WELCOME TO OUR OFFICE

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Internal Medicine
Associate Professor of Medicine

Erenee Sirinian, D.O.
Internal Medicine

TODAY'S DATE

Thank you for choosing our office.

In order to serve you properly we will need the following information. (Please Print.) All information will be strictly confidential.

Patient's Name	Birthdate	Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence Address Apt # City State Zip		Home Phone
E-mail Address		Cellular Number (if applicable)

Social Security Number	**Race**	**Ethnicity**	
	Black or African American White	Hispanic or Latino Non Hispanic or Latino	
Nationality Language	Asian American Indian/Alaskan Native Hawaiian/Pacific Islander Refuse to Answer	Refuse to Answer	Occupation
Name of Employer	Work Address		Business Phone

Communication Preference

☐Phone ☐US Mail ☐Email

Name of Spouse	Address	Phone Number
Do you have an advanced directives? ☐Yes ☐No	Employment Status Employed Unemployed Retired Full-time Student Part-time Student	
Nearest friend or relative not residing with you	Relationship to Patient	Phone

Who may we thank for referring you? Address

What is your chief complaint?

Pharmacy Name/Address/Phone

If no e-mail address, or if you would like to designate a family member to have access to your health records, please indicate who:

Designated Proxy Name:	**Relationship:**	**Address**
Phone Number	**Birthdate:**	**E-mail**

This document appoints the above person or person who is authorized by the patient to receive your information and releases Tilahun Sirinian Medical Group for any liability for sharing the information.

Patient, Parent/Guardian Signature Date

Please see opposite side*

AUTHORIZATION

I. General Consent To Treatment:

I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

II. Release of Information:

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party named on this patient information form (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes, I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

III. Assignment of Insurance or Third Party Coverage

A. I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.

B. I authorize assignment to the physician who has provided services to the patient the insured's rights to penalties and attorney's fees in the event that the insurer fails to timely pay such benefits.

IV. Acknowledgement of Responsibility to Pay For Services

I understand that the physician will, as a courtesy, file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payor unless there is a specific written agreement between the physician and the patient or between the physician and the payor.

V. Medicare Patients

I request that payment of authorized Medicare benefits be made either to me or on by behalf _____ for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

DATE PATIENT'S SIGNATURE

PATIENT PAST AND PRESENT MEDICAL PROBLEMS

Note: Please complete all information. All information is confidential and will not be released unless you grant permission.

Check ( ) all items either yes or no and give approximate date if illness is past.	No	Yes Now	Yes Past	If Past, Date?
Asthma				
Abnormal E.K.G.				
Angina				
Anemia (Type)				
Arthritis				
Blindness Either Eye				
Broken Bones				
Cataracts				
Chronic Bronchitis/Lung Disease				
Cirrhosis of Liver				
Colon or Bowel Trouble				
Deafness				
Dysentery				
Diabetes				
Ear Infections				
Emphysema				
Enlarged Heart				
Glaucoma				
Gallstones				
Gout				
Goiter				
Gonorrhea				
Hay Fever				
Heart Murmur as Adult				
Heart Attack				
High Blood Pressure				
Hepatitis				
Hemorrhoids				
Kidney Infection				
Kidney Stones				
Nervous Breakdown				
Poor Blood Clotting				
Polio				
Phlebitis				
Rheumatic Fever				
Rectal Trouble				
Recurrent Boils				
Stroke				
Stomach or Duodenal Ulcer				
Syphilis				

Check ( ) all items either yes or no and give approximate date if illness is past.	No	Yes Now	Yes Past	If Past, Date?
Skin Disease				
Serious Depression				
Serious Emotional Problems				
Tuberculosis				
Thyroid (Overactive)				
Thyroid (Underactive)				
Varicose Veins				
MEN				
Prostate Problems				
WOMEN				
Menstrual Difficulties				
Cystitis				
Ovarian Cyst				
Breast Cancer				
Other Breast Disease*				
History of STD				

Last Pap Smear

Abnormal Pap Smear

Age Period Began _____

Age Period Stopped _____

Why Period Stopped _____

Number of Pregnancies _____

Number of Children _____

Number of Miscarriages _____

*Explain:

Hospitalizations/Reason Date:

Do you wear artificial devices? Yes No

Please List

Do you have allergies? Yes No

Please List