Please provide the following information at the time of your visit:

#1. A list of all the current medications you are taking.

#2. Brief description of your present problem and past medical history.

#3. Please try to bring with you the CT scan and MRI films of the head, neck or the back that you may have had in the past. If you cannot obtain the films, please bring in the reports.

#4. If it is possible, come to the office with someone who is familiar with your personal and medical history and can provide further information about you to the doctor.

#5. Please be on time, however there may be about a 20-40 minute waiting time depending on hospital emergency cases and the complexity of the office patients seen prior to your scheduled time.

#6. Cancellation of your appointment should be done 72 hrs. in advance. Please see the no show policy for further explanation.

Please feel free to contact our office at (310) 514-8034 with any questions you may have. We look forward to the opportunity to service your health care needs.

Sincerely,

Office Manager

Majid Molaie, M.D.

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAYTIME PHONE: ( ) _____

CELL PHONE: ( ) _____

DATE OF BIRTH: _____ AGE: _____

Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

SS#: _____ CA ID/Drivers License: _____

REFERRING PHYSICIAN: _____

EMPLOYER: _____

PRIMARY INSURANCE: _____

Subscriber's name if not self: _____
Relationship _____
Subscriber ID#_____ Policy# _____

SECONDARY INSURANCE:

Subscriber's name if not self: _____
Relationship _____
Subscriber ID# _____ Policy # _____

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT
I have read the Privacy Notice posted in the office.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF INSURANCE BENEFITS:
The undersigned hereby assigns Dr. Majid Molaie rendering services and authorized payment directly to him. I certify that the above information that I have reported in regards to my insurance is true and correct. I understand that I am liable for any unpaid balance to my account.

SIGNATURE: _____DATE: _____

MAJID MOLAIE, M.D.

PATIENT QUESTIONNAIRE

1. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information.
   PHONE #_____

2. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voice mail?

   YES _____ NO _____

3. Please list the family members, or other persons, if any, whom we may inform about your general medical condition, and your diagnosis (including treatment, payment and health care operations):

   NAME_____ PHONE #_____
   NAME_____ PHONE #_____

4. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

   Name_____ PHONE #_____
   NAME_____ PHONE #_____

5. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   Address _____
   City _____ State _____ Zip Code _____

6. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".

   YES_____ NO_____

   "I am fully aware that a cell phone is not a secure and private line"

   PATIENT NAME _____ (guardian if under 18 years)

_____ _____
PATIENT / GUARDIAN SIGNATURE **DATE**

IMPORTANT INFORMATION FOR OUR PATIENTS

No Show Policy

Over the past few years, we are seeing an increase in the number of patients who fail to show up for their scheduled appointment or fail to call the office to cancel their scheduled appointment within a reasonable time frame. Every scheduled appointment that is missed jeopardizes the patient/physician relationship and prevents us from providing care to other patients in need.

In an effort to correct the problem, effective Jan 1, 2008, we are instituting a new policy in which we reserve the right to charge a fee in the amount of $50.00 for a *"no show"* appointment, or for calling the office the day of the scheduled appointment to cancel. This charge is not billable to insurance and will be the patient's responsibility to pay before another appointment will be scheduled. Emergency exception allowed.

We truly regret having to take this action, but hope that this will improve access to *all* patients needing care.

As Always, we appreciate your understanding and cooperation to call at least 24 hours in advance for cancellation.

INITALS: _____ **DATE: _____**

LIST OF MEDICATIONS

NAME: _____DATE: _____

MEDICATION	*DOSAGE*	*DIRECTIONS*

PLEASE LIST ANY ALLERGIES:

_____