Patient Demographics

Last Name/Apellido:_____ First Name/PrimerNombre_____M.I:_____

Social Security #: _____-____-_____ Date of Birth/ Fecha de Nacimito: _____-_____-_____ Age/Edad:_____

Sex: M ☐ F ☐ Marital Status: S ☐ M ☐ D ☐ W ☐

Referred By: Doctor ☐ Hospital ☐ Patient ☐ Ins. Comp ☐ Google ☐ Other _____

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

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

E-Mail: _____

Employed By: _____Occupation: _____

Primary Care Physician's Name & Number: _____

Referring Physician's Name & Number:_____

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
(Office use only) – (solo para uso de officina)

MR # _____ Date of Injury:_____

Primary Insurance: _____

Insurance Address: _____
City State Zip Code

Adjuster: _____Contact #: _____ Ext _____ Fax: _____

NCM: _____Contact #: _____ Ext _____ Fax:_____

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

Relationship to Insured: Self Spouse Child _____

Secondary Insurance_____

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

HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Smoking __No __Yes Weight _____lbs Drug Allergies_____
Alcohol __ No __Yes Height _____

Surgeries _____

Medications _____

Family History/Historia Clinica Familiar: (check only those that apply)

Has any blood relative ever had the following: **Algun Familiar ha padecido alguna de las siguientes condiciones:**

___Breast Cancer/Cancer de Mamas:
___Melanoma:
___Kidney Disease/ Enfermedad Renal
___High Blood Pressure/ Presion Alta
___Heart Disease/ Enfermedad Cardiaca
___Depression

Past Medical History/ Historia Clinica Pasada:
Have You ever had the following **Alguna vez has padecido de las siguentes condiciones:**

___Heart Disease/Enfermedad Cardica
___Mitral Valve Prolapse/Prolapso de la valvula Mitral
___Cancer
___Stomach Ulcer/Ulcera en el estomago
___Bleeding Tendency/ Hemorragia
___Tuberculosis
___Glaucoma
___Rheumatic Fever/ Fiebre Reumatica
___Thyroid Disease/ Enfermedad de Tiroides
___Diabetes
___Arthritis/ Artritis
___Kidney Disease/Enfermedad Renal
___Asthma/ Asma
___Anemia
___Stroke/ Derrame Cerebral
___Hepatitis
___HIV
___High Blood Pressure/ Presion Alta
___Blood Clotting Disorder/Coagulas en la Sangre

Review of Systems:
Do you have now or have you had within the last year **Usted padece o ha padecido en este ultimo ano**

___Weight Change/ Cambio de Peso
___Dry Eyes/ Resequedad en los Ojos
___Chronic Cough./ Tos Cronica
___Chest Pain/ Dolor de Pecho
___Rapid Heart Beat/ Palpitaciones
___Swollen Feet/ Pies Hinchados
___Skin Rash/ Erupcion Cutanea
___Chronic Diarrhea/ Diarrea Cronica
___Seizures/ Incautaciones
___Joint-Muscle Pain/ Dolor de Huesos o Musculos
___Swollen Lymph Nodes/ Inflamacion de Ganglios Linfaticos
___Depression
___Easy Bleeding/ Sangrado Facil
___Easy Bruising/ Facil de contraer Moretones
___Jaundice/ Icterisia (Cutis Amarillo)

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEAST OF MY KNOLEDGE
YO VERIFICO QUE ESTA INFORMACION ES VERDADERA Y EXACTA A LO MEJOR DE MI CONOCIMIENTO

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