Beverly Hills Internal Medicine

Distinctly Superior Medical Care.

CLEAR FORM

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:**_____

RESET FORM

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 our/fainting
- ☐ Tremor/shaking
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Numbness
- ☐ Paralysis/weakness

Have you or your partner ever had exposure to:

- ☐ Human Papillomavirus (HPV)
- ☐ Human Immunodeficiency Virus (HIV)
- ☐ Hepatitis A B or C
- ☐ Mononucleosis / Epstein Barr Virus (EBV)