Samira Mehrizi, D.P.M.
1687 Erringer rd Suite 206 Simi Valley CA, 93065

Patient Demographics

Date of Birth: ______________________ SSN: ______________________

Full Name: ______________________________________ Gender: ☐M ☐F
First Middle Initial Last

Address: ______________________________________
Apt #

____
City State Zip

Phone Number: ______________________ ______________________
Primary Secondary

Marital Status: ☐ Married ☐ Single ☐ Other Email Address: ______________________

Emergency Contact: ______________________ Number: ______________________

Employer Name: ______________________________________

Referred by: ______________________ Preferred Pharmacy: ______________________

Primary Physician: ______________________ Number: ______________________

Insurance

Primary Insurance: ______________________________________

ID#: ______________________ Group: ______________________

Insurance Address: ______________________ Guarantor's D.O.B.: ______________

Secondary Insurance: ______________________________________

ID #: ______________________ Group #: ______________________

Insurance Address: ______________________ Guarantor's D.O.B. ______________

Medical History

Are you currently under your physicians care? If yes, what reason? Please list your Doctor.

____

____

Have you had previous treatment by a podiatrist? If yes, what reason?

____

What is your chief complaint for seeing the podiatrist today?

____

How long has this condition existed?

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____

Do you have any allergies? (Including prescription medication, over the counter medicines, adhesives, tape, and food, seasonal.)

____

Please list all medicines you are currently taking:

____

Please list any herbal or dietary supplements you are currently taking:

____

Please list all surgeries you have had in the past:

____

Have you ever been hospitalized? Please list when and for what?

____

Please list any diseases that run in your family:

____

Is there anything else you would like to mention bout your visit today?

____

SZM MEDICAL CORP

PATIENT AUTHORIZATION/RELEASE FORM/FINANCIAL AGREEMENT

NOTICE

AUTHORIZATION & CONSENT FOR TREATMENT:

I understand that my treatment will be initiated, evaluated, and screened by SAMIRA MEHRIZI, DPM. I do hereby voluntarily consent to routine diagnostic procedures, examination, treatments, and therapy.

RELEASE OF INFORMATION:

I hereby authorize Samira Mehrizi, DPM. To release all relevant diagnosis, report, or other information to Medicare, Medicaid, or to any other third-party payer or insurance carrier, in order to obtain payment for the services I received.

FINANCIAL AGREEMENT:

ALL- co-pays and fees are due at the same time of service. I understand that if I fail to make payment, or if I have not made suitable payment arrangements SAMIRA MEHRIZA, DPM. Has the right to pursue the collection of my bill.

CANCELLATION POLICY:

A $75.00 CANCELLATION FEE WILL BE APPLIED TO APPOINTMENTS THAT ARE NOT CANCELLED WITH 24 HOURS

ASSIGNMENT OF INSURANCE BENFITS:

This document is authorization for insurance benefits to be paid directly to SAMIRA MEHRIZI, D.P.M. I understand that I am responsible for the amounts not covered by my insurance and agree to make prompt payments.

I UNDERSTAND THAT THIS DOCUMENT AND ALL OF THE COMMITMENTS AND AUTHORIZATIONS IT CONTAINS WILL CONTINUE IN EFFECT AS LONG AS I RECEIVE SERVICES FROM SAMIRA MEHRIZI, D.P.M. SUCH TIME AS I REVOKE THIS DOCUMENT IN WRITING.

____________________________ __________________

Signature of patient, parent, Guardian, Etc. Date

Please provide us with your email we would like to send you a review for today's Visit

Patient name:______________________________

Email:____________________________________