Marco M. Zahedi M.D., M.P.H.
1200 N. Tustin Ave #120
Santa Ana, CA 92705

New Patient Intake Form

Name:____Today's Date:____________
First Middle Last

Home Address:____
City:______________________________________State:________Zip:_________________
Home Phone ( )______________________Cell Phone ( )__________________________
Birth date:_________________Age:_______Sex:___________SSN:_____________________
Email ____

Employer:____
Employer's Address____
City:__________________State:_____Zip:_________Occupation:____________________
Work Phone ( )________________________

Primary Insurance
Name of Insurance Company: ____
Address:____
City:_____________________________________State:____________Zip:_______________
Insured's Name: ____
Group Number:____________________Policy ID Number: ______________________________

Preferred Pharmacy
Name:____
Pharmacy Address: ____
City:__________________State: ____________ Zip: __________________

Consent to Treat
I (or my legal guardian or parent) authorize Marco M. Zahedi, MD, to provide medical care reasonable by today's standards.

Signature of Patient/Legal Guardian:________________________________Date:_________

Reason for Visit____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Condition	
Abnormal Pap Smear	
Acne	
ADD/ADHD	
Alcohol Abuse	
Anemia	
Anxiety Disorder	
Asthma	
Bipolar Disorder	
Blood Clot	
Blood Transfusion	
Cancer (What kind)	
Chronic Bronchitis	
Crohn's Disease or IBS	
Colon Polyps	
Depression	
Diabetes	
Diverticulitis	
Drug Abuse	
Eating Disorder	

Condition	
Eczema	
Emphysema	
Frequent UTI's	
Freq Sinus Infections	
Gallstones	
Glaucoma	
Gout	
Heart Attack	
Heart Condition (specify)	
Hepatitis (specify A, B, C)	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Kidney Infections	
Kidney Stones	
Lupus	
Melanoma or Skin Cancer	
Migraines	
Osteoarthritis	

Condition	
Osteopenia	
Osteoporosis	
Positive TB Skin Test	
Prostate Problems	
Psoriasis	
Reflux (heartburn)	
Rheumatoid Arthritis	
Rosacea	
Seasonal Allergies	
Seizures	
Sexually Trans. Disease (specify)	
Stomach Ulcers	
Stroke	
Tuberculosis	
Thyroid Disease	
Ulcerative Colitis	
Warts	

Other medical problem not on list:____

Please check or list all of the **SURGERIES** you have had:

	Type of surgery:	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of surgery:	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Mastectomy/Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications: (please include over the counter medications and food supplements)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

NAME: ______________________

Health Maintenance:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /
Last colonoscopy	/ /

Last tetanus shot	
Last flu shot	
Last pneumonia shot	
Age of first period	
Are you menopausal	Y N

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

If you have any children, please list ages: ______________________________

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member:
	Heart Disease/attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family Member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Any other illness in the family not listed? ______________________________

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed
Highest Level of Education: Jr. High, High School, College Graduate school, Professional
Occupation:______________________________

Health Habits:

1. Do you **smoke currently**? **Yes** **No** If so, how much? Cig/d_______# of years smoking _____
   If no, did you smoke in the past? **Yes** **No** How many years? __ How much?_____ Quit date _____________
   Are you exposed to smoke? **Yes** **No**
   Any **other** tobacco use? **Yes** **No** Type: Cigars chewing tobacco snuff other
2. Do you drink **Alcohol?** **Yes** **No** What kind? Beer Wine Liquor Other:_____________
   If so, how many drinks per week?________month?________year? __________
   Have you ever had a social or legal problem with alcohol? **Yes** **No**
3. Have you ever used **Street Drugs?** **Yes** **No**
   Which ones? Marijuana IV drugs Amphetamines Cocaine Heroin Downers Inhalants Other
   Are you still using? **Yes** **No** Which ones? _____
4. Have you been **Sexually Active** in the last year? **Yes** **No**
   Please circle all that apply: 1 Partner Multiple Partners
   Sexual Orientation: Heterosexual Homosexual
   Which birth control do you or your partner use? None Condoms The pill Vasectomy/Tubal other_________
5. Do you **exercise**? **Yes** **No** If so, what type and how often?_______________________
6. Do you have an advanced medical directive? **Yes** **No** If yes, please provide a copy to Dr. Zahedi.

NAME: ______________________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

X ______________________________
Patient's or Patient Representative's **Initials**

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________ ____________
Physician's or Authorized Representative's Signature (Date)

By: ______________________________ ____________
Patient's or Patient Representative's Signature (Date)

By: ______________________________
Print Patient's Name

____
Print or Stamp Name of Physician, Medical Group or Association Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I,____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

____

In effort to protect our patient's health, we are requesting that all patients read over this consent form and sign it prior to being seen By Marco M. Zahedi, MD.

- I currently do not have any flu like symptoms
- I currently do not have any health-related concerns to the Novel Corona Virus 2019 (COVID-19)
- Cough
- Fever
- Shortness of breath
- I have not traveled Outside the United States in the last 2-3 months.
- To my knowledge, I have not had exposure to any confirmed positive COVID-19 patients.

Furthermore, I understand with the rapidly evolving global pandemic, the CDC has advised for people to practice social distancing and isolation, unless deemed necessary. I understand that my appointment today was elective, (not a sick visit), I was given the opportunity to reschedule for Tele-med or for future appointments. By singing this document I attest, I was given an opportunity to ask any questions or making any changes to my visit. I hereby release Marco M Zahedi, MD; Ageless Life Institute staff and specific technicians from any liability associated with the Novel Corona Virus 2019 (COVID-19).

Patient name (PRINT): ______________________________

Patient Signature: ______________________________

Date: ____________________