

Health and Vitality Center

Shiva Lalezar, D.O.

11600 Wilshire Blvd. Suite 120 LA, CA 90025

Office: (310) 477-1166 Fax: (310) 477-9911

www.healthandvitalitycenter.com

(Please Print Clearly)

Today's Date ____/____/____ Driver. Lic. # _____ SS# _____ - _____ - _____

Name: _____

(First, Middle Initial and Last)

Primary Reason for Visit: _____

Sex: _____ Birth Date: ____/____/____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Home: (____) _____ - _____ cell: (____) _____ - _____ work: (____) _____ - _____

Occupation: _____ Employer: _____

Spouse/Partner Name: _____ Spouse/Partner Birth Date: ____/____/____

Emergency Contact: _____ Phone: _____

Relationship: _____

Referral Information

How did you hear about us? Please circle the referral type and specify the name in the space below.

Healthcare practitioner, Friend or Family, Website, Search Engine, Print Media, Mailer, Other

Please specify: _____

Payment must be made at the time of service. At this time we do not accept Medicare, HMO, Medi-Cal or private PPO insurances for office visits. However, we will provide a super bill that could be submitted to your insurance company.

If appointments are not cancelled within 24 hours, doctor's **cancellation fee is \$50.00** and the IV nurse cancellation fee is **\$25.00**. Please be on time for your appointments.

Who is financially responsible for this bill? _____

I will be paying today with: Cash____ Check____ Visa/MC____

If you are a minor (under 18) or dependent, please provide us with your guardian information:

Name of Guardian: _____

Tel: _____

I understand and agree that, regardless of my insurance status, I am ultimately Responsible, for the balance of my account for any professional services rendered. I certify the information above is true and correct to the best of my knowledge. I will notify Health and Vitality Center of any changes in the status of the above information.

Signature: _____ Date: _____

Parent Signature (if minor) _____ Date: _____

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Past Medical and Surgical History:

Social History:

1. Do you smoke? Yes or No How much per day? _____
2. Do you drink alcohol? Yes or No How much and how often?

3. Do use any street drugs? Yes or No How much and how often?

4. Do you exercise? Yes or No How often? What type?

5. Tell us about your diet: _____

Family History: Who of your blood relatives have or had any of the following problems?

1. Heart Attack/Coronary artery disease: _____
2. Sudden death at an early age: _____
3. High Cholesterol: _____
4. High Blood Pressure: _____
5. Stroke: _____
6. Diabetes: _____
7. Cancer: Yes or No
Who: _____ Type: _____

Allergies (Please list anything you are allergic to (medications, food, environmental, pets, etc.))

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Medications:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Nutritional Supplements and Over the Counter Medications:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Patient Signature

Date

Physician Signature

Date