MALEK MEDICINE

3610 Atlantic Ave
Long Beach, CA, 90807
P: (562)492-9288
F: (562)595-9346
MalekMedicine.com

(Please fill out Pages 1-8)

Full Name: _____ Today's Date: _____

Address: _____ DOB: _____

_____ Male / Female

Home Phone: _____ Cell Phone: _____

Social Security#:_____ Email:_____

(For billing purposes)

Marital Status (circle one): Single /Married /Widow /Divorced /Domestic Partner

Ethnicity: American Indian or Alaska Native / Asian/ Black of African American/ White/ Native Hawaiian /Refuse / Other: _____

Do you have an Advance Directive _____YES _____NO
Would you like information regarding an Advance Directive? _____YES _____NO

Primary Language: _____ Interpreter Services required: _____YES _____NO

Referring Physician: _____ Phone#:_____

Pharmacy: _____ / City: _____ / Phone#:_____

Cross Streets: _____

Primary Insurance: _____ ID#:_____

Policy Holder's Name: _____ DOB: _____

Social Security#: _____

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Patient's Name:
_____ Date: _____

Under 18, Parent(s) Name(s): _____

Emergency Contact: _____ Phone Number: _____

Relationship: Spouse / Domestic Partner / Child / Other

I hereby give my permission to the office of Dr. Irene Malek to administer treatment and to perform such procedures as may be deemed necessary due to my diagnosis and or condition. I hereby authorize my insurance benefits to be paid directly to the office of Dr. Irene Malek and the release of any information required by third party payers in claim processing, and understand that I am financially responsible for any remaining balance.

Patient/Guardian Signature: _____ Date: _____

Request for Limitations and Restrictions of Protected Health Information

Patient Name: _____ DOB: _____

If you do have restrictions that you would like our office to go by, please detail below the restrictions, i.e. "no detailed phone messages allowed."

_____
_____
_____

If you have **NO** requested restrictions, please simply check off no restrictions and also sign the bottom of the form.

___ No Restrictions

_____ _____
Signature of Patient or Legal Guardian **Date**

Patient's Name: _____ Date: _____

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Patient's Name: _____ Date: _____

Health Questionnaire

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do no answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THE QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT CONFIDENTIAL.

Allergies: list anything that you are allergic to (medications, food, bee stings, etc…) and how each affects you.

_____ _____

_____ _____

Medications: Please list all medications you are taking. Include prescribed drugs and over the counter drugs:

Drug Name: _____ Strength and Frequency Taken: _____

Drug Name: _____ Strength and Frequency Taken: _____

Drug Name: _____ Strength and Frequency Taken: _____

Drug Name: _____ Strength and Frequency Taken: _____

Current Sexual partner is: female: _____ male: _____ both: _____

Do you use condoms? Yes_____ No_____ Other birth control method used: _____

Interested in being screened for STD's: Yes _____ No_____

(Women only) Obstetric and Gynecological History:

Last Pap smear _____ Date: _____ Result: _____

Last Mammogram: _____Date: _____Result:_____

Age of first Menstrual Period: _____ Number of Pregnancies: _____

Number of Cesarean sections: _____ Number of births: _____ Number of Abortions: _____

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Patient's Name:
_____ Date: _____

Immunization History:

Please list immunizations and most recent date:

Chickenpox: _____ Flu Shot: _____

Gardasil/HPV: _____Hepatitis A: _____

Hepatitis B: _____ Meningococcal: _____

MMR: _____ Pneumonia: _____

Tdap: _____ Tetanus: _____ Zostavax (Shingles): _____

Past Medical History: (Please check next to all that apply)

Anxiety Disorder_____ Arthritis_____ Asthma _____ Bleeding Disorder_____ Blood Clots _____
Cancer _____ (what kind) _____ Coronary Artery Disease _____
Claustrophobic _____ Diabetes – Insulin _____ diabetes – Non Insulin _____ Dialysis _____
Diverticulitis _____ Fibromyalgia _____ Gout _____ Pacemaker _____ Heart Attack _____
Heart Murmur _____ Hiatal Hernia or Reflux Disease _____ HIV or AIDS _____ High Cholesterol _____
High Blood Pressure _____ Thyroid _____ Kidney Disease _____ Kidney Stones _____
Leg/foot Ulcers _____ Liver Disease _____ Osteoporosis _____ Polio _____ Pulmonary Embolism _____
Reflux or Ulcers _____ Stroke _____ Tuberculosis _____
Other:_____
_____
_____
_____

Past Surgical History:

Surgery _____ Reason _____ Year _____

Surgery _____ Reason _____ Year _____

Surgery _____ Reason _____ Year _____

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Patient's Name: _____ Date: _____

Family Health History: (please list next to disease which family member and age)

Alcoholism: _____

Heart Disease: _____

Arthritis: _____

Hypertension: _____

Depression: _____

Osteoporosis: _____

Cancer: _____

Stroke: _____

Diabetes: _____

Suicide: _____

Genetic Disease: _____

Social History:

Tobacco: Do you use tobacco? Yes _____ No _____ did you ever use tobacco Yes _____ No _____
If yes:

How many cigarettes / packs per day: _____ Chew _____
# of years used: _____ year quit _____

Drink Alcohol: Yes _____ No _____
If yes:

How often: _____ occasionally _____ Less than 3/week _____ More than 3/week _____

Drugs: Do you currently use recreational or street drugs: Yes _____ No _____
If yes please explain:

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Patients Name: _____ **Date:** _____

If you have **"FORMS"** you must let the front desk know. Please pay for the processing of your forms at the time of drop off. We kindly ask for a five business day turnaround time. Please see our fee schedule below.

- DMV: $50
- FMLA: $50
- State Disability: $50.00

-Extensions: $10

- Sport Physicals and other School Forms - $15.00
- Physical Paperwork: $15
- Jury Duty Paperwork: $10
- Placard Handicap: $15
- Medical Records - $45.00

_____
Patient's Name

_____
Patient's Signature

_____
Date

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Appointment Policy

No shows and cancellations with less than two (2) weekdays notice are a significant problem for our small practice. Many practices overbook on purpose so that no-shows and cancellations won't limit access for other patients as well as cause a financial hardship for the practice.

When it comes to no-shows and cancellations, we have three choices:

1. **A strict policy or**
2. **Overbooking (leading to long wait times at our office) or**
3. **Charging for no shows**

As a result, we will begin imposing a $50 cancellation fee if you do not cancel an appointment within 48 hours of the appointment or by Thursday for an appointment on the following Monday.

_____
Patient's Name

_____
Patient's Signature

_____
Date

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Date of Request: _____

To: _____
(Name of individual or entities in possession of health information)

_____
(Address of individual or entities in possession of health information)

_____ _____
Telephone Number Fax Number

I, _____ DOB: _____
(Name of recipient/legally authorized representative)

Hereby consent and authorize you to release all my medical information to the office of

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I understand that this authorization is subject to revocation at any time, except to the intent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.
I also understand and agree that this authorization will terminate only upon the execution of my written statement indication my intent to revoke this authorization and without such written revocation this authorization shall remain in full force and effect and shall not otherwise expire.

Signature: _____ Date: _____

It is the policy of this medical practice that we will adopt, maintain and comply with our notice of privacy practices, which shall be consistent with HIPPA And California law.