Sharareh Daghighi, DAOM, L.Ac, FABORM
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
www.acuandherbs.com

Please PRINT clearly –All information must be completed

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Social Security # ____-____-_____ Sex: F M

Home Address: _____

Street Apt# City State Zip code

Home Phone: (_____) _____ Cell Phone: (___) _____

Marital Status: Single / Married / Other Email Address:_____

Emergency Contact Information: _____

Medical Questioner

Present Illness:

What is your chief complaint?

_____

_____

_____

_____

When did this condition begin?

_____

_____

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What treatments have you received already?

_____

_____

_____

Medical History:

What surgeries have you had? When did you have them?

_____

Do you have any known allergies (food or medications)?

_____

_____

_____

What medications are you currently taking?

_____

_____

What supplements are you currently taking?

_____

_____

Have any of your blood relatives had any of the following?

Stroke__	Heart Disease __	High BP __
Cancer__	Bleeding disorders __	
High Cholesterol __	Diabetes __	

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For Female patients please complete the following:

Age of your first period?
Are you pregnant?
Date of last period?
Length of your cycle?
Color of Blood?
Menstrual cramps__
Emotional changes with your period__
Menstrual blood clots__
Excessive bleeding __
Breast pain with your period __
Vaginal discharge __
Menopausal symptoms __
Vaginal yeast infections _

Please complete the following as accurately as possible:

Indicate if you have any of the followings:

Headache __
Dizziness __
Fainting __
Epilepsy & convulsion __
Stroke __
Loss of memory __
Loss of any five senses __
Thyroid problem __
Asthma __
Pneumonia __
Emphysema __
Cough __
Tuberculosis __
Frequent colds _
High blood pressure__
High Cholesterol __
Heart Disorder __
Cardiac pacemaker __
Palpitation __
Indigestion/gas __
Heart burn __
Constipation __
Diarrhea__
Irritable bowel Syndrome __
Peptic ulcer __
Jaundice __
Fatty liver __
Pancreatitis __
Gallstone __
Diabetes __
Hepatitis __
Hernia __
Kidney stones __
Frequent urination __
Urinary tract infection __
Impotence __
Infertility __
Premature ejaculation __
Prostate problem __
Sexually transmitted disease
Indicate __

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Sores that don't heal __
Cancer __
Insomnia __
Skin disease __
Arthritis __
Osteoarthritis __
Osteoporosis __
Lupus __
Rheumatic Arthritis __
Herniated disk __
Muscle spasm __
Numbness & tingling __
Fibromyalgia _
Chronic fatigue syndrome __
Anemia __
Bleeding disorders __

Do you or any blood relative suffer from any autoimmune conditions?

_____

_____

What treatments have you received?

_____

_____

This will constitute authorization for treatment by Sharareh Daghigihi, L.Ac for my child/ward or me. In the event of default, patient responsible party agrees to pay all collections and attorney fees. I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance. A copy of this authorization shall be considered as valid as the original.

Signature: _____ Date:_____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____
Social Security# _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:
• A basis for planning care and treatment.
• A means of communication among the many healthcare professionals who contribute to care.
• A source of information for applying diagnostic and medical information to a bill.
• A means by which a third-party payer can verify that services billed were actually provided.
• A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:
• To object to the use of health information for directory purposes.
• To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
• To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

Patient/Legal Representative signature: _____

Witness signature: _____

Date: _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Sharareh Daghighi Acupuncture/Acuwellness Center. We strive to render excellent medical care to you, your family and all of our patients. In order to be consistent with this philosophy, Acuwellness Center uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling phone number is 818-642-3512.
2. If you miss an appointment and do not contact us with at least 24 hours prior notice we will consider this to be a missed appointment and a $50.00 fee will be assessed to you.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

If you have any questions regarding this policy, please contact Sherry Daghighi at the above address or phone number and he will be glad to clarify any questions you may have. We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

_____

Signature (Parent / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

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By signing this authorization, I authorize you to use and/or disclose certain protected health information (PHI) about me to:

Sharareh Daghighi, DAOM, L.Ac.
16260 Ventura Blvd, Suite LL16
Encino, CA 91436
Phone: 818-642-3512
Fax: 818-789-8890

Dear Dr, _____

I authorize you to release a copy of the medical records of:

Patient name: _____ Date of birth: _____

Social Security #: _____ covering the period of _____to _____

Please fax the records to above address.

The specific information requested is the office visits, labs, x-ray, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make informed decision whether to allow release of the information.

The authorization will expire on _____

I release you from all legal responsibility or liability that may arise from this authorization.

Please release my medical records, including:

□ All of my medical records (excluding HIV testing)

□ All of my medical records (Including HIV testing)

□ please exclude the followings: _____

Patient's signature: _____ Date: _____

Patient's name: _____

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