Slimlife Solutions…Afshin Eslami, M.D.
7501 Hospital Drive, Suite 305
Sacramento, California 95823
Phone 916.423.2022 Fax 916.681.0673

Dear _____,

You have been scheduled at our office for the following appointment (s):

❒ Thursday ❒ Friday

_____at_____ with Dr. Eslami & at_____ with Randee (dietitian).

PLEASE NOTE*:* IF YOUR PAPERWORK IS NOT COMPLETED,
YOUR APPOINTMENT WILL BE RESCHEDULED.

Please arrive 15 minutes early for your appointment.

Please bring the following items with you to your appointment:

- ❑ Your insurance card(s) and your photo ID

  Due to new privacy laws, if you do not bring your photo ID and your insurance card (s), your appointment will have to be rescheduled.
- ❑ Your co-pay, if applicable. Dr. Eslami *accepts cash, check, or credit*
- ❑ Your completed forms (attached) ***Please complete packet (s) before your appointment.***
- ❑ Your completed dietary and weight history (also enclosed in this mailing)
- ❑ Any applicable medical records (either tests that have been completed or records requested by the office)

If you will not be able to attend your scheduled appointment, please do us the courtesy of calling at least 24 hours ahead of time to reschedule or cancel.

Thank you and we look forward to seeing you here in our office!

DIRECTIONS:

From South*:*
Take 99 North to Calvine Road/Cosumnes exit
Exit on Calvine/Cosumnes, make a left – cross over the overpass
Turn right at Bruceville Road (Target is on the corner of the intersection)
Make the second right onto Hospital Drive (after Emergency Room sign)
Our office is the first building on the left once you turn onto Hospital; we are on the 3rd floor

From North*:*
Take 99 South to Mack Rd East / Bruceville Rd
Exit towards Bruceville, make a left onto Bruceville
Turn left onto Hospital Drive (after passing Kaiser and Sierra Vista Hospital)
Our office is the first building on the left once you turn onto Hospital; we are on the 3rd floor

Please fill out the following as completely as possible.

WELCOME!

PATIENT INFORMATION

Patient Name: _____ Sex ☐ M ☐ F Age _____
Last First Middle

Birthdate _____ Social Security Number _____

Phone Numbers:
Home (____) _____ Work (____) _____ x _____ Cell (____) _____

What is the best time and place to reach you? _____

Address _____

City _____ State _____ Zip _____

Email _____

☐ Married ☐ Single
☐ Separated ☐ Divorced
☐ Widowed ☐ Minor
☐ Partnered for ___ years

Occupation _____ Patient Employer / School _____

Spouse's Name _____ Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship to Patient _____

Home Phone (____) _____ Cell Phone (____) _____ Other (____) _____

Primary Care Doctor _____ Phone (____) _____

Address _____ Fax (____) _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____ Relationship to Patient _____

Primary Insurance	Secondary Insurance
Insurance Co _____	Insurance Co _____
Subscriber's Name _____	Subscriber's Name _____
Subscriber's SSN _____	Subscriber's SSN _____
Subscriber's Birthdate _____	Subscriber's Birthdate _____

INSURANCE ASSIGNMENT AND RELEASE: *(Please sign at bottom for all insurances)*

I certify that I have insurance coverage with the company (ies) I have listed above, and assign directly to Dr Eslami and all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay any outstanding balances within 90 days.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I authorize the use of my signature on all insurance submissions. This consent will end when my current treatment is completed.

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Dr Eslami and for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____ _____
Signature of Beneficiary/Representative Name of Beneficiary/Representative Relationship to Beneficiary

Today's Date: _____

Reviewed by (office staff): _____

MEDICAL HISTORY

All information is strictly confidential.

NAME: _____ SEX: M or F AGE: _____

Please list all your medications, including over the counter, injections, and supplements (attach separate list if needed)**:**

_____ _____ _____

_____ _____ _____

Do you take aspirin / Plavix / Warfarin / Coumadin / Pletal or other blood thinners? Yes No

ALLERGIC TO MEDICINES? NO / YES

IF YES, PLEASE LIST:

_____

Please indicate how frequently you use the following:

Alcohol: ☐ Never ☐ Occasionally ☐ Frequently

Tobacco: ☐ None ☐ _____ packs per _____

DO YOU HAVE NOW OR HAVE YOU HAD: *(PLEASE CHECK ANY AND ALL THAT APPLY)*

GENERAL

- ☐ Dizziness/Fainting
- ☐ Fever/Chills/Sweats
- ☐ Loss of Weight
- ☐ Poor appetite
- ☐ Depression
- ☐ Anxiety / Panic Disorder

NEUROLOGIC

- ☐ Blurred Vision
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke – *when?*_____

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Heart attack *when?* _____
- ☐ Heart disease
- ☐ Heart failure
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular or Rapid heart beat
- ☐ Leg / ankle swelling
- ☐ Poor circulation
- ☐ Varicose veins

BLOOD

- ☐ Anemia
- ☐ Blood clots
- ☐ Other _____

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Shortness of breath
- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Stomach Pain

GASTROINTESTINAL

- ☐ Blood in stool
- ☐ Constipation / Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn/Acid Reflux
  - ☐ Occasional ☐ Frequent
- ☐ Nausea/Vomiting
- ☐ Sleep apnea
  Were you tested? Y N

LIVER/KIDNEYS

- ☐ Cirrhosis of the liver
- ☐ Fatty/enlarged liver
- ☐ Hepatitis
  Which type: A B C
- ☐ Gallstones
- ☐ Blood in urine
- ☐ Burning / painful urine
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Lack of bladder control
- ☐ Prostate problem
- ☐ Other _____

ENDOCRINE

- ☐ Diabetes:
  - ☐ Juvenile ☐ Adult-onset
  - ☐ Insulin ☐ Pills (oral)
  - ☐ Controlled with diet
- ☐ Thyroid Disorder
- ☐ Polycystic ovaries

INFECTION/ILLNESS

- ☐ Cancer – *where* _____
  *Diagnosed when?*_____
- ☐ HIV
- ☐ Tuberculosis

MUSCLE/JOINT/BONE

- ☐ Arthritis
  - ☐ Rheumatoid ☐ Osteo
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Muscle cramps
- ☐ Pain: ☐ Back ☐ Joints
  - ☐ Other: _____
- ☐ Weakness / numbness in:
  *(where)*_____

SKIN

- ☐ Bruise easily
- ☐ Rash / Sores / Cellulitis
  *(where)*_____
- ☐ Hernia *(where)*_____

WOMEN only

- ☐ Breast lump
- ☐ Nipple discharge
- ☐ Menopause
- ☐ Abnormal periods
  (not menopause- related)

Date of last period _____

Could you be pregnant? Y N

SCREENING TESTS

Write the year of your last:

(Check any that were abnormal ↓)

- Pap Smear _____ ☐
- Mammogram _____ ☐
- Colonoscopy _____ ☐
- Upper endoscopy _____ ☐
- H Pylori _____ ☐
- PSA (prostate) _____ ☐

FAMILY HISTORY

Has anyone in your *immediate* family ever had:

- ☐ Bleeding problems
- ☐ Cancer
  *(where)*_____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Problems w/ anesthesia

Please list any other major illnesses or medical problems that you have had (other than childhood diseases):

_____

NAMES OF PREVIOUS SURGERIES, INCLUDING MINOR PROCEDURES (attach separate list if needed)**:**

_____ _____ _____

This information is complete and correct to the best of my knowledge. I understand that I must inform my doctor if anything above changes.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY:_____ **DATE:** _____

PHYSICIAN'S SIGNATURE:_____ **Reviewed on (date):** _____

AUTHORIZATION OF PRIVATE INFORMATION

Slimlife Solutions…Afshin Eslami, MD
7501 Hospital Drive, Suite 305
Sacramento, California 95823
Phone 916.423.2022 Fax 916.681.0673

We need to have your permission below on how we are able to communicate with you about medical information and scheduling.

May we contact you by the following methods? (Please circle)

Telephone	**YES**	**NO**
Answering machine	**YES**	**NO**
Mail	**YES**	**NO**
E-Mail	**YES**	**NO**

E-Mail Address: _____

Please list any people you authorize to receive your health information for you: (e.g. translator, family member, etc)

	Name	**Relation to you**
1.		
2.		
3.		
4.		

❒ **I do not authorize my private information to be released to any person other than myself.**

We have provided you with a copy of our *Notice of Privacy Practices*. You are not required to read this notice. However, we would like your acknowledgement that you have received this *Notice of Privacy Practices*.

Patient's Name: *(Printed)* _____

Patient Signature: _____