Serenity Ketamine Center

20929 Ventura Blvd., Ste 25
Woodland Hills, CA 91364
(818) 800-0082

PATIENT REGISTRATION (Page 1)

I. PATIENT INFORMATION

LAST NAME	FIRST NAME / MIDDLE INTIAL	DATE OF BIRTH	
ADDRESS	CITY	STATE	POSTAL CODE
HOME PHONE NO. ( )	CELL PHONE NO. ( )	SOC. SEC. NO.	
DRIVER LICENSE NO.	DRIVER LICENSE STATE	SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOW/ER

II. LEGAL GAURDIAN INFORMATION (IF A MINOR)

LAST NAME	FIRST NAME / MIDDLE INTIAL	RELATIONSHIP TO PATIENT	☐ MALE ☐ FEMALE
HOME PHONE NO. ( )	CELL PHONE NO. ( )	WORK PHONE NO. ( )	

III. INSURANCE INFORMATION

LAST NAME	FIRST NAME / MIDDLE INTIAL	DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURANCE COMPANY		INSURANCE CO PHONE NO.	
INSURANCE CO ADDRESS			
POLICY NO.	GROUP NO.		

IV. CERTIFICATION STATEMENT

I verify that the above and all information I provide to this office is factually correct and true to the best of my knowledge. I authorize Dr. Hossein Gharakhani to employ blood tests, urine tests, medicines, and any other treatment modalities or aids as he deems necessary in order to provide the proper medical care. I understand that payment, proof of insurance, and/or copay is due at the time of service. I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information that I have provided is factual and correct. I also understand if Dr. Gharakhani is not a provider of my insurance company or be denied for any reason I will be solely responsible for all and full charges. I understand that Dr. Gharakhani / Serenity Ketamine Center can refuse my insurance company at all time.

SIGNATURE ▶	TODAY'S DATE

Serenity Ketamine Center

PATIENT FULL NAME ____________________

DATE OF BIRTH ____________________

PATIENT REGISTRATION (Page 2)

V. MEDICAL HISTORY QUESTIONAIRE (Please indicate with a check if you have OR had any of the following)

SYMPTOMS

- ☐ Poor Stress Control
- ☐ Sensitivity to Bright Light
- ☐ History of a Reading Disorder
- ☐ History of Underachievement
- ☐ Little or No Dream Recall
- ☐ Poor Short Term Memory
- ☐ Sensitivity to Loud Noises
- ☐ History of Perfectionism
- ☐ Seasonal Allergies
- ☐ Compulsive Tendencies
- ☐ Self-Motivated in School
- ☐ Very Strong Willed
- ☐ Phobias
- ☐ Hyperactivity
- ☐ Good Antihistamine[1] Response
- ☐ Adverse Antihistamine[1] Response
- ☐ Good SSRI[2] Response
- ☐ Adverse SSRI[2] Response
- ☐ Good Benzodiazepine Response
- ☐ Adverse Benzodiazepine Response
- ☐ Dietary inflexibility
- ☐ Temperature Imbalance (Hot/Cold)
- ☐ High Irritability and Temper
- ☐ White Spots on Fingernails
- ☐ Tendency to Skip Breakfast
- ☐ Affinity for Spicy/Salty Foods
- ☐ Sensitivity to Foods/Chemicals
- ☐ Artistic or Musical Affinity

SYMPTOMS

- ☐ Mood Swings
- ☐ Abnormal Menstrual Period
- ☐ Intolerance To Estrogen
- ☐ Intolerance to Birth Control Pills
- ☐ High Anxiety
- ☐ Skin Sensitivity (Metals/Tags)
- ☐ Sensitivity to Food Dyes
- ☐ Sensitivity to Shellfish
- ☐ Tendency to Panic
- ☐ Low Libido
- ☐ Frequent Headaches
- ☐ Ringing in Ears
- ☐ Other: ____________________

MENTAL HEALTH

- ☐ None Apply
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Obs. Compulsive Disorder
- ☐ PTSD
- ☐ Schizoaffective Disorder
- ☐ Alcohol Dependence
- ☐ Drug Dependence
- ☐ Chronic Pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Cancer: ______________
- ☐ Diabetes
- ☐ Hypertension
- ☐ Stroke
- ☐ Other: ________________

ALLERGIES

- ☐ NONE APPLY
- ☐ Penicillin
- ☐ Bacterium/Sulfa
- ☐ Other: ______________________

SMOKE/ALCOHOL USE

- ☐ I do not smoke
- ☐ I smoke, Qty: ______________
- ☐ I do not drink
- ☐ I drink, Qty: ________________

LEGEND

1. Antihistamines such as Benadryl, Allegra, Claritin, etc.
2. Selective Serotonin Reuptake Inhibitors such as Celexa, Lexapro, Paxil, Zoloft, etc.

REASON FOR VISIT TODAY

VI. CURRENT MEDICATIONS

Medication	*Dosage*	*Reason*

VII. MEDICAL HISTORY CERTIFICATION STATEMENT

I CERTIFY THAT THE FOLLOWING PROVIDED MEDICAL HISTORY IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	TODAY'S DATE