



BEVERLY HILLS Internal Medicine

Distinctly Superior Medical Care.

Please indicate Physician:

Farhad Melamed, M.D. Soly Melamed, M.D. Alan G. Silverman, M.D. Alan Engelberg, M.D.

PATIENT INFORMATION

LAST NAME		FIRST NAME		DATE	
ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE		CELL PHONE		WORK PHONE	
SOCIAL SECURITY #	SEX M F	DATE OF BIRTH		AGE	
MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DOMESTIC PARTNERSHIP DIVORCED WIDOWED					
EMERGENCY CONTACT		PATIENT CONFIDENTIAL EMAIL ADDRESS			
PHONE NUMBER		PHARMACY NAME, PHONE NUMBER and ZIP CODE			
RELATIONSHIP TO PATIENT					

INSURANCE INFORMATION

PRIMARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE	ID #	RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

LIFE TIME INSURANCE AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize B.H.I.M. to release for insurance purposes requested information related to my evaluation and treatment.

AUTHORIZATION TO PAY

I hereby authorize B.H.I.M. to bill my insurance company for services rendered, and that I am financially responsible for the charges NOT covered by my insurance plan, including co-payments, deductibles, and co-insurance. In the event that there is an unpaid balance by my insurance, I guarantee to pay the balance promptly. I acknowledge that I am responsible for any fees related to collections agencies or banks fees for returned checks.

SIGNATURE: _____ **DATE:** _____

Name: _____

Date of planned visit: _____

What is the purpose for your visit: _____

Establish Primary Care: YES NO

Annual Physical Exam: YES NO

Other Concern: _____

Who was kind enough to refer you? _____

Do you have any of the following conditions?

Cataracts	Glaucoma	Refractive Error	Hearing loss	Tinnitus
Allergic Rhinitis	Asthma	COPD/Emphysema	Sleep apnea	
Heart disease/CAD	Heart failure	Hypertension	Atrial Fibrillation	Atherosclerosis
Arthritis	Gout	Back Pain	Osteoporosis/penia	
High Cholesterol	Thyroid disorder	Diabetes (Insulin/Non-Insulin) or Metabolic Syndrome		
Breast Cancer	Uterine Cancer	Colon Cancer	Prostate Cancer	Lung cancer
Depression	Anxiety Disorder	Eating disorder		

Other Conditions: _____

What Operations have you had in the past?

None	Tonsillectomy/Adenoidectomy	Appendix	Gallbladder
Hysterectomy	Prostate	Cosmetic procedures	

Other: _____

What Medications do you take?

Do you have any drug Allergies?

None	Penicillin	Sulfa	Iodine
------	------------	-------	--------

Other: _____

Do you smoke? Yes No

Do you drink alcohol? Yes No

Do you use recreational or other drugs? Yes No

How much caffeine do you consume daily? _____

Are you: Single Married Divorced Widow Other

Do you have Children? Yes No Ages _____

What is your Profession: _____

How old are your: Father _____ Mother _____ Brothers _____ Sisters _____

Do any of the following conditions run in the family?

- | | | | | |
|---------------------|---------------------|------------------|-----------------------|-------------|
| Alzheimer's Disease | Parkinson's Disease | Migraines | Stroke | Sleep apnea |
| Allergic Rhinitis | Asthma | COPD/Emphysema | | |
| Heart disease | High blood pressure | Hi cholesterol | Atrial Fibrillation | |
| Arthritis | Osteoporosis | Gout | Auto immune Disorders | |
| Diabetes | Hyperthyroidism | Hypothyroidism | | |
| Breast Cancer | Uterine Cancer | Colon Cancer | Prostate Cancer | Lung Cancer |
| Anxiety | Depression | Bipolar disorder | Schizophrenia | |
| Other | | | | |

Have you recently noticed any of the following?

- | | | | |
|---|---|--------------------------------|---|
| Fatigue | Weight gain or loss | Fever | Red eye |
| Blurry vision | Loss of sight | Ear pain | Sinus pain /Snoring |
| Sore throat | Runny Nose | Post Nasal Drip | Sneezing |
| Cough | Shortness of breath | Stop breathing during sleep | |
| Chest pain/tightness | Palpitations | Swelling of feet | Snoring |
| Nausea or vomiting | Episodic bloating, constipation, diarrhea | | Change in bowel habits |
| Heartburn/indigestion/stomach ache | | Persistent constipation | Black bowel movement or rectal bleeding |
| Difficulty swallowing/food getting stuck | | Burning/ Pain with urination | |
| Difficulty starting or stopping urination | | Nighttime urinary difficulties | |
| Rash | Yellow skin | Eczema | Blood in the urine |
| Nosebleed | Easy bruising | Lymph enlargement | Sexual difficulties |
| Back Pain | Foot pain | Joint aches/swelling | |
| Heat/Cold Intolerance | Thirst/Frequent Urination | | |
| Insomnia | Depression | Anxiety | |
| Dizzy spells | Passing out/fainting | Tremor/shaking | |
| Forgetfulness | Headaches | Numbness | Paralysis/weakness |