Marco M. Zahedi M.D., M.P.H.
1830 E. Commercenter Dr
San Bernadino, CA
92705

Formulario de Paciente Nuevo

Nombre:_____ Fecha de Hoy:_____
Primer Segundo Apellido

Domicillo:_____
Cuidad:_____ Estado:_____ Codigo Postal:_____
Numero de Telefono Casa ( )_____ Cellular ( )_____
Fecha de Nacimiento:_____ Edad:_____ Sexo:_____ SSN:_____
Correo Electronico: _____

Empleador:_____
Domicillo de Empleador:_____
Cuidad:_____ Estado:_____ Codigo Postal:_____ Ocupacion:_____
Numero de Telefono de Empleador ( )_____

[Informacion Sobre su Aseguranza]
Nombre de Aseguranza: _____
Domicilio:_____
Cuidad:_____ Estado:_____ Codigo Postal:_____
Nombre del Miembro/a: _____
Numero de grupo del Miembro/a:_____ Mumero de ID del Miembro/a: _____

Farmacia de Preferencia
Nombre:_____
Domicillio de la Farmacia: _____
Cuidad: _____ Estado:_____ Codigo Postal: _____

Consentimiento Para Tratamiento
Yo (o mi Guardian legal o mis Padres) autorizo a Marco M. Zahedi M.D. a brindar attencion medica razonable segun los estandares actuales.

Firma del/a Paciente, Tutor/a, Legal _____ Fecha:_____

Razon de La Visita:_____

Historia Medica Pasada:

Revise la lista a continuacion y verifique cualquier problema que haya tenido ahora o en el pasado

Papanicolaou Anormal	
Acne	
ADD/ADHD	
Abuso deAlcohol	
Anemia	
Trastorno de Ansiedad	
Asma	
Desorden Bipolar	
Coagulo de Sangre	
Transfusion de Sangre	
Cancer (Que Clase)	
Bronquitis Cronica	
Enfermedad de Crohn's/IBS	
Polipos de Colon	
Depresion	
Diabetes	
Diverticulitis	
Abuso de Drogas	
Desorden Alimenticio	

Eczema	
Enfisema	
UTI Frecuente	
Infeccciones sinusales Frec.	
Calculos Billares	
Glaucoma	
Gota	
Ataque al Corazon	
Condicion Cardiaca Especific.	
Hepatitis (especifique)	
Alta Presion	
Colesterol Alto	
Enfermedad del Rinon	
Infecciones Renales	
Calculos Renales	
Lupus	
Melanoma o Cancer de Piel	
Migrañas	
Osteoartritis	

Osteopenia	
Osteoporosis	
Prueva Cutanea de TB Positiva	
Problemas de Prostata	
Psoriasis	
Reflujo (ardor de corazon)	
Artritis Reumatoide	
Rosacea/o	
Alergias Estacionales	
Convulsiones	
Enfermedad de Transmision Sexual	
Carrera	
Tuberculosis	
Enfermedad de Tiroides	
Ulcerosa Colitis	
Verugas	

Otro problema medico que no este en la lista:_____

Por favor verifique o enumere todas las **CIRUGIAS** que ha tenido:

	Tipo de cirugia:	**AÑO**
	Apendectomia	
	Articulacion de Artroscopia	
	Cirugia de Espalada O Cuello	
	Cirugia de Cataratas	
	Cesarea	
	Extraccion de la Vesicula Biliar	
	Cirugia Cardiaca (especificar)	
	Hemorroides	
	Hernia	

	Tipo de cirugia:	**AÑO**
	Histerectomia	
	Remplaso de Rodilla o Cadera	
	Mastectomia o Tumorectomia	
	Mastectomy/Lumpectomy	
	Eliminacion de Polipos de Colon	
	Amigdalectomia/Adenoidectomia	
	Ligadura de Trompa o Vasectomia	
	Cirugia Plastica (especifique)	
	Otro (especifique)	

Medicamentos Actuales:(porfavor incluya medicamentos de venta libre y suplementos alimenticios)

Nombre de la Droga:	Dosis:	Con que Frecuencia

Nombre de la Droga:	Dosis:	Con que Frecuencia?

Eres **ALERGICO/A** a algun medicamento? **Si No**

Nombre de la Droga:	Reaccion:

Nombre: _____

Mantenimiento de Salud:

Ultimo Periodo Menstrual	/ /
Ultimo Papanicolaou n/a	/ /
Ultimo Mamografia n/a	/ /
Ultima Densidad Osea	/ /
Ultima Colonoscopia	/ /

Ultima Vacuna contra el Tetanos	
Ultima vacuna contra la Gripe	
Vacuna de Neumonia	
Edad de Pimer Periodo	
Eres Menopausica	Si No

# de Embarazos	
# de Nacimientos Vivos	
# de Abortos Espontaneos	
# de Abortos	
# De Hijos Vivos	

Si tiene Hijos, Indique sus edades: _____

Antecedentes Familiares Algun miembro de su familia ha tenido alguno de los siguientes problemas?

X	Condicion:	Miembro de la Familia
	Ataque/Enfermedad Cardiaca	
	Carrera	
	Diabetes	
	Alta Pression	
	Colesterol Alto	
	Enfermedad de Tiroides	
	Depresion	
	Otra Enfermedad Mental	
	Alcoholismo	
	Asma	

X	Condition:	Family Member:
	Osteoporosis	
	Migrañas	
	Cancer de Mama	
	Cancer de Colon	
	Cancer de Prostata	
	Cancer de Pulmo	
	Cancer de Ovarios	
	Cancer Uterino	
	Cancer de Piel	
	Otro Cancer	

Cualquier otra Enfermedad en la familia no mencionada? _____

Historia Social:

Estado Civil (circule uno): Soltero/a Comprometido/a Casado/a Separado/a Divorciado/a Viudo/a
Nivel mas alto de Educacion : 6to grado Secundaria Universidad Escuela de posgrado
Ocupasion:_____

Habitos Saludables:

1. **Fuma** Actualmente? **Si** **No** Si es asi cuanto al dia_____ # de Años Fumando _____
   Si No, Fumastes en el pasado? **Si** **No** Cuantos años? __ Cuanto al dia?____Dia que dejo de Fumar _____
   Estas expuesto al Humo? **Si** **No**
   Cualquier otro uso de tabaco? **Si** **No** **Tipo:** Cigarros Mascar Tabaco Otros
2. Bebes **Alcohol?** **Si** **No** Que Tipo: Cervesa Vino Liqor Otro:_____
   Si es asi Cunatas Bebidas por Semana?_____Mes?_____Año? _____
   A tenido algun problema social o Legal con el Alcohol? **Si** **No**
3. Alguna vez has usado **Drogas** Callejeros? **Si** **No**
   Cuales? Marihuana Drogas Anfetaminas Cocaina Heroina Downers Inhalantes Otros:
   Sigues Usando? **Si** **No** Cuales? _____
4. Has estado **Sexualmente Activo** en el Ultimo Año? **Si** **No**
   Porfavor circule el que aplique: **1 compañero/a** **Multiple Socios**
   Orentacion Sexual : **Heterosexual** **Homosexual**
   Que **motodo anticonceptivo** utilizas tu o tu pareja? Ninguno Condones Pastillas Vasectomia Ligadura de trompas _____
5. Hace Ejercisio? **Si** **No** Si es asi que tipo y con que Frecuencia?_____
6. Tiene uan Directiva Medica Avanzada? **Si** **No**
   En caso Afirmativo Proporcione una copia al Dr. Zahedi.

Nombre: _____

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.

_____
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: _____ _____ _____
s or Authorized Representative's
Physician' 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.

Reconocimiento del paciente del AVISO DE PRACTICAS DE PRIVACIDAD y consentimiento para el uso y divulgacion de informacion de salud personal.

_____

Imprimir Nombre del Paciente Fecha

Yo,_____, Reconosco
(firma del Paciente o Padre o Tutor Legal)

Que he recibido una copia del AVISO DE PRACTICAS DE PRIVACIDAD de esta oficina o que el AVISO DE PRACTICAS DE PRIVACIDAD de esta oficina se puso a mi disposicion para recibir.

Yo,_____, consiento en el uso y divulgacion de mi
(Firma de Paciente o Padre o Tutor Legal)

Informacion personal de salud por parte de su oficina para operaciones de tratamiento facturacion/Pago y atencion medica como se describe en el AVISO DE PRACTICA DE PRIVACIDAD