Saeid Aryan, D.O.

David Rubin, M.D.

Phone: 817.502.7411/Fax: 817.502.7412
www.brainandback.com

New Patient Office Information

First Name: _________________________ Initial: _____ Last Name: ______________________________

Address: ____________________________ Apt# _____ City: _________________ State: ____ Zip: _______

Gender: □ M □ F Date of Birth: ____/____/____ SSN # ____-____-____

Email Address: ____

Home Phone: (____) _____ - _______ Cell Phone: (____) _____ - _______ Alt Phone: (____) _____-______

Parent/ Legal Guardian if Patient is a Minor: ____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Spouse's Name: __________________ Spouse's DOB: ____/____/____ Spouse's Phone: (____) ____-______

Race: □ Asian □ White □ American Indian/Alaska Native □ Hispanic □ African American □ Other: __________

Language: □ English □ Spanish □ Other: ________________

Employers Name: _________________________________ Occupation: ______________________________

Employers Number: (_____) _____ - _______ Are you a Veteran of the US Armed Forces? □ YES □ NO

Emergency Contact

Name: ____Relationship: ____________________________

Home #: (_____) _____ - _______ Cell #: (_____) _____ - _______ Alternate #: (_____) _____ - _______

Insurance Information

Policy Holder: ________________________________ SSN # _____-_____-______ D.O.B ____/____/_____

Primary Insurance Company: ____________________Policy #________________Group # ______________

Second Insurance Company: ____________________ Policy # ________________ Group #________________

How were you referred?

Referring Doctor ________________________________ Phone Number/City___________________________

Primary Doctor _________________________________ Phone Number/ City __________________________

□ Insurance Carrier □ Friend/Family □ Internet □ VA □ Other_____________ □ Hospital: _____________

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Patient Medical History

Check all that apply: □ None apply

□ Osteoarthritis	□ Depression	□ High Blood Pressure	□ Diabetes	□ Kidney Failure
□ Anemia	□ Migraines	□ Seizures	□ Heart Attack	□ Osteoporosis
□ Blood Clot(s)	□ Liver Disease	□ Stroke	□ Cholesterol	□ Cancer: ________
□ Lung Disease	□ Heart Failure	□ Chronic Pain	□ Asthma	□ Rheumatoid Arthritis

Medication Allergies (Food, Latex): □ No Known Drug Allergies

____

Past Surgical History:

Type of Surgery	Approx. Year	Type of Surgery	Approx. Year
___________________________	____________	______________________________	____________
___________________________	____________	______________________________	____________
___________________________	____________	______________________________	____________
___________________________	____________	______________________________	____________

Pharmacy Information

Pharmacy Name: ______________________ Phone#: (____) ____-_______ Location: _______________________

List **ALL CURRENT** Medications and doses: □ None

______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________
______________________ ______________________ ______________________ ______________________

Do you smoke? □ Yes □ No ______ packs/day for ___ years Do you drink alcohol? □ Yes □ No
□ Quit ____ months/years Do you dip/chew tobacco? □ Yes □ No □ Daily □ 1-2 x/week □ Occasional

Family History

Check all that apply: □ None apply □ Deceased □ Mother (M) ______ □ Father (F) ______

□ Stroke M/F □ Diabetes M/F □ Seizures M/F □Heart Disease M/F □ High Blood Pressure M/F
□ Mental Illness M/F □ Arthritis M/F □ Gout M/F □ Cancer M/F ________ □ Bleeding Disorders M/F

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Chief Complaint: □ Neck Pain □ Back Pain □ Leg pain □ Arm pain □ Other___________

On what date did your symptoms start? ________________

Symptoms described as: □ Sharp □ Dull □ Achy □Burning

□ Spasms □ Other _____________

Do your symptoms interfere with your daily activities? □ Yes □ No

Is your condition the result of a Work Injury? □ Yes □ No Auto Accident? □ Yes □ No

Was there a trauma or inciting incident? __________________ Date of injury? _____________

1. Arm symptoms: □ Pain □ Numbness □ Weakness □ Right Arm □ Left Arm

   Leg symptoms: □ Pain □ Numbness □ Weakness □ Right Leg □ Left Leg
2. Do you have problems with balance or frequent falling/tripping? □ Yes □ No

   Pain is: □ Improving □ Worsening □ Same (unchanged) □ Other: ___________________
3. Activities that worsen your pain: □ Sitting □ Standing □ Walking □ Lying Down

   □Bending/twisting □ Other______________
4. Activities that relieve your pain: □ Sitting □ Standing □ Walking □ Lying Down

   □Bending/twisting □ Other______________
5. How many minutes can you stand/walk before you need to rest?

   □ less than 5 □ less than 30 □ less than 60 □ 60 or more □ Other: ______________

Treatments Include:

□ **NONE** (no medications, physical therapy, chiropractic manipulations, injections or bracing)

□ Anti-inflammatory medication □ Physical Therapy □ Acupuncture □ Oral steroids □ Bracing

□ Muscle relaxants □ Acupuncture □ Chiropractic Manipulation □ Narcotic/Opioid pain medication

Injections: □Trigger Point □ Epidural Steroid □ Facet □ Sacroiliac

Axis Brain & Back Institute, PLLC

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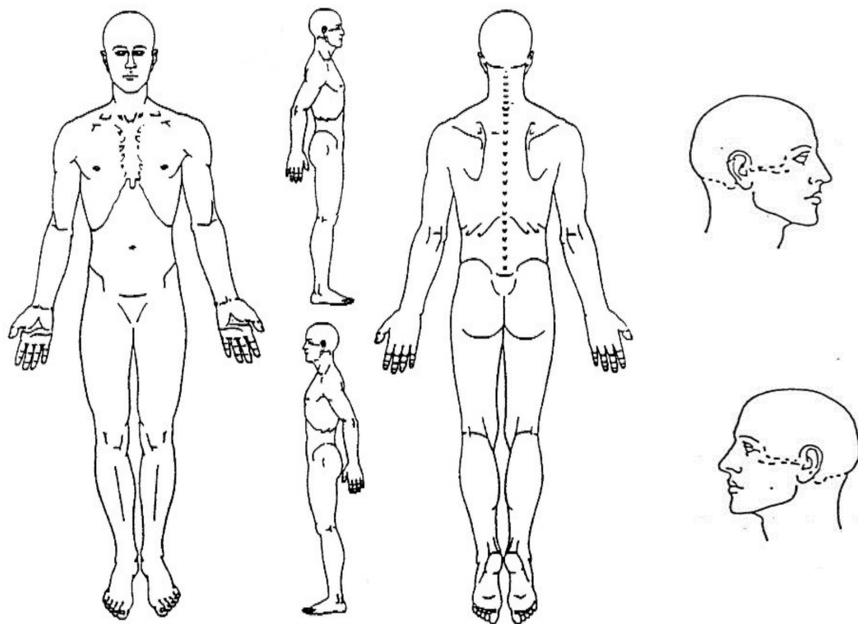


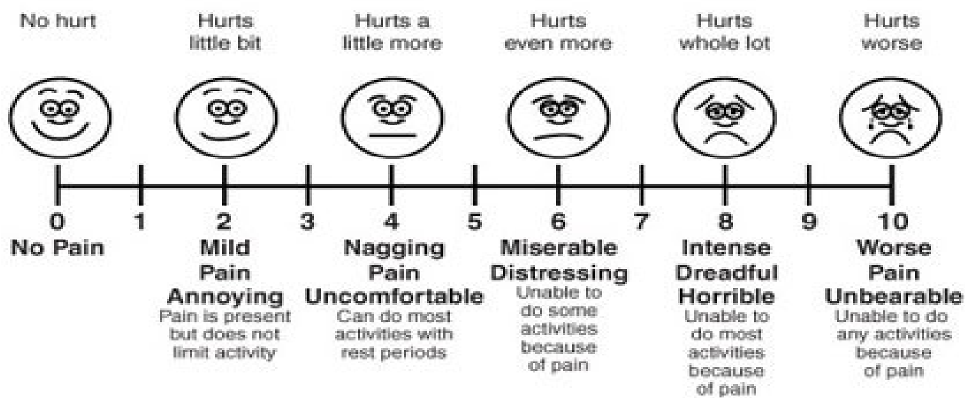
Please mark the area of discomfort by using the appropriate letter(s).

X = Pain B = Burning

T = Tingling W = Weakness

On a PAIN SCALE of 1- 10 what number would you consider yourself?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10



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CONSENT FOR TREATMENT FORM

__________ I understand that I have presented myself to AXBBI, PLLC for evaluation and/or treatment for my condition. I authorize and direct
(Initial) AXBBI, PLLC to perform quality care upon me, and understand that all options will be discussed prior to the administration of treatment. I acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his/her associates, or colleagues.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

__________ I hereby give authorization of insurance benefits to be made directly to AXBBI, PLLC services rendered. I understand that I am financially
(Initial) responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

ACKNOWLEDGEMENT OF PATIENT RIGHTS

__________ I, have read the **NOTICE OF PATIENT RIGHTS** and have had any questions answered by this office. I understand that by
(Initial) signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. But any disclosures given in reliance on this prior consent will be permissible.

ACKNOWLEDGMENT OF PATIENT RESPONSIBILITIES

__________ I have read the **NOTICE OF PATIENT RESPONSIBILITIES** and have had any questions answered by this office. I understand that by signing
(Initial) this form I acknowledge that I have read the **Patient Responsibilities Notice posted in all AXBBI, PLLC locations.** My consent is freely given. I understand that I may revoke this consent at any time, if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

_________ I acknowledge that Dr. Saeid Aryan and/or Dr. David Rubin at any given time may be a consultant, owner, manager, director, or
(Initial) developer of various entities including but not limited to companies that develop, distribute, and/or manufacture spinal biologics and implants and may have financial interests in various physician owned entities including but not limited to: management companies, laboratories, medical device manufacturers, pharmacies, neuromonitoring, imaging, first assist and/or anesthesia companies, ambulatory surgery centers and/or hospitals, that may pertain to your care. Some of which may be out of network, and as a result you may receive an out of network bill. However, you have the right to choose the providers and healthcare facilities of your choice.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_________ I acknowledge that AXBBI, PLLC has provided me with the opportunity to view and read a written copy of
(Initial) **NOTICE OF PRIVACY PRACTICE.**

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO FAMILY MEMBERS & CONSENT OF DISCLOSURE OF INFORMATION

_________ I **AGREE** and acknowledge that AXBBI, PLLC will disclose my protected Health Information (PHI) to a family member, other relative, close
(Initial) friend or any other person I identify that directly relates to that person's involvement in my care. The following are authorized person(s) who my PHI may be disclosed to: Name(s):____

□ Spouse: (____) ____-______ □ Mother/Father: (____) ___-______ □ Brother/Sister: (____) ___-_____ □ Other: (___) ____-________

_________ I **OBJECT** to the disclosure of my Protected Health Information to a family member, other relative, close friend or any other person.
(Initial)

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SHARING OF INFORMATION FOR PURPOSE OF PAYMENT

_________ I acknowledge that AXBBI, PLLC will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare,
(Initial) Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies.
Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_________ I acknowledge that AXBBI, PLLC may communicate with me via US mail, Home/Cell Phone and through patient portal.
(Initial)

PAIN MEDICATION POLICY

At Axis Brain & Back Institute, PLLC, our goal is to address your condition with the most innovative, minimally invasive, and cost-conscious treatments available. When appropriate, providers at Axis Brain & Back Institute, PLLC will prescribe **ONE 30-day supply of pain medication for post-operative pain**. This prescription is given to you after surgery upon discharge from the hospital.

There are federal and state laws, regulations and policies regarding the use and prescribing of controlled substances. Controlled substances are drugs that are subject to statutory control. **If patients experience pain beyond the 30-day post-operative follow-up appointment they will be referred to a pain management provider for continued care**. If the prescription are lost or stolen, they will not be replaced.

By signing below, I agree to the Pain Medication Policy and understand the following:

I. Pain medication is **NOT** prescribed before surgery
II. Pain medication prescribed to me will be **after surgery for post-operative pain**
III. I will only be prescribed **ONE 30-day supply** of pain medication
IV. If prescription is lost or stolen they **will not be replaced**
V. If pain management is needed, Axis Brain & Back Institute, PLLC will refer me to an appropriate pain management provider
VI. If I am under Pain Management, **it is my responsibility to comply** with my pain contract in regards to prescriptions

____ _______________________________
Patient or Legal Guardian Signature Date

____
Patient Printed Name