ALAIN KARAGUEZIAN M.D.

18546 Roscoe Blvd Suite 304 Northridge, CA 91324
(818) 772-7100 office | (818) 772-7112 fax | http://dralaink.com

DATE _____

HOME _____ CELL_____ eMAIL_____

PATIENT _____

RESPONSIBLE PARTY (if a minor) _____

STREET ADDRESS _____

SEX ☐M ☐F AGE_____ BIRTHDATE _____ ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

PATIENT EMPLOYED BY _____

BUSINESS ADDRESS _____

OCCUPATION _____BUSINESS PHONE _____

SPOUSE (or responsible party) EMPLOYED BY _____

BUSINESS ADDRESS _____

OCCUPATION _____BUSINESS PHONE _____

PURPOSE OF VISIT _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

DO YOU HAVE MEDICAL INSURANCE ☐N ☐Y

NAME OF PRIMARY INSURER _____

CONTRACT # _____ GROUP# _____ CLAIM ID# _____

NAME OF SECONDARY INSURER _____

CONTRACT # _____ GROUP# _____ CLAIM ID# _____

☐MEDICARE ☐MEDICAID CLAIM ID# _____

IF WELFARE, YOUR NUMBER _____

I PREFER TO ☐ PAY MY BALANCE AT TIME OF SERVICE

☐ PAY MY BALANCE IN FULL UPON RECEIPT OF STATEMENT

☐ MAKE PAYMENT ARRANGEMENTS PRIOR TO SERVICE BEING RENDERED

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ PHONE_____

YOUR DRUGSTORE NAME _____ PHONE_____

HOW DID YOU LEARN OF OUR PRACTICE? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____ to pay and hereby assign directly to

Alain Karaguezian all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further understand that any insurance benefits, when received bay and paid to _____ will be credited to my account in accordance with the above.

(AUTHORIZED SIGNATURE OF SUBSCRIBER) (DATE)

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NAME _____ AGE_____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: (check box if yes)

☐Measles ☐Mumps ☐Chickenpox ☐Diabetes ☐Strokes ☐Cancer ☐Rheumatic fever or heart disease ☐Tuberculosis

☐Veneral disease ☐Congenital abnormalities☐Other serious disease _____

☐Have you had any serious illness? _____

☐Have you ever been hospitalized or been under extended medical care?

For what reason? _____

☐Have you had any surgery? _____

_____

☐ Broken bones ☐ Head concussions or injuries ☐ Knocked unconscious?

FAMILY HISTORY:

IF LIVING			IF DECEASED (age at death / cause)
Father	Age _____	Health _____	Father _____
Mother	Age _____	Health _____	Mother _____
Brother/Sister	Age _____	Health _____	Brother/Sister _____
Husband/Wife	Age _____	Health _____	Husband/Wife _____
Son/Daughter	Age _____	Health _____	Son/Daughter _____

Has any blood relatives ever had: (check if yes, what age and who)

☐Cancer	Age _____	Who _____
☐Tuberculosis	Age _____	Who _____
☐Diabetes	Age _____	Who _____
☐Heart trouble	Age _____	Who _____
☐High blood pressure	Age _____	Who _____
☐High cholesterol	Age _____	Who _____
☐Stroke	Age _____	Who _____
☐Convulsions	Age _____	Who _____
☐Mental illness/Suicide	Age _____	Who _____
☐Bleeding tendencies	Age _____	Who _____
☐Gout or other arthritis	Age _____	Who _____

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NAME _____ AGE_____ DATE _____

ADDRESS _____ PHONE _____

SOCIAL HISTORY: (check box if yes)

☐Single ☐Married ☐Separated ☐Windowed ☐Divorced

☐ Y ☐ N Are you living with your husband or wife?

☐ Y ☐ N Do you have dependents at home?

☐ Y ☐ N Is your sex life satisfactory?

☐ Y ☐ N Do you exercise? How often? _____

Alcoholic beverages : ☐ Y ☐ N ☐ NEVER ☐ RARELY ☐ MODERATELY ☐ DAILY ☐ EVER ? _____

Tobacco: Cigarettes _____ Packs a day ☐ Don't smoke ☐ Ever smoked? _____

Employment ☐ Full time ☐ Part time ☐ Unemployed What is your job? _____

Are you exposed to fumes, dusts or solvents? ☐ Y ☐ N _____

Education (years)

Grade school _____
High school _____
College _____
Postgraduate _____

How much time have you lost from work because of your health during the past?

☐ Six months
☐ One year
☐ Five years

SYSTEMIC REVIEW: (do you have any of the following?)

General

☐ Y ☐ N Recent weight change?

☐ Y ☐ N Have you been in good health most of your life?

Skin

☐ Y ☐ N Skin disease

☐ Y ☐ N Jaundice

☐ Y ☐ N Hives, eczema or rash

☐ Y ☐ N Frequent infection or boils

☐ Y ☐ N Abnormal pigmentation

Head-Eyes-Ears-Nose-Throat

☐ Y ☐ N Eye disease or injury

☐ Y ☐ N Do you wear glasses?

☐ Y ☐ N Double vision

☐ Y ☐ N Headaches

☐ Y ☐ N Glaucoma

☐ Y ☐ N Itching eyes or nose

Head-Eyes-Ears-Nose-Throat (cont'd)

☐ Y ☐ N Sneezing or runny nose

☐ Y ☐ N Nosebleeds

☐ Y ☐ N Chronic sinus trouble

☐ Y ☐ N Ear disease

☐ Y ☐ N Impaired hearing

☐ Y ☐ N Dizziness or transient episodes of unconsciousness

Neck

☐ Y ☐ N Stiffness

☐ Y ☐ N Thyroid trouble

☐ Y ☐ N Enlarged glands

Respiratory

☐ Y ☐ N URI (cold) now

☐ Y ☐ N Spitting up blood

☐ Y ☐ N Chronic or frequent cough

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NAME _____ AGE_____ DATE _____

ADDRESS _____ PHONE _____

SYSTEMIC REVIEW: (do you have any of the following?)

Respiratory (cont'd)

☐ Y ☐ N Asthma or wheezing?
☐ Y ☐ N Difficulty breathing
☐ Y ☐ N Any trouble with lungs
☐ Y ☐ N Pleurisy or Pneumonia

Cardiovascular

☐ Y ☐ N Chest pain or angina pectoris
☐ Y ☐ N Shortness of breath with walking or lying down
☐ Y ☐ N Difficulty walking two blocks
☐ Y ☐ N Heart trouble or heart attacks
☐ Y ☐ N High blood pressue
☐ Y ☐ N Swelling of hands, feet or ankles
☐ Y ☐ N Awakening in the night smothering
☐ Y ☐ N Heart murmur

Gastrointestinal

☐ Y ☐ N Stomach ulcer
☐ Y ☐ N Vomiting blood or food
☐ Y ☐ N Gallbladder disease
☐ Y ☐ N Liver trouble
☐ Y ☐ N Hepatitis
☐ Y ☐ N Painful bowel movements
☐ Y ☐ N Bleeding with bowel movements
☐ Y ☐ N Black stools
☐ Y ☐ N Hemorrhoids or piles
☐ Y ☐ N Recent change in bowel habits
☐ Y ☐ N Frequent diarrhea
☐ Y ☐ N Heartburn or indigestion
☐ Y ☐ N Cramping or pain in the abdomen
☐ Y ☐ N Does food stick in throat

Genitourniary

☐ Y ☐ N Loss of urine
☐ Y ☐ N Frequent urination
☐ Y ☐ N Burning or painful urination
☐ Y ☐ N Blood in urine
☐ Y ☐ N Kidney disease
☐ Y ☐ N Kidney stones

Gynecological

_____ Age periods started
_____ How long period lasts (days)
_____ Number of pregnancies

Gynecological (cont'd)

_____ Number of miscarriages
_____ Date of last cancer smear and results
_____
_____ Frequency of periods (every __ days)
☐ Y ☐ N Pain with period
_____ Number of children
_____ Ages

Locomoter-Musculoskeletal

☐ Y ☐ N Varicose veins
☐ Y ☐ N Weakness of muscles or joints
☐ Y ☐ N Any difficulty walking
☐ Y ☐ N Any pain in calves or buttocks on on walking relieved by rest

Neuro-Psychiatric

☐ Y ☐ N Have you ever had psychiatric care?
☐ Y ☐ N Have you been advised to see a psychiatrist?
☐ Y ☐ N Do you ever have, or have had fainting spells?
☐ Y ☐ N Convulsions
☐ Y ☐ N Paralysis

Hematologic

☐ Y ☐ N Are you slow to heal after cuts
☐ Y ☐ N Blood disease
☐ Y ☐ N Anemia
☐ Y ☐ N Phlebitis
☐ Y ☐ N Have you had difficulty with bleeding excessively after tooth extraction or surgery?
☐ Y ☐ N Have you had abnormal bruising or bleeding?

Allergic

☐ Y ☐ N Any allergies, including medication
_____

Endocrine

☐ Y ☐ N Thyroid disease
☐ Y ☐ N Hormone therapy
☐ Y ☐ N Any change in hat or glove size?
☐ Y ☐ N Any change in hair growth?
☐ Y ☐ N Have you become colder than before or skin dryer
_____ Height
_____ Weight

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NAME _____ AGE_____ DATE _____

ADDRESS _____ PHONE _____

CURRENT MEDICATIONS

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administraion of:

☐ Y ☐ N ☐ Unsure Penicillin or other antibiotics _____

☐ Y ☐ N ☐ Unsure Morphine, Codeine, Demerol or other narcotics _____

☐ Y ☐ N ☐ Unsure Novocain or other anesthetics _____

☐ Y ☐ N ☐ Unsure Aspirin, empirin, or other pain remedies _____

☐ Y ☐ N ☐ Unsure Sulfa drugs _____

☐ Y ☐ N ☐ Unsure Tetanus antitoxin or other serums _____

☐ Y ☐ N ☐ Unsure Adhesive tape _____

☐ Y ☐ N ☐ Unsure Iodine or merthiolate _____

☐ Y ☐ N ☐ Unsure Any drug or medication _____

☐ Y ☐ N ☐ Unsure Any foods, such as egg, milk, chocolate _____

2. Drugs recently taken: Within the past six months has patient taken:

☐ Y ☐ N ☐ Unsure Cortisone

☐ Y ☐ N ☐ Unsure ACTH

☐ Y ☐ N ☐ Unsure Anticoagulants

☐ Y ☐ N ☐ Unsure Tranquilizers

☐ Y ☐ N ☐ Unsure Hypotensives (high blood pressure medicines)

☐ Y ☐ N ☐ Unsure Has the patient ever received treatment for asthma, rheumatism, or rheumatic fever

☐ Y ☐ N ☐ Unsure Aspirin

SOURCE OF INFORMATION (if other than patient) _____

Signature of person acquiring this information _____

_____ _____ _____

DOCTOR DATE SIGNATURE OF PATIENT