PATIENT NO.

PATIENT REGISTRATION FORM

F. John Hajaliloo, M.D.

TODAY'S DATE

PLEASE PRINT IN **BLACK** INK **(CHILD OR MINOR)**

PATIENT

LAST NAME | FIRST NAME | MIDDLE | NICKNAME

STREET ADDRESS | APT. NO. | CITY | STATE | ZIP CODE

PHONE NO. | AGE | DATE OF BIRTH | SEX

PATIENT'S SOCIAL SECURITY | DATE OF INJURY/ONSET

NAME OF FRIEND/NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY | RELATIONSHIP | PHONE NO.

FATHER'S INFO

FATHER'S LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH

STREET ADDRESS | APT. NO. | CITY | STATE | ZIP CODE | PHONE NO.

FATHER'S OCCUPATION | FATHER'S SOCIAL SECURITY NUMBER

EMPLOYER'S NAME | PHONE NO.

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

MOTHER'S INFO

MOTHER'S LAST NAME | FIRST NAME | MIDDLE | DATE OF BIRTH

STREET ADDRESS | APT. NO. | CITY | STATE | ZIP CODE | PHONE NO.

MOTHER'S OCCUPATION | MOTHER'S SOCIAL SECURITY NUMBER

EMPLOYER'S NAME | PHONE NO.

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

REFERRAL

REFERRED BY

REFERRING DOCTOR'S ADDRESS | CITY | STATE | ZIP CODE

OFFICE PHONE NO. | FAX NO.

INSURANCE

PLEASE COMPLETE THE SECTION BELOW

DO YOU BELONG TO A PPO? ☐ YES ☐ NO

DO YOU BELONG TO AN IPA/HMO? ☐ YES ☐ NO IF YES, NAME OF PRIMARY CARE PHYSICIAN

PRIMARY INSURANCE NAME | NAME OF POLICY HOLDER (SUBSCRIBER) | POLICY /CERTIFICATION NUMBER

SECONDARY INSURANCE NAME | NAME OF POLICY HOLDER (SUBSCRIBER) | POLICY/CERTIFICATION NUMBER

OUR OFFICE POLICY: THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED

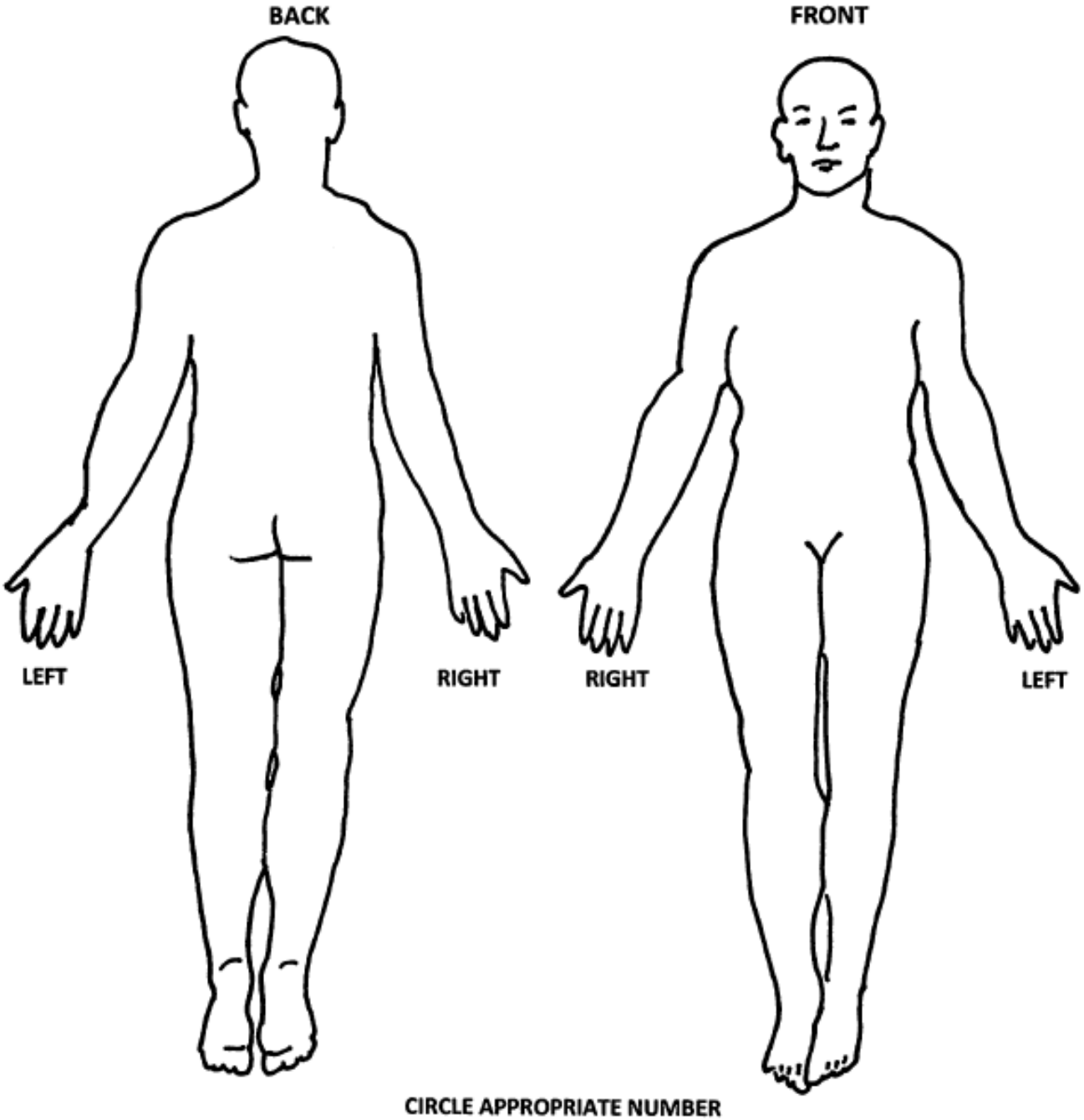
F. John Hajaliloo, M.D.

PAIN DRAWING

Name: _____ Date: _____

Be sure to fill this out extremely accurately. Mark the area on the body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	=====	Pins & Needles	oooo	Burning Pain	xxxx	Stabbing Pain	////	Aching Pain	((((
	=====		oooo		xxxx		////		((((
	=====		oooo		xxxx		////		((((



CIRCLE APPROPRIATE NUMBER

Rate your pain:	0 = No pain										10 = Extremely intense
1. Right now	0	1	2	3	4	5	6	7	8	9	10
2. At its worst	0	1	2	3	4	5	6	7	8	9	10
3. At its best	0	1	2	3	4	5	6	7	8	9	10

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History and Physical

Patient Name: _____ Date of Appointment:_____
Last First M.I.

Date of Birth: _____/_____/_____ Age:_____ Occupation:_____

Referred By:_____

Primary Care Physician:_____ Date of Last Exam:_____

Address:_____ Tel:_____ Fax:_____

Preferred Pharmacy:_____ Address:_____Tel:_____Fax:_____

Is this work related: [ ] YES [ ] NO

Is an attorney involved? [ ] YES [ ] NO If yes, name of attorney:_____

Date of Onset of Pain or Injury:_____

Chief Complaint:_____
(Please describe they type and location of pain or problem you are experiencing):

_____

_____

_____

1. History of injury *(describe in detail how you injured yourself or the history of the onset of your pain):*

_____

_____

_____

2. History of treatment: What type of treatment have you received for this problem?
(*Describe in detail, i.e: epidural injection/ physical treatment, number of treatments, & name of provider*)

_____

_____

_____

3. Length of treatment for the injury or onset of pain?_____
4. Have your symptoms improved with the above treatment? [ ] YES [ ] NO
5. Do you have previous history or injury to the same body part? [ ] YES [ ] NO

If yes, please describe:_____

_____

6. Onset of pain: How did you get injured or start experiencing present complaint:

[ ] Suddenly [ ] Gradually [ ] Lifting [ ] Twisting [ ] Fall
[ ] Bending [ ] Pulling [ ] Auto Accident [ ] Injured at Work [ ] Hit from Behind
[ ] Sports_____ [ ] No apparent Reason

7. What activities make the pain worse?

[ ] During Exercise [ ] After Exercise [ ] Sitting [ ] Standing [ ]Walking
[ ] Bending Forward [ ]Bending Backward [ ]Coughing [ ]Sneezing [ ]_____

8. What reduces your pain?

[ ] Lying Down [ ] Sitting [ ] Standing [ ] Walking [ ] Nothing
[ ] Manipulation [ ]Exercise [ ] Physical Therapy [ ] Pain Pills [ ] Injections
[ ]Aspirin [ ] Anti-inflammatories [ ] _____

9. How long have you had this pain? ___Years ___Months ___Weeks ___Days

10. How long have you had similar pain? ___Years ___Months ___Weeks ___Days

11. Have you had any of the following Diagnostic Tests?

	DATE	FACILITY
[ ] X-Ray	_____	_____
[ ] MRI	_____	_____
[ ] CAT Scan	_____	_____
[ ] EMG/Nerve cond study	_____	_____
[ ]Ultrasound	_____	_____
[ ] Injection	_____	_____

WORK HISTORY

12. If applicable, are you still working? [ ] YES [ ] NO -Last Day Worked _____,

If not working, please skip to next section, "Past Medical History", on next page

13. Present occupation and the type of work you perform _____

14. Name of employer or location where you were injured, if different from present employer or location:

_____

15. Do your job duties consist of:

[ ] Stooping [ ] Squatting [ ] Bending [ ] Pushing [ ] Pulling
[ ] Prolonged Standing [ ] Climbing [ ] Crawling [ ] Prolonged Sitting [ ] Overhead Reaching

16. How many hours a week do you work? _____

17. Are you currently working with restrictions? [ ] YES [ ] NO
If yes, please indicate restrictions:_____
_____

PAST MEDICAL HISTORY

VITALS:

Your Height: _____ Weight:_____ Are you [ ] RIGHT or [ ] LEFT handed?

Regular Blood Pressure: _____

Do you Smoke? [ ] YES [ ] NO
If yes, how many packs a day? _____

Do you Drink Alcohol? [ ] YES [ ] NO
If yes, how many glasses a week? _____

ALLERGIES: Do you have any allergies to Drugs or Foods? [ ] YES [ ] NO
If yes, please specify (& include reaction type, i.e_____) :
_____

MEDICATIONS: List all medications you are presently taking *(including dosage and frequency)*:

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY: Have you had any of the following illnesses:

	YES	NO	If yes, list treating physician and contact info:
Hypertension----------	[ ]	[ ]	_____
Cancer----------	[ ]	[ ]	_____
Heart Disease ----------	[ ]	[ ]	_____
Glaucoma ----------	[ ]	[ ]	_____
TB ----------	[ ]	[ ]	_____
Thyroid Disorder -------	[ ]	[ ]	_____
Colitis ----------	[ ]	[ ]	_____
Arthritis ----------	[ ]	[ ]	_____
Asthma ----------	[ ]	[ ]	_____
Back Problems ----------	[ ]	[ ]	_____
Blood Disorders ---------	[ ]	[ ]	_____
Bone Disease ----------	[ ]	[ ]	_____
Diabetes ----------	[ ]	[ ]	_____
High Blood Pressure ---	[ ]	[ ]	_____
Pulmonary (lung) -------	[ ]	[ ]	_____
Tumor ----------	[ ]	[ ]	_____
Ulcers ----------	[ ]	[ ]	_____
Urination Problems ----	[ ]	[ ]	_____
Other, please specify _____			_____

FAMILY HISTORY:

	Mother	Father	Sister	Brother
Arthritis	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]
Tuberculosis	[ ]	[ ]	[ ]	[ ]
Other, _____	[ ]	[ ]	[ ]	[ ]

SURGICAL HISTORY: Include all past surgeries, including those performed by Dr. Hajaliloo

PROCEDURE ,including <u>Body Part and Side (Left/Right)</u>: DATE: SURGEON & FACILITY:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Telephone messages: If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding test results and/or appointments on your answering device, or with another person who answers the phone? [ ] YES [ ] NO

Patient Name:_____

Today's Date:_____

F. John Hajaliloo, MD
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AUTHORIZATION FOR MEDICAL CARE & RELEASE OF INFORMATION

I hereby authorize F. John Hajaliloo, M.D. and staff to render necessary medical services to me. I also authorize Dr. Hajaliloo to provide information to the insurance carrier(s) and Medical Billing service concerning my illness and treatment. A copy of this authorization shall be as valid as the original.

Name of Patient:_____

Name of Representative (if applicable):_____

Signature of Patient or Representative:_____**Date:**_____

ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT POLICY

I request that payment of authorized benefits be made to F. John Hajaliloo, M.D. , INC. on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, state medical assistance agency, or any governmental private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services.

I understand that it is the patient's responsibility to know if F. John Hajaliloo, M.D., INC. is a provider with my insurance carrier, as well as the plan benefits, limitations, and referral authorization requirements. Medicare and other insurance do not pay for certain services and supplies. If my insurance denies payment, I agree to pay for all charges not covered. A copy of this authorization shall be as valid as the original.

Unless prior arrangements are made in writing, all co-payments are due at the time of your office visit. Deductibles not met for the year will be balance billed to the patient/ guarantor upon receipt of the Explanation of Benefits from your insurance carrier(s). All unpaid claims and open account balances are the responsibility of the patient/ guarantor. Patients will receive a monthly statement and must follow-up with their insurance carrier(s) on unpaid claims.

Name of Patient:_____

Name of Representative (if applicable):_____

Signature of Patient or Representative:_____**Date:**_____

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NOTICE OF PRIVACY PRACTICES RECEIPT

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Name of Patient:_____

Date of Birth:_____

Signature of Patient:_____

Date:_____

For Personal Representative of the Patient (If Applicable)

Name of Representative:_____

Relationship to Patient:_____

Signature of Representative:_____

Date:_____

For Practice Use Only:

_____

_____

_____

Signature of Practice Employee:_____

Date:_____