PROSPECTIVE NEW PATIENT QUESTIONNAIRE

Thank you for your interest in ***Be Hive of Healing*** and our doctors: ***Dr. Habib Sadeghi*** and ***Dr. Robert Gross***
We are committed in providing care for our existing patients as well as extending our services to prospective new patients who are open to healing through integrative medicine. Our doctors will review each request on an individual basis and one of our medical staff will contact you regarding the status of your request. Please note that we currently have a large number of new patient requests as well as a patient waiting list which may delay the new patient scheduling process. We appreciate your patience and cooperation. In the meantime, be sure to seek the professional medical attention that you must receive if you have an existing medical condition.
NOTE*: If possible, please print out this form and complete by hand. If not, you may type your response.*

YOUR NAME:	First:	Last:
E-MAIL ADDRESS:		DATE OF BIRTH:
MAILING ADDRESS:		
PHONE NUMBERS:	Cell:	Home:
WHO REFFERED YOU:	Name:	Phone Number:
Are you seeing another doctor for a condition? Please explain:		
Briefly explain the reason you would like to see our doctors:		

List any medications you are currently taking or have taken in the recent past:

Medication Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

List any vitamins, herbs, or nutritional supplements you are currently taking:

Supplement Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

Would you like to receive our monthly newsletter? ☐Yes ☐No

To view our current newsletters, please visit http://behiveofhealing.com/newsletter/

Please note that ***Be Hive of Healing*** operates on a "fee-for-service" basis. We do not have contracts with insurance companies and have an "Opt-Out" status with Medicare. Payment for our services is due on or before the time the services are provided. Thank you. Be well.

***NOTE*: Please return the completed form to either of the following *options*:**
MAIL: Be Hive of Healing Integrative Medical and Dental Center, ATTN: New Patient Request,
5017 Lewis Road, Suite A, Agoura Hills, California 91301, USA
E-MAIL: admin@behiveofhealing.com ***FAX:*** 1 (818) 452-4488
For any questions, please call: 1 (818) 452-4483