Patient Demographics

Last Name / Apellido:_____ First Name / Primer Nombre_____M.I:_____

Social Security #: ___-___-___ Date of Birth/ Fecha de Nacimiento: ___-___-___ Age/Edad:_____
Seguridad Social

Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐
Sexo Estado Civil

Home Address:_____
Direccion: City/Ciudad State/Estado Zip Code

Phone #: _____ // _____ // _____
Telefono: Home/ Casa Work/Trabajo Cell/ Mobil

E-Mail / Correo Electronico: _____

Employed By / Empleado Por: _____Occupation / Ocupación: _____

Primary Care Physician's Name & Number: _____
Nombre y Telefono de el Medico Atención Primaria

Referring Physician's Name & Number: _____
Nombre y Telefono de el Medico Remitentes

SPOUSE, PARENT, LEGAL GUARDIAN, OR EMERGENCY CONTACT INFORMATION

Last Name/Apellido: _____ First Name/Primer Nombre: _____M.I._____

Phone Number/Telefono : _____ Relation to Patient/Relacion con el Paciente: _____

This signature authorizes us to release medical information for insurance purposes and certifies the information on this form is correct and if insured, the benefits are assigned directly to this practice.

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____DATE_____

TERMS OF PAYMENT: I (WE) HEREBY AGREE TO PAY KHALIQUE S. ZAHIR, M.D., LOCATED ON 3301 WOODBBURN ROAD, SUITE 202 ANNANDALE, VA 22003, AT THE TIME OF SERVICE IN CONSIDERATION OF PROFESIONAL SERVICES RENDERED, AT ITS PREVAILING RATE AND ACCORDING TO THE TERMS HEREIN SET FORTH, OR ANY BALANCE DUE IN EXCESS OF ANY AMOUNT PAID BY OTHER PERSON OR AGENCY. I (WE) ALSO UNDERSTAND THE PAYMENT IS CONSIDERED LATE IF NOT PAID IN FULL WITHIN 30 DAYS OF PROVISION OF SERVICES, THEREFORE; I (WE) AGREE TO PAY AN ADDDITIONAL CHARGE OF 1% (OR MAXIMUM PRECENTEGE ALLOWED BY LAW, WHICHEVER IS LOWER) OF THE INVOICED AMOUNT PER MONTH FOR ANY PAYMENT RECEIVED BY AETHETIQUE COSMETIC & PLASTIC SURGERY, LLC MORE THAT 30 DAYS FROM THE DATE OF THE INVOICE OR BILL FOR SERVICES. IN THE EVENT COLLECTION OF MY/OUR ACCOUNT IS REFERRED TO AN ATTORNEY, I (WE) AGREE TO PAY ALL EXPENSES INCURRED BY AESTHETIQUE COSMETIC & PLASTIC SURGERY, LLC IN EFFECTING PAYMENT SPECIFICALLY INCLUDING ATTORNEY'S FEES OF 33% OF THE PRINCIPAL DUE AND OWING.

INSURANCE INFORMATION / INFORMACIÓN DEL SEGURO

MR # _____ Date of Injury / Fecha de Herida:_____

Primary Insurance: _____

Insurance Address: _____
City State Zip Code

Policy #// Claim #: _____ Group #: _____

Name of Policy Holder:_____ DOB of Policy Holder: _____

Relationship to Patient: Self Spouse Child

Adjuster: _____Contact #: _____ Ext _____ Fax: _____

NCM: _____Contact #: _____ Ext _____ Fax:_____

Secondary Insurance_____

HEALTH HISTORY // HISTORIA DE SALUD

Patient Name / Nombre del Paciente: _____ **Date of Birth / Fecha de Nacimiento:** _____

Smoking / Fuma: __No __Yes **Weight / Peso:** _____lbs **Drug Allergies / Alergias Medicamentos:**_____
Alcohol / Toma: __ No __Yes **Height / Altura:** _____

Surgeries / Cirugías:

_____

Medications / Medicamentos:

_____

_____

Family History/Historia Clinica Familiar: (check only those that apply / verifique solo aquellos que aplican)

____N/A	**Who / Quien:**
____Breast Cancer/Cancer de Mamas	_____
____High Blood Pressure/ Presion Alta	_____
____Melanoma	_____
____Heart Disease/ Enfermedad Cardiaca	_____
____Kidney Disease/ Enfermedad Renal	_____
____Depression / Depresión	_____
____Diabetes	_____

Past Medical History/ Historia Clinica Pasada:

___Anemia
___Anxiety / Ansiedad
___Arthritis / Artritis
___Asthma / Asma
___Atrial Fibrillation / Fibrilación Auricular
___Auto-Immune Disease / Enfermedad Autoinmune
___Biopolar Disorder / Desorden Bipolar
___Blood Clotting Disorder / Coagulas en la Sangre
___Bone Marrow Transplantation / Transplante de Médula
___BPH(Benign Prostatic Hyperplasia)
___Breast Cancer / Cancer de Mamas
___High Cholesterol / Colesterol Alto
___Heart Disease / Enfermedad Cardica
___Chronic Pain / Dolor Crónico
___Colon Cancer / Cancer de Colon
___COPD (Chronic Obstructive Pulmonary Disease)
___Coronary Artery Disease / Enfermedad Arteria
___Deep Venous Thrombosis / Trombosis Venosa Profunda
___Depression / Depresión
___Diabetes (Insulin / Non Insulin)
___Easy Bruising / Facil de Contraer Moretones
___End Stage Renal Disease / Enfermedad Renal
___GERD (Gastroesophageal Reflux Disease)
___Glaucoma
___Hepatitis
___High Blood Pressure/ Presion Alta
___HIV / VIH
___Hypothyroidism (Thyroid Disease) / Tiroides
___Kidney Disease/Enfermedad Renal
___Leukemia / Leucemia
___Lung Cancer / Cancer de Pulmón
___Lupus
___Lymphoma / Linfoma
___Mitral Valve Prolapse/Prolapso de la valvula Mitr
___Prostate Cancer / Cancer de Prostata
___Rheumatic Fever/ Fiebre Reumatica
___Seizures / Convulsiones
___Stomach Ulcer/Ulcera en el estomago Derrame
___Stroke/ Carrera
___Tuberculosis

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

X_____ _____
Signature of Patient or Parent (If Minor)// Firma de Patient o Padre (Si es Menor) **Date//Fecha**