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BEVERLY HILLS INTERNAL MEDICINE

Distinctly Superior Medical Care

Please indicate which Physician:

◯ Farhad Melamed, M.D. ◯ SolyMelamed, M.D ◯ Alan D. Engelberg, M.D. ◯ Daniel Hoffman D. O.

PATIENT INFORMATION

LAST NAME	FIRST NAME		DATE
ADDRESS	CITY	STATE	ZIP CODE
CELL PHONE	HOME PHONE	EMAIL ADDRESS	
SOCIAL SECURITY #	SEX ◯ M ◯ F	DATE OF BIRTH	AGE
MARITAL STATUS	◯ SINGLE	◯ WIDOWED	◯ DOMESTIC PARTNERSHIP
	◯ MARRIED	◯ DIVORCED	
EMERGENCY CONTACT		PHARMACY NAME	
PHONE NUMBER		PHONE NUMBER	
RELATIONSHIP TO PATIENT		CITY	ZIP CODE
		ADRESS	

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 any requested information related to my evaluation and treatment.

AUTHORIZATION TO PAY

I hereby authorize B.H.I.M. to bill my insurance 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 such balance promptly. I understand that I am responsible for any collections agency charges and bank fees for returned checks.

SIGNATURE:_____ **DATE:**_____

BEVERLY HILLS
INTERNAL MEDICINE
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Appointment Cancellation Policy, CLIA Notification, Billing Disclosure and HIPAA Guidelines

To our valued clients:

Your appointment requires us to reserve a specific amount of time exclusively for your evaluation. We have a policy regarding cancellations and missed appointments that we believe is fair to you, this office and other patients who are waiting for appointments. If you can't keep a scheduled appointment, please call us at least 24hours in advance to cancel. You may leave a voice message and we'll confirm the cancellation with you. If you fail to give us a 24 hour notice of your cancellation, we may bill you for the visit at $200 for physical examinations, or $100 for follow-up appointments. Please note that your insurance will not pay for this fee and you are personally responsible for it. Exceptions to this policy will be made for true emergencies only.

Beverly Hills Internal Medicine uses our in office CLIA certified laboratory to perform some or all of the tests for our patients. Dr. Melamed and Dr. Hoffman have a financial interest, financial responsibility, and supervision responsibilities for the clinical laboratory services done at our lab. Please inform the doctor if you prefer another laboratory to provide this service.

At BHIM, we want the focus of our attention to be your health, and not billing and financial matters. As such, we request a $250 retainer deposit to cover any copayments, deductibles and non-covered services. Our billing company will reach out to you with a maximum of two statements, via text, email, us mail and a phone call for any outstanding balance once this retainer has been exhausted. It is imperative to bring any questions, errors or discrepancies noted on an insurance EOB or our billing statement to our attention promptly so that we may address it promptly.

Given this policy, it is incredibly rare for us to receive a "Bounced" check, or for an account to be sent to a collections agency; however, in such cases please be aware that YOU will be responsible for any associated fees.

Also in recognition of the HIPAA guidelines, please be advised that all information taken in this office is completely confidential and will only be released with your written consent.

Finally to ensure excellent patient services and to protect you from identity theft, we request a copy of your driver's license, insurance card, and your photograph for our electronic medical records system. Please feel free to discuss any concerns you may have.

Sincerely,

BHIM Management

I have read and understand, and agree with the above cancellation policy, CLIA notification, Billing disclosures and HIPAA guidelines.

Name (Printed)	Signature	Date

LAST NAME **FIRST NAME**

BEVERLY HILLS INTERNAL MEDICINE
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Date of planned visit:

Reason for your visit:

Establish Primary Care ☐

Annual Physical Exam ☐

Other Concern:

Who was kind enough to refer you?

Please provide a current list of your healthcare professionals:

Provider Name	Speciality	Condition being treated

Please provide your pharmacy information:

Phramacy Name	City	Phone#	Zip Code

Have you been **hospitalized** in the past 30 days? ○ Yes ○ No

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:

LAST NAME **FIRST NAME**

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What Operations have you had in the past?

☐ None ☐ Tonsillectomy/Adenoidectomy ☐ Appendix ☐ Gallbladder
☐ Hysterectomy ☐ Prostate ☐ Cosmetic procedures
☐ Other:

What Medications do you take?

Name of Medication	Dose	Frequency

Do you have any drug Allergies?

Name of Drug	Severity of Allergy	Reaction During Allergy

Do you smoke? ◯ No ◯ Yes, and I might quit ◯ Yes, but I am not ready to quit
Do you drink alcohol? ◯ Yes ◯ No
Do you use recreational or other drugs? ◯ Yes ◯ No
How much caffeine drinks do you consume daily?

Marital Status: ◯ Single ◯ Married ◯ Domestic ◯ Divorced ◯ Widowed
Do you have Children? ◯ Yes ◯ No
Residence: ◯ House ◯ Apartment ◯ Skilled Nursing Facility
Are you Sexually Active: ◯ Yes ◯ No
Have you ever had a sexually transmitted disease: ◯ Yes ◯ No

LAST NAME **FIRST NAME**

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What is your Profession?

Family History

Father Mother Brother(s) Sister(s)

How old are your:
Age at Death:

Do any of the following conditions run in the family? And if so whom?

Alzheimers 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				

In the last four weeks, have you noted any of the following?

☐ Fatigue	☐ Weight gain or loss	☐ Fever	☐ Red eye
☐ Blurry vision/visual change	☐ Loss of sight	☐ Ear pain/Hearing Loss	☐ 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 or/fainting	☐ Tremor/shaking	
☐ Forgetfulness	☐ Headaches	☐ Numbness	☐ Paralysis/weakness

☐ Trouble eating well	☐ Problem using telephone	☐ Difficulty driving	☐ Trouble with teeth/dentures

☐ Little interest in doing things ☐ Down, depressed or hopeless

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General Health Maintenance:

Colon cancer screening: Date done: With Doctor:

Colonoscopy ☐ Cologuard ☐ iFOBT ☐ CT Colonography ☐ Colon Capsule ☐

Please write in the dates of the following vaccines you may have received:

Influenza COVID-19 Shingrix (Shingles)

TDAP Gardasil Prevnar Pneumovax

Date of last Mammography / Breast Ultrasound:

Date of Last Gyn Exam / Pap smear:

Other testing you may have received:

Carotid Ultrasound: ☐

Echocardiogram: ☐

Cardiac Stress ☐

Test: Bone Density: ☐ Date of tests:

Ultrasound: ☐ Body part:

CT Scans: Head ☐ Chest ☐ Abdomen ☐ Pelvis ☐

MRI: Brain ☐ Spine ☐

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Activities of Daily Living / Instrumental Activities of Daily Living	Yes	No
Have you fallen two or more times in the past year?	◯	◯
Were you injured in any falls in the past year?	◯	◯
Can you drive a car, shop for groceries without help?	◯	◯
Can you prepare your own meals?	◯	◯
Can you handle your own housework without help?	◯	◯
Can you handle your own money without help?	◯	◯
Do you need help eating, bathing, dressing or getting around your home?	◯	◯
Have you been given information to help you keep track of your medications?	◯	◯
Have you noticed or has any other person had concern about your mental status or memory?	◯	◯
Have you been given any information to help you identify hazards in your home that may hurt you?	◯	◯
Do you always fasten your seatbelt when you are in a car?	◯	◯
Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?	◯	◯
If you have space heaters are they away from flammable objects?	◯	◯
Do you have a fire exit plan?	◯	◯
Do you have working smoke detectors and regularly change the batteries?	◯	◯

During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious or depressed, irritable, sad or downhearted and blue?

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

◯ Not at all ◯ Slightly ◯ Moderately ◯ Quite a bit ◯ Extremely

During the past 4 weeks, how would you rate your general health?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

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During the past 4 weeks, how have things been going for you?

◯ Very well ◯ Pretty good ◯ Good & bad equally ◯ Pretty bad ◯ Very bad

During the past 4 weeks, how much bodily pain have you generally had?

◯ No Pain ◯ Very Mild Pain ◯ Mild Pain ◯ Moderate Pain ◯ Severe Pain

During the past 4 weeks, was **someone available** to help you if you needed and wanted help?
* For example, if you felt nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

◯ Yes, as much as I wanted ◯ Yes, quite a bit ◯ Yes, some ◯ Yes, a little ◯ None

Do any of these issues pose a **psychosocial stressor** (select all that apply) :

☐ Home ☐ Work ☐ Social life ☐ Finances ☐ Health

Advanced Care Planning

Do you have a living will? ◯ Yes ◯ No

Do you have an advanced directive? ◯ Yes ◯ No

Do you have a durable power of attorney for healthcare? ◯ Yes ◯ No

Who is your decision maker should you not be able to medical decisions on your own?

Name	Relation	Phone Number

The answers on this form have been reviewed and discussed in detail with the patient.

Physician Signature

Date

LAST NAME **FIRST NAME**

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Sleep Disorder Assessment

Your physician is requesting that you complete this Sleep Assessment Form,
This form determines the need for you to have a sleep test, which will evaluate if you have a sleep disorder. Sleep Disorders negatively affect your cardiovascular health and well being, but can be effectively treated.

Part 1.

1. Have you ever been told you have Congestive Heart Failure?	Yes	No
2. Have you ever been told you have Coronary Artery Disease?	Yes	No
3. Have you ever had a stroke?	Yes	No
4. Do you take 3 or more medications for high blood pressure?	Yes	No
5. Have you ever experienced irregular heart rhythms (atrial fibrillation)	Yes	No
6. Have you ever been told that you stop breathing at night?	Yes	No
7. Do you have Diabetes?	Yes	No

Part 2

1. Have you been told that you snore loudly?	Yes	No
2. Do you awaken from sleep with chest pain or shortness of breath?	Yes	No
3. Docs your family have a history of premature death in sleep?	Yes	No
4. Is your neck size larger than 15.5 (female) or 17.0 (male)	Yes	No
5. Have you ever been diagnosed with Obstructive Sleep Apnea?	Yes	No
6. Are you currently being treated for sleep apnea?	Yes	No
6a. If yes, are you using your apparatus every night?	Yes	No

Part 3-Epworth Sleepiness Scale

How likely are you to doze off while doing the following activities? Please use the following scale: 0 = never, 1 == slight, 2 = moderate, 3 = high. Circle one of the following numbers

1. Being a passenger in a motor vehicle for an hour or more	0	1	2	3
2. Sitting and talking to someone	0	1	2	3
3. Sitting and reading	0	1	2	3
4. Watching TV	0	1	2	3
5. Sitting inactive in a public place	0	1	2	3
6. Lying down to rest in the afternoon	0	1	2	3
7. Sitting quietly after lunch without alcohol.....	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score _____

Scoring Methodology

One "Yes" in Part1 and/or one "Yes" in Part 2, order sleep test.
If total score in Part 3 is greater than 8, order sleep test.

Physician Signature _____ Date _____

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Risk Assessment for Hereditary Cancer Syndromes

Beverly Hills Internal Medicine is committed to providing you with the highest level of quality care. Risk Assessment for Hereditary Cancer Syndromes identifies patients at high or elevated risk for cancers so that appropriate screenings can be made available. Your personal and family cancer history will be evaluated as part of your treatment to provide you with the most optimal care.

Blood Related Family Members List: Parent, Siblings, Children, Half-siblings, Aunts/Uncles, Grandparents

Please answer the questions below:

Circle NO or YES

1	Are you or any family member in the list above of Ashkenazi Jewish ancestry with Breast, Colon, or Prostate Cancer?	**NO**	**YES**
2	Have you or any family member in the list above had one of these cancers (breast, prostate, colorectal or endometrial cancer) younger than 50?	**NO**	**YES**
3	Have you had cancer between the ages of 46 – 50 AND one family member in the list above had cancer? (breast, prostate, colorectal, or endometrial cancer)	**NO**	**YES**
4	Have you had 10 or more colon polyps (adenomas) in your lifetime?	**NO**	**YES**
5	Have you or any family member in the list above had 3 or more cancers all on the same side of the family (all on dad's or mom's side)? (breast, prostate, colorectal, or endometrial cancer)	**NO**	**YES**
6	Have any MALE family members in the list above had breast cancer or metastatic prostate cancer at any age?	**NO**	**YES**
7	Have you or any family member listed above been diagnosed with Triple-Negative Breast Cancer at age 60 or younger?	**NO**	**YES**
8	Have you or any family member in the list above had pancreatic OR ovarian cancer at any age?	**NO**	**YES**
9	**Have you or any family member in the list above had previous genetic testing (23 and me does not apply)** **If yes, check: Positive □ list gene (if known) _____ Negative**	**Date Tested**	

To the best of my knowledge, I have provided the most accurate answers to the above questions.

Patient Signature: _____ **Date:**_____

Print Name: _____