NEW PATIENT DOCUMENTS

Raymond M. Shaheen MD, FACS, RPVI, RPhS

P: 650-965-1909 F: 650-965-1944

305 South Dr. Suite 7
Mountain View CA 94040

835 Cass Street
Monterey, CA 93940

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Emergency Contact: _____ Phone: _____

Pharmacy: _____ Pharmacy Phone Number: _____

☐ Male ☐ Female Referred By: _____

Occupation: _____

PRIMARY INSURANCE

Insurance Company: _____ ID #: _____

Group #: _____ Subscriber #: _____

Name on Account: _____ Relation: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ADDITIONAL INSURANCE

Insurance Company: _____ ID #: _____

Group #: _____ Subscriber #: _____

Name on Account: _____ Relation: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Raymond Shaheen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ **DATE:** _____

GENERAL HEALTH QUESTIONNAIRE

Primary Doctor:_____ Phone:_____

Chief Complaint(s):

□ Swelling □ Hotness/Coldness □ Cramps □ Redness
□ Pain □ Sores/Wounds □ Varicose Veins
□ Tingling Sensation □ Bruising/Discoloration □ Numbness or Weakness
□ Other:_____ □ Other:_____
□ Other:_____ □ Other:_____

History of Present Illness:

Severity of Present Symptoms (1 as lowest intensity, 10 as highest discomfort):

1 2 3 4 5 6 7 8 9 10

Longevity of Present Symptoms: Symptoms have been bothering me for:

□ Less than 6 mo □ More than 6 mo □ One Year □ More than 1 year (if so, specify):_____

How have you tried to manage your symptoms?:

□ Compression Therapy □Medication:_____ □Other:_____

What Daily Living Activities Do Your Symptoms Inhibit?

□Work □Walking/Sitting for Periods of Time □Exercise □Sleeping □Other: _____

Review of Systems:

Constitutional
☐ Fatigue ☐ Fever ☐ Recent Weight Change

Gastrointestinal
☐ Nausea/Vomiting ☐ Abdominal Pain
☐ Constipation ☐ Diarrhea

Eyes
☐ Eye Disease ☐ Wear Glasses/Contacts
☐ Blurry/Double Vision

Ears/Nose/Throat
☐ Hearing Loss ☐ Change in Voice
☐Ringing in Ears

Genitourinary
☐ Frequent Urination ☐ Blood in Urine
☐ Impotence

Cardiovascular
☐ Palpitations ☐ Chest Pain/Tightness
☐ Syncope/Fainting

Respiratory
☐ Chronic Cough ☐ Shortness of Breath
☐ Wheezing

Neurological
☐ Seizures ☐ Paralysis
☐ Numbness/Tingling
☐ Headaches

Musculoskeletal
☐ Arthritis ☐ Back Pain

Vascular
☐ Leg Pain with Walking ☐ Pain in Toes at Rest

Skin
☐ Rashes ☐ Lesions/Wounds

Psychiatric
☐ Memory Loss ☐ Depression/Anxiety

Past Medical History:

□ High Blood Pressure
□ Irregular Heart Rhythm
□ Heart Attack
□ High Cholesterol
□ Lung Problems (Specify): _____
□ Stroke
□ Seizure OR Epilepsy
□ Diabetes
□ Kidney or Bladder Problems (Specify): _____
□ Liver Problems or Hepatitis (Specify): _____
□ Cancer (Specify): _____
□ Blood Clot or Embolus
□ Abnormal Bleeding/Bruising
□ Thyroid Problems (Specify): _____
□ Rheumatoid Arthritis
□ Serious Depression
□ Other Psychiatric Illness: _____
□ Alcoholism
□ Headaches
□ Other (Specify): _____

Past Surgical History:

□ Surgery: _____ Year(s):_____
□ Surgery: _____ Year(s):_____
□ Surgery:_____ Year(s):_____
□ Surgery: _____ Year(s):_____
□ Surgery: _____ Year(s):_____

Family History:

□ Heart Disease
□ Lung Disease
□ Stroke
□ Varicose Veins
□ Serious Mental Illness
□ Alcoholism
□ Rheumatoid Arthritis
□ Blood Clots
□ Liver Disease
□ Kidney Disease
□ Diabetes
□ Vascular Disease
□Cancer (Specify):_____ □ Other (Specify):_____

Social History:

□ Alcohol Duration/Amount/Frequency:_____
□ Smoking Duration/Amount/Frequency:_____
□ Other (specify):_____

Medications (with dose and directions):

□_____ □_____
□_____ □_____
□_____ □_____
□_____ □_____
□_____ □_____

Allergies (Specify):

☐_____ ☐_____

☐_____ ☐_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of service and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep you medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the charges.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians and medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in caring for you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Printed Name:_____ Date of Birth:_____

Signature:_____Date:_____