PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First, MI)	Date of Birth	Age	Marital Status	Today's Date

Address	Email

Home Phone	Cell Phone

Race	Ethnicity	SSN	Language Preferred

Employer	Employer's Address	Occupation

Pharmacy	Address	Phone Number

Primary Care Provider	Address	Phone Number

Spouse	Date of birth	Phone Number

Spouse Employer	Spouse Work Address	Spouse Work Phone Number

Emergency Contact:	Phone Number:

Insurance Information

Primary Insurance	Subscriber ID	Group Number

Subscriber (if not patient)	Relationship to PT.	Subscriber Date of Birth	Provider Phone #

Secondary Insurance	Secondary Insurance ID Number	Secondary Insurance Phone #

How did you hear about us?	Friend's name	Referring Physician Name	

1. I consent to treatment necessary for the care of the above-named patient. Yes No
2. I consent to JAMES DANIELZADEH M.D. contacting me by email and text messaging. Yes No
3. I acknowledge that I was provided with a copy of the JAMES DANIELZADEH M.D. Notice of Privacy Practices. (copy is available on our website) Initial _____
4. I authorize payment of all accounts for services rendered to me. For payment of said accounts for services which I hereby waive all claims of exemption under the laws of the State of California, and agree to pay, if necessary, all costs of collection handling, legal and/or attorney 's fees. Initial_____
5. I have read and acknowledge the financial policy of this practice and agree to its terms and conditions. Initial_____

Patient Signature _____ Date _____