes No Type 1: ___ Type 2: ___ Relation: _____

Cancer Yes No (Survivor? _____) Relation: _____ Type: _____ Age: _____

High Blood Pressure Yes No Relation: _____

Heart Attack Yes No Relation: _____ Age: _____

Stroke Yes No Relation: _____ Age: _____

Asthma Yes No Relation: _____

Mental Illness Yes No Relation: _____

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Preventive Screenings	
Dates and Results of most recent screenings you have received.	
Screening:	**Date and Result (I.E. Normal, Abnormal):**
Physical Exam: (All Ages):	
STD Check: (If active sexually):	
Pap Smear WWE: (21+):	
Mammogram: (40+)	
Colonoscopy: (50+)	
Eye exam: (50+)	
Bone Density Scan (DEXA): (65+)	
Diabetic Foot Exam: (Indicated)	
Diabetic Eye Exam: (Indicated)	
Vaccines: Are you behind on your vaccine schedule? _____	Flu Shot: _____ (Yearly) Pneumonia Shot: _____ (Age 50+) Covid _____ T-Dap: _____ (10 Years) Shingles Shot: _____ (Age 65+) (Tetanus)

Medication Information		
Medication Name and Strength/dosage:	**Times taken Per day**	**Length of time on Medication**

Previous Primary Care:

Specialists involved with care:

Patient Financial statement and agreement of Financial Responsibility and notification of **POTENTIAL** in office fees:

No-Show Appointment Fee: $35.00

Unless 24-hours' notice is given regarding cancellation or time change of appointment.

Form Fee Filing Fee: $30.00

School/Work/DMV physical forms as well as certain letters or evaluations.

As the patient I fully understand and agree to the following terms of service with DR. A. SHAMANI INC.:

1.) I, as the patient, am ultimately responsible for knowing and being aware of my/ my beneficiary's insurance coverage and status. Additionally, I will provide the office with any additional insurance information that I may have at the time. If none is given to the office at the time; I will be responsible for the charges unpaid by secondary/primary insurance plan.

2.) I am aware that my insurance plan may or may not fully pay for all charges filed; and accept the left over/unpaid amount to be my responsibility as stated on insurance EOB.

3.) I will notify the office at the time of new insurance coverage/changes to my policy and provide them with sufficient/acceptable documentation of such changes. (ID number change / change of carrier / insurance status.)

4.) I as the patient am ultimately responsible for knowing the contractual agreement held between myself and my insurance company; including deductible, co-insurance, and co-payment due to the office as well as limitations set by the contract agreed upon with my Insurance carrier.

5.) I understand that DR. A. SHAMANI INC. as a courtesy may verify insurance coverage and benefits. However, if a service was rendered that was medically necessary or agreed upon with physician at the time is denied/not covered; I will accept the fees as listed on my EOB as my total responsibility and pay in full within reasonable time period

6.) If I do not furnish payment to the office within a 90-Day time period from the date of office notification of non-payment or receipt of Insurance EOB. I understand that they may send me/my beneficiary to an outside collections agency that may alter or cause a negative influence on my credit score.

7.) I will follow with payment plans agreed upon by myself/beneficiary and DR. A. SHAMANI INC.; in the event that I am delinquent or non-compliment they also reserve the right to send me to collections with a reasonable fee attached to the remaining unpaid amount. Additionally, if any of my payments are returned to the office (IE. Checks/Recurring payment plan) I will be charged an additional $12.00 fee per transaction unsuccessful in accordance to the costs DR. A. SHAMANI INC. may face such events.

By signing below, I am agreeing to the preceding terms and conditions and fully understand the entirety of the agreement.

Patient Signature: **Date:**