SOUTH BAY MEDICAL WEIGHT LOSS CLINIC, INC

DRS ASIF AZIMI, MD AND CLAUDIA KWON, MD
16705 HAWTHORNE BLVD * LAWNDALE * CA * 90260 * TEL 310-370-2577

PATIENT INFORMATION FORM

Date: _____

NAME: (Miss, Mrs., Mr., MD, JD, Ph D, Ed D) □Male □Female

_____ Age: _____ Birthdate: _____
(Last) (First) (Middle)

ADDRESS: _____
(Number) (Street) (Apt. #)

_____ Phone: _____
(City) (State) (Zip)

EMPLOYER: _____S.S. # _____ Phone: _____

Address: _____

FAMILY-PHYSICIAN'S-NAME: _____Phone: _____

Address: _____

EMERGENCY CONTACT INFORMATION

CONTACT #1: _____ **CONTACT #2:** _____

Address: _____ Address: _____

Phone: _____ Phone: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request all communications from Drs. Asif Azimi, MD Claudia Kwon, MD and staff be delivered to me in the following way: (PLEASE CHECK ALL APPROPRIATE BOXES)

[ ] Home number: ( ) _____ - _____
{ } Leave detailed information { } Leave name and return phone number only

[ ] Cell phone number ( ) _____ - _____
{ } Leave detailed information { } Leave name and return phone number only

[ ] Work number: ( ) _____ - _____
{ } Leave detailed information { } Leave name and return phone number only

[ ] Other: _____

*Whom may we Thank for Referring You to Us? _____
*How did you Hear About Us? _____
*I certify that I have answered the questions to the best of my ability and will notify South Bay Medical Clinic, Inc. immediately for any pertinent changes in my medical conditions and/or change in address/telephone number.

_____ _____
Patient's Signature **Date/Time**