

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Age _____ Sex F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Social Security # _____

Home Phone# _____ Cell Phone# _____ Business # _____

MEDICATION:

DRUG ALLERGIES:

Marital Status Single Married Separated Divorced Widowed

Spouse's Name _____ Date of Birth _____ Social Security # _____

Name of nearest relative not living with you: _____ Phone # _____

Employment Status Full Time Part Time Not Employed Retired

Employer's Name _____ Phone # _____

• Is this claim the result of an illness? Yes No

• Is this claim the result of an injury? Yes No Was the injury connected with your employment? Yes No

• If yes: Date of Injury _____ Adjuster's Name _____ Phone # _____ Claim # _____

• Is this claim the result of an automobile accident? Yes No

• If yes: Date of Accident _____ Name of insured or attorney _____ Phone # _____

• **REFERRED BY:** _____ Phone # _____

• **PRIMARY CARE PHYSICIAN:** _____ Phone # _____

PRIMARY INSURANCE INFORMATION

Please present your license and insurance cards to our receptionist for a photo copy.

I authorize Abbass Sekhavat, M.D., P.A. to perform injections, draw blood and /or other procedures/treatment he determines advisable for my well being in this office. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the treatment.

I hereby assign and transfer irrevocable payment of medical benefits provided by my insurance policy to the attending physician and release all medical information to physicians, attorneys and insurance companies.

SIGNATURE: _____

DATE: _____

We wish to notify you that Dr. Sekhavat has an ownership interest in *Metroplex Imaging, L.P.*, and shares in the profits derived if any, in part from payments made by patients whom may be referred for diagnostic imaging to this facility. You are under no obligation to use *Metroplex Imaging, L.P.*, but are free to choose another facility if you so desire.

ORTHOPEDIC CLINIC OF RICHARDSON

399 W. Campbell Rd., Ste. 406

Richardson, TX 75080

(972) 644-7115

CONSENT TO RELEASE MEDICAL INFORMATION

The information contained in your file is privileged and confidential. Dr. Sekhvat however prefers to provide clinical information to all referring physicians, and primary care physicians.

With your consent - this will allow Dr. Sekhvat, to better establish a rapport with each physician, by notifying them of your future course of treatment.

I hereby authorize release of my medical information to the following physicians:

(Primary Care Physician)

(Date)

(Referring Physician)

(Date)

Patient's signature: _____

Date: _____

Name: _____

Date: _____/_____/_____

Age: _____

Occupation: _____

1. How did your pain start? (Check box)

- Lifting
- Twisting
- Fall
- Bending
- Pulling
- Hit in the back
- Auto accident
- No accident

3. Your pain is worse in your (Check boxes)

- Back
- Neck
- Head
- Arm(s)
- Back and hip(s)
- Down the leg(s)
- All of these
- None of these

4. How long have you been unable to work or do normal housework? _____

5. How long have you had any problems with your back, neck, legs or arms? _____

6. Your pain is: (Check appropriate boxes)

Better	Worse	No Different	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing or sneezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting in a straight chair
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting in a soft easy chair
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending forward to brush your teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waking up in the morning
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In the middle of the night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Midday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying flat on your back
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying flat on your stomach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying on your side with your knees bent

7. Do you have to rest during the day because of your pain? (Check appropriate box)

- No
- A little
- Half the day
- More than half the day

8. Have you ever had a myelogram - (X-ray of the spine with dye injection)? Yes No
If Yes, Give dates and # of time _____

9. Have you ever had an electromyogram (EMG)?

- Yes No Give Dates _____

10. Have you ever had neck or back surgery?

- Yes No # of time & dates _____
Describe _____

11. Have you ever been in the hospital for other medical problems? Yes No # of times
Describe & give dates _____

12. Do you exercise on a regular basis?

- Yes No

13. What other medical problems do you have? (Check appropriate boxes)

- Diabetes
- Arthritis
- Gout
- Cancer
- Stomach problems, ulcer, etc.
- Heart problems
- Epilepsy (fits)
- Other

14. Have you ever had epidural (ESI) injections?

- Yes No Dates _____

15. Have you been to physical therapy for this problem? Yes No

16. Do other members of your family have neck or back problems? Yes No
Who (relationship) _____

17. What treatments have made your pain better?

18. What treatments have made your pain worse?

19. What is the most aggravating thing about your pain? _____

20. What brought you to this office? _____

21. Please add any other information you would like to include or additions to your answer to previous questions? _____

ORTHOPEDIC CLINIC OF RICHARDSON

BONE AND JOINT SURGERY AND SPORTS MEDICINE

A. SEKHAVAT, M.D.
Diplomate of the American Board
of Orthopedic Surgery

PATIENT PAIN DRAWING

Name _____

Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching
▲ ▲ ▲

Numbness
= = =

Pins and needles:
○ ○ ○

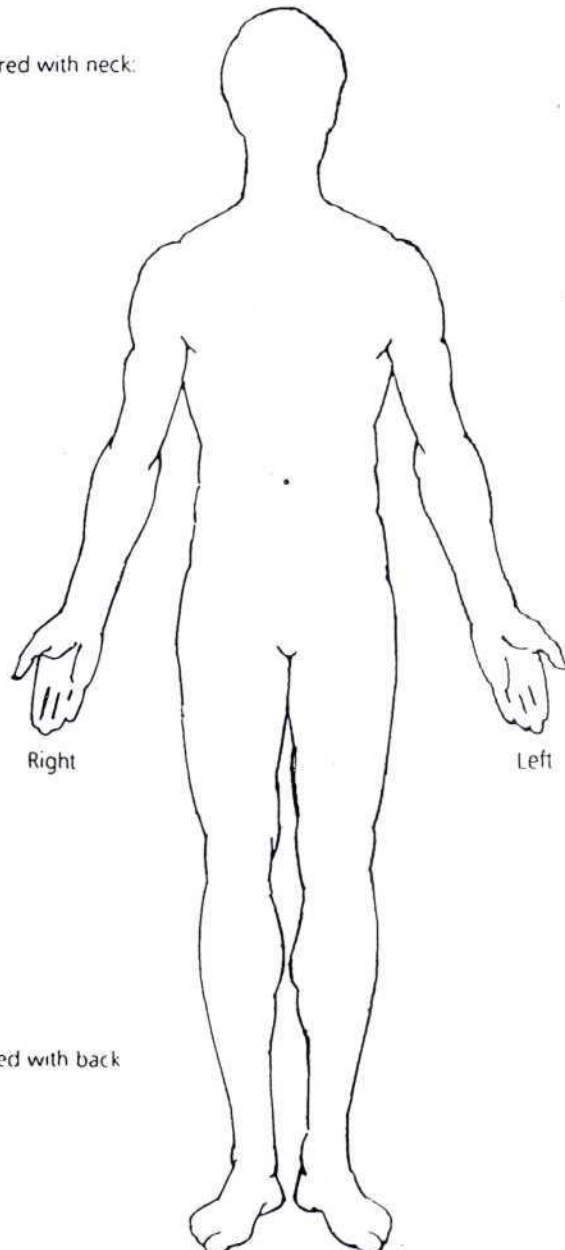
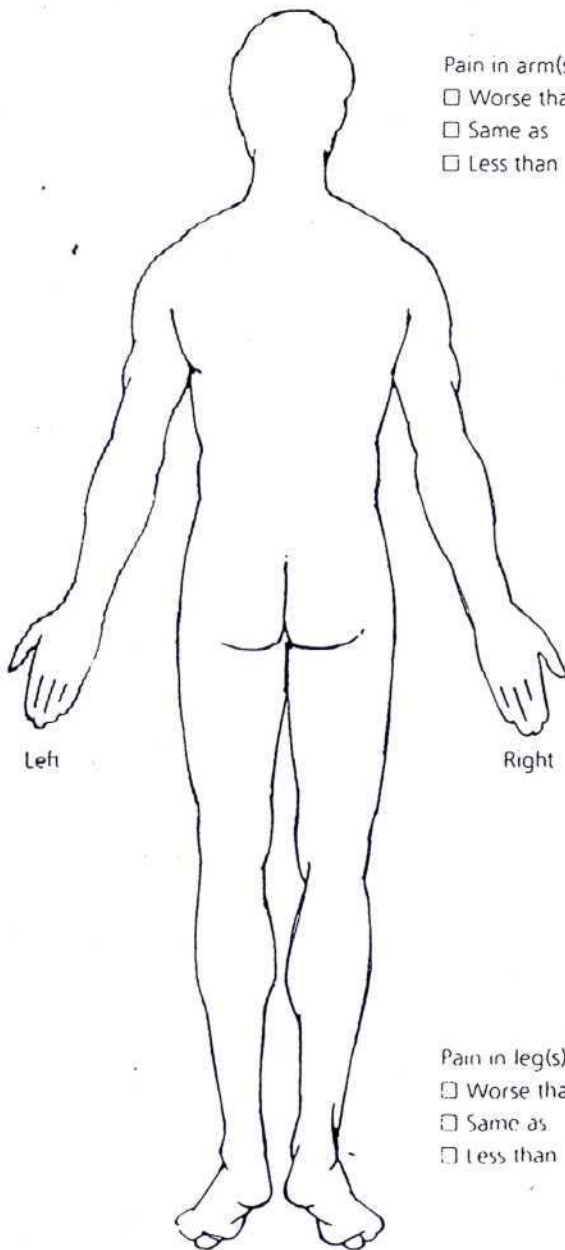
Burning
x x x

Stabbing
/ / /

Other
• • •

Back

Front



Pain in arm(s) compared with neck:

- Worse than
- Same as
- Less than

Pain in leg(s) compared with back:

- Worse than
- Same as
- Less than

ORTHOPEDIC CLINIC OF RICHARDSON

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Orthopedic Clinic of Richardson to use and disclose protected health information (PHI) about me to carry our treatment, payment and healthcare operations (TPO).

Orthopedic Clinic of Richardson's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orthopedic Clinic of Richardson reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request Orthopedic Clinic of Richardson (Privacy Officer at 399 W. Campbell Rd. Suite 406 Richardson, Texas 75080.

With this consent, Orthopedic Clinic of Richardson may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among other.

With this consent, Orthopedic Clinic of Richardson may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Orthopedic Clinic of Richardson may **e-mail** to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Orthopedic Clinic of Richardson restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Orthopedic Clinic of Richardson's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Orthopedic Clinic of Richardson may decline to provide treatment to me.

(Signature of Patient or Legal Guardian) Date _____

(Patient's Name)

(Print Name of Patient or Legal Guardian)

ORTHOPEDIC CLINIC OF RICHARDSON
399 WEST CAMPBELL ROAD, #406
RICHARDSON, TEXAS 75080

Patient _____

I recognize that I am responsible for providing my insurance information to Orthopedic Clinic of Richardson at the time of service. If I do not have this information, I must pay for my visit and will be provided a statement to file with my insurance carrier myself. _____ (initials)

I agree to pay for any and all medical services I receive from Abbass Sekhavat M.D. that my insurance company refuses to pay, for whatever reason. This office will file a claim on my behalf. However, if my insurance company denies payment for any reason, such as, non-covered services, terminated coverage, my failure to secure a referral from my primary care physician, then I will pay for it upon written/verbal notice of their refusal. Failure by my insurance company to pay for a "clean claim" within 45 days of filing is, for the purpose of this agreement, a refusal to pay. _____ (initials)

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from insurance is inappropriate and may result in a fraudulent act. _____ (initials)

I hereby assign and transfer irrevocable payment to Orthopedic Clinic of Richardson/Abbass Sekhavat M.D. of all office and/or surgical payments.

_____ (patient signature)

I, hereby authorize this office to release any information acquired in the course of my examination or treatment to the following:

Name of insurance company: _____

Name of your attorney representing you:
