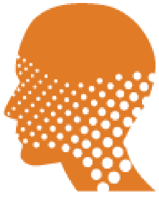

Jahangir Sharifi, M.D.

Ears, Nose, and Throat

Patient Information

Date:

Name:	DOB:	Gender: M / F	Social Security #:
Home Tel#:	Cell #:	Email:	
Address:	City:	State:	Zip:
Employment:	Occupation:		
Emergency Contact Name:	Tel#:	Relationship to Patient:	
Other Contact Name (If Minor, Parent/ Guardian):	Tel#:	Relationship to Patient:	

Referring Physician:

Physician Name:	Tel #:

Reason for Visit: ____

____

____

Patient Medical History: (*please check the ones that apply*)

□ Diabetes □ Stroke □ Asthma □ Gastritis □Heartburn □ Migraine	□Hepatitis □ HIV □ Anxiety □ Depression □Hemophilia □ Anemia	□ Hypo-Thyroid □ Hyper-Thyroid □ Kidney Problems □ High Blood Pressure □ Heart Attack □ High Cholesterol	Cancer: (Type) Other:

Surgery History:

Surgery:	Date:	Hospital:	Surgeon:

Family Medical History:

□ Hearing Loss	Which Family Member:
□ Migraines	Which Family Member:
□ Thyroid Problems	Which Family Member:
□ Cancer:(Type)	Which Family Member:
□ Other	Which Famlily Member:

Current Medications:

1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Allergies:

Medications:	Food:

Pharmacy:

Pharmacy Name:	Tel #:
Address:	

Social History:

Tobacco:	Yes/ No	How many years?	What year did you quit?	How many cigarettes per day?
Alcohol:	Yes/ No	□Beer □ Liquor □ Wine	How many drinks per week?	
Drug Use: (Marijuana, Etc.)	Yes/ No	If yes, what type?		

Insurance Information/Aseguranza:

Primary:	Secondary:
Responsible party for payment:	

J. Sharifi M.D., Inc.

NOTICE TO CONSUMERS
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(800) 633-2322
www.mbc.ca.gov

Policy Signatures:

I acknowledge that I have read and accepted the practice's Privacy Policy.

Reconozco que he leido y aceptado la politica privada de la practica.

Patient or guardian signature X____

I authorize payment of medical and surgical benefits to J. Sharifi M.D.

Autorizo pago de beneficios medicos y quirurgicos a J. Sharifi M.D.

Patient or guardian signature X____

Please note: You will be billed a cancellation fee of $20 (which is NOT covered by your insurance) if you fail to show for any scheduled appointment without cancelling or rescheduling within 24 hours prior to your appointment time.

I have read the above statement and agree to pay such fee if this situation should occur.

Por favor note: Usted sera responsable de pagar una tarifa de $20 (No lo cubre la aseguranza) si falla a su cita sin cancelar 24 horas antes del tiempo de su cita.

He leido y estoy deacuerdo de pagar si esta situacion ocurre.

Patient or guardian signature X____

Patient name (Print): ____

Patient guardian/Legal representative name (Print):_________________________________

Date: _________________