A. SHAMS PIRZADEH, M.D., F.A.C.R.
716 Maiden Choice Lane, Suite 301
Baltimore, Maryland 21228
410-788-2000

Name: _____

Primary Care Doctor:

Name: _____
Address: _____
Phone: _____

Past History:

Please list all of your past medical illnesses and all past surgeries.

_____
_____
_____
_____
_____
_____

Family History:

Describe any family history of Arthritis, Systemic Lupus, Heart Disease, or any other major illness.

_____
_____
_____
_____
_____

Current Medications:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Allergies: (Especially to medications)

_____
_____
_____
_____

Social History:

Please place a check next to either YES or NO

Do you smoke?	____YES	____NO	If yes, for how long?
Do you drink alcohol?	____YES	____NO	
Do you drink coffee?	____YES	____NO	
Do you now, or did you ever, use illegal drugs?	____YES	____NO	
Do you wear a seat belt?	____YES	____NO	
Do you exercise?	____YES	____NO	

What is bothering you? _____

_____

When did this problem start? _____
_____

What aggravates your symptoms? _____
_____

Are you tired? ____YES ____NO
Do you have morning stiffness? ____YES ____NO
If so, how long does it last? _____

Have you gained or lost weight recently?	____YES	____NO
Do you have any skin rash?	____YES	____NO
Are you sensitive to the sun?	____YES	____NO
Do you have any problems with cold weather?	____YES	____NO
Do your hands change color with cold exposure?	____YES	____NO
Do you have headaches?	____YES	____NO
Do you have dizziness?	____YES	____NO
Do you have fainting spells?	____YES	____NO
Do you have nasal congestion or sinus problems?	____YES	____NO
Do you have breathing problems?	____YES	____NO
Asthma?	____YES	____NO
Bronchitis?	____YES	____NO
Do you have chest pain?	____YES	____NO
Heart Disease?	____YES	____NO
Hypertension?	____YES	____NO
Do you have stomach problems?	____YES	____NO
Indigestion?	____YES	____NO
Heartburn?	____YES	____NO
Abdominal Pain?	____YES	____NO
Nausea?	____YES	____NO
Vomiting?	____YES	____NO
Diarrhea?	____YES	____NO
Constipation?	____YES	____NO
Do you have any urinary problems?	____YES	____NO
Do you have a history of kidney stones?	____YES	____NO
Do you have any prostate problems?	____YES	____NO
Do you have any female problems?	____YES	____NO

Explain: _____

Do you have any numbness or weakness of your upper or lower extremities?	____YES	____NO

Where? _____

Do you have any joint pain or swelling?	____YES	____NO

Where? _____

Place a check next to any of the following that give you difficulty:

_____ Using your hands to grasp small objects
_____ Climbing or descending stairs
_____ Getting up out of a chair
_____ Reaching behind your head
_____ Bathing
_____ Working
____ Walking
____ Sitting down
____ Reaching behind your back
____ Dressing yourself
____ Eating

Do you use a cane, walker, crutches or wheelchair? ____ YES ____ NO

Any additional information that you think the doctor should have:

_____

_____

_____

_____

_____

Assignment of Benefits:

I authorize direct payment of benefits for professional services.

_____

Signature Date

Release of Information:

_____

Signature Date

If your account remains delinquent for over 120 days your account will be sent to a collection agency.
There will be a $25.00 charge for any checks that are returned from the bank.
Co-pays are due and will be expected on the date of service.

Dear Valued Patient,

Please be advised that our office does not verify benefits through your insurance company. Any and all deductibles, co-payments, co-insurances, out of pocket maximums and services not covered by your insurance company are your responsibility and are due at the time of service.

As a courtesy to you, we submit your claims to your specified insurance company (companies). We will also do whatever follow-up is necessary in order to receive payment. However, if it becomes apparent that your insurance company is failing to pay us in a reasonable amount of time, the balance will be turned over to your responsibility. Please remember that although our office is submitting the claims for you, and following up on claims submitted, it is a *courtesy* to you that we do this. The balance on your account is ultimately your responsibility.

It is also your responsibility to provide our office with a copy of all your insurance cards and notify our office of any changes to your insurance. Failure to do so could result in the full balance becoming your responsibility.

To all our Medicare patients: Please be advised that you are fully responsible for all co-pays, co-insurances, deductibles, and any service that Medicare does not cover under your policy with them.

It is highly recommended that you verify coverage through any and all of your insurance companies prior to your visit with us.

PLEASE NOTE: FAILURE TO PAY ANY BALANCES DUE WILL RESULT IN YOUR ACCOUNT BEING FORWARDED TO A COLLECTIONS AGENCY. THIS WILL NOT ONLY RESULT IN A NEGATIVE REPORT TO THE CREDIT BUREAU, BUT YOU ALSO WILL BECOME RESPONSIBLE FOR ANY APPLICABLE FEES THAT ARE THE RESULT OF SUBMITTING YOUR ACCOUNT TO COLLECTIONS.

I have read and understand the above information and by signing below I agree to all terms.

_____ _____

SIGNATURE OF PATIENT **DATE**