



Saeid Aryan, D.O.
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New Patient Intake Forms

Patient Information

Last Name: _____ First Name: _____ Initial: _____
Address: _____ Apt# _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Date of Birth: ____/____/____ Gender: M F SSN # ____-____-____
Marital Status: Single Married Divorced Widowed
Parent/ Legal Guardian if Patient is a Minor: _____

Primary Doctor _____ Phone Number/ City _____

Referring Doctor _____ Phone Number/City _____

Insurance Carrier Friend/Family Internet VA Other _____ Hospital: _____

Employer's 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 # _____

Email Address: _____

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

Language: English Spanish Other: _____

Pharmacy Name: _____ **Phone#:** (____) _____ - _____ **Location:** _____



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Office Policies

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 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 hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. If I have multiple primary insurance policies, I acknowledge I am responsible for coordinating primary vs. secondary with my insurance companies. Failure to do so will result in claim denials and refusal to pay. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ I understand payment is due at time of service. Payment can be made by cash, check Visa, MasterCard, Discover or Amex. There is a \$1500 limit for credit card transactions.

_____ I understand that I am financially responsible for all charges at time of service including copays, deductibles and coinsurances. In the event of denials, errors, service caps, policy exclusions or non-covered services, I am responsible for payment of all services rendered. I understand that any account balance incurred must be paid in full prior to scheduling surgery.

_____ I understand AXBBI, PLLC reserves the right to report any unpaid balances greater than 120 days old to a collection agency for payment recovery. In the event of default, I agree to pay all costs of collections which constitutes balance due plus a 35% collection fee.

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, 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.



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COMMUNICATION AUTHORIZATION

I acknowledge that AXBBI, PLLC may communicate with me via US mail, Home/Cell Phone (____) ____ - ____ and through the patient portal for both medical and financial purposes.

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 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.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

ACKNOWLEDGEMENT OF FINANCIAL INTERESTS

I acknowledge that Dr. Saeid Aryan at any given time may be a consultant, owner, manager, director, or 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.

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

I acknowledge that AXBBI, PLLC will disclose my protected Health Information (PHI) to a family member, other relative, close 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): _____
Name(s): _____
Name(s): _____

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

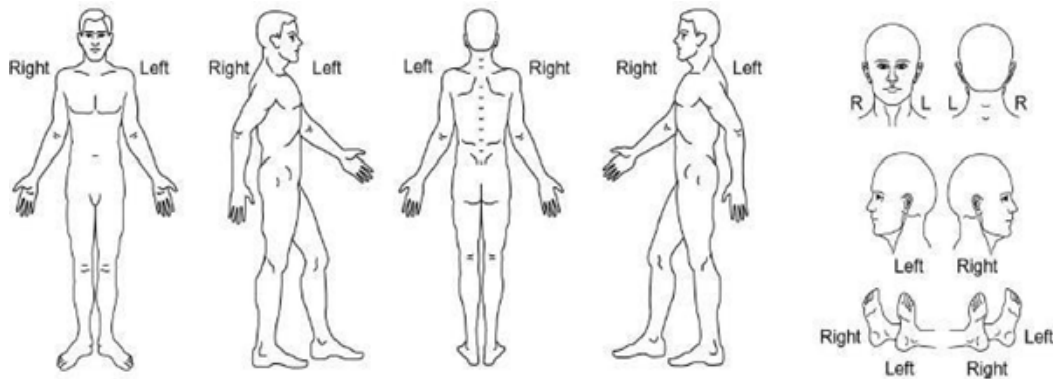
Patient or Legal Guardian Signature

Date

Printed Patient name

Chief Complaint

What is the reason for your visit today?: _____
(Please use the diagram to indicate the area of your pain. Mark the location with an "X")



Symptoms have been present since: Years _____ Months _____ Weeks _____

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

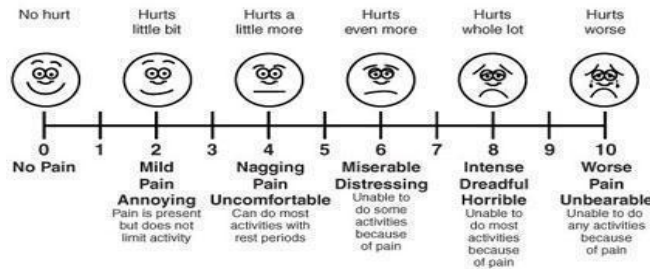
Was there a trauma or inciting incident? _____ Date of injury? _____

Does this pain radiate? If so, where?: _____

How would you describe the pain?: (eg sharp, dull, achy, burning, stabbing, throbbing, electric, numbness, other _____)

What makes the pain better?: _____

What makes the pain worse?: _____



On a PAIN SCALE of 1- 10 using the scale above, how would you rate your pain?

Currently: _____ On average: _____ The Best It Gets: _____ The Worst It Gets: _____

How often is the pain present?

- Constant
- Frequent (several times per hour)
- Sporadic (several times per day)
- Occasional (several times per week)
- Rare (several times per month)



Does your pain interfere with your daily activities? **Yes / No**

Please list 3 specific things you are unable to do because of your pain:

Does your pain affect your sleep? **Yes / No**

Do you have night sweats?: **Yes / No**

Do you have bladder or bowel incontinence? **Yes / No**

Do you have unexplained weight loss? **Yes / No**

Does your pain affect your mood?: **Yes / No**

Do you have problems with balance/falling/tripping? **Yes / No**

What is your current activity level?

sedentary

some activity

exercise regularly

Do you use any assistive devices for ambulation?: (eg cane, walker, wheelchair) **Yes / No** _____

What is your goal with pain management?: _____

Previous Treatment

Please identify which medications have been tried in the past for this complaint such as tylenol, anti-inflammatories, oral steroids, muscle relaxers, creams, patches, narcotics, other, etc:

Have you ever been to another Pain Center? Yes / No

If Yes, where/when: _____

Reason for leaving: _____

Have you had Physical Therapy before? Yes / No

If Yes, where/when: _____

Have you had any previous injections?: Yes / No

Trigger Point

Epidural Steroid

Facet

Sacroiliac

Other: _____

Have you had previous surgery(ies) related to the chief complaint?: Yes / No

If yes, surgeon and when: _____

Have you tried any of the following?:

Acupuncture

Biofeedback

Chiropractic Manipulation

Hot/Cold Packs

Massage

Meditation

Pain Psychology

TENS Unit



List ALL CURRENT Medications and doses: None

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

Past Surgical History:

<u>Type of Surgery</u>	<u>Approx. Year</u>	<u>Type of Surgery</u>	<u>Approx. Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History None apply

- Check all that apply:**
- Deceased Mother (M) _____ Father (F) _____ Substance Abuse M/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

Additional Questions

Do you smoke/use tobacco? Yes / No _____ packs/day for ___ years (Quit?: Y /N If yes, when: _____)

Do you drink alcohol? Yes / No (If yes, frequency: Daily 1-2 x/week Occasional)

Do you have a history of substance abuse? Yes / No (If yes, what substance and when last used: _____)