Harvinder Bedi

CONFIDENTIAL BILLING INFORMATION

You were referred to us by: _____

Your primary care physician Is: _____

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Address) _____ (City) _____ (State) _____ (ZIP)

Phone: _____ Cell: _____

Age: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Marital Status: _____ Social Security #: _____

Employer: _____ Business Phone: _____

Employer Address: _____

Parent/Spouse's Name: _____ Parent/Spouse's SS#: _____

Parent/Spouse's Birth Date _____

Parent/Spouse's Employer: _____ Business Phone: _____

Student: ☐ Yes ☐ No ☐ Full Time ☐ Part Time

School Name: _____

Emergency Contact - other than a relative in the same home:

Name: _____

Address: _____

Phone: _____

Harvinder Bedi

Address correspondence to:
3815 East Bell Road, #2400
Phoenix, Arizona 85032
(602) 482-2116
FAX: 482-9563

Patient's Name: _____ Date: _____

I hereby authorize my insurance company to make direct payment to:

Center for Neurology and Spine

And I understand I am financially responsible for any co-payments, deductibles, coinsurance and all charges which are considered to be not a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.

I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signed: _____

RELEASE OF INFORMATION:

I hereby authorize release of medical Information to my referring physician and/or to any other physicians who have been or may become Involved in my medical care. I also authorize release of Information that may be necessary in the processing of any Insurance claims.

Signature: _____ Date: _____

A photostatic copy of this authorization shall be considered as effective and valid as the original

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MISSED APPOINTMENT POLICY:

We want to thank you for choosing us as your health care provider. In order to give you and all our patients the best possible care we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 48-hours.

Please remember that we have reserved appointment times especlally for you. Therefore, we request at least a 48 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least 48~hours in advance in order to avoid a missed appointment fee. This charge is not covered by Insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fall to give us notice of your missed appointment, you will be charged a $50 missed appointment fee.

ACKNOWLEDGEMENT:

I have read and understand the policy stated a bove.

Patient/Guardian Signature: _____ Date: _____

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HEADING NAME TO BE PROVIDED BY SEWARJ

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

What is the main reason for your visit today? _____

How long this has been a problem:

☐ Less than 2 Months ☐ 2-6 Months ☐ 6-12 Months ☐ >than 1 year

☐ Describe injury or onset of problem (include date of Injury):

Have you been treated by any other caregiver for this conditlon(s)? ☐ Yes ☐ No

If yes, please list: _____

☐ Physical Therapy: ☐ Streching ☐ Strengthening ☐ Traction ☐ Iontophoresis/Topical Steroid ☐ Tens ☐ Massage ☐ Ultrasound ☐ Heat/Ice ☐ Therapeutic Ball

☐ Medications: ☐ Muscle Relaxants ☐ Pain Medication ☐ Anti-Inflammatory (Prescription) ☐ Chiropractic Care ☐ Anti-Inflammatory over the counter(Aspirin, Tylenol, etc) ☐ Acupuncture ☐ Injections ☐ Other _____

Have you had any other tests for this problem? ☐ Yes ☐ No

☐ X-ray ☐ MRI ☐ Discography ☐ CT ☐ EMG
☐ CT/Myelogram ☐ Bone Scan ☐ Other (Please Specify): _____

Current problem is the result of a(n) (Check all that apply):

☐ Injured at work ☐ Auto Accident ☐ Sports ☐ No apparent cause ☐ Other

Is there any litigation pending?

☐ Law Suit ☐ Workers Comps ☐ Disability Claim ☐ Social Security Claim

Current problem began:

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting
☐ Fall ☐ Bending ☐ Pulling ☐ Other

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PATIENT MEDICAL HISTORY

Patient Name: _____ (Last) _____ (First) _____ (Middle)

What makes the pian worst?

☐ During Exercise ☐ After Exercise ☐ Prolonged Sitting ☐ Prolonged Standing
☐ Walking ☐ Bending Forward ☐ Bending Backward ☐ Pushing
☐ Pulling ☐ Squatting ☐ Night Pain ☐ Other _____

What reduces the pain?

☐ Nothing ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking
☐ Medication ☐ Shifting/Changing positions ☐ Other _____

PAST MEDICAL HISTORY

Spine Surgical History

Date: _____ Surgery: _____ Complication: _____
Date: _____ Surgery: _____ Complication: _____
Date: _____ Surgery: _____ Complication: _____

Other Surgical History

Date: _____ Surgery: _____ Complication: _____
Date: _____ Surgery: _____ Complication: _____
Date: _____ Surgery: _____ Complication: _____

Current or Past Medical Conditions (i.e. hypertension, cardiac disorders, diabetes, asthma etc):

Date: _____ Illness or Hospitalization: _____
Date: _____ Illness or Hospitalization: _____
Date: _____ Illness or Hospitalization: _____

Are you Allergic to Latex? ☐ Yes ☐ No

Medication Allergies (List and describe any allergic reactions):

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Patient Name: _____ (Last) _____ (First) _____ (Middle)

Medication & Dosage

	Name	Strength	No of pills per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SOCIAL HISTORY

Age: _____ Occupation: _____

Are you:

☐ R handed ☐ L handed ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you working?

☐ Full Time ☐ Part Time ☐ Disable ☐ Retired ☐ Not Working

What is your education level?

☐ High School ☐ College ☐ Graduate Work

Do you exercise?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Type of Exercise: _____

Do you have children? ☐ Yes ☐ No How many? _____

Do you live alone? ☐ Yes ☐ No

Do you have lots of stairs? ☐ Yes ☐ No

Caffieine? ☐ Yes ☐ No How many? _____

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Patient Name: _____ (Last) _____ (First) _____ (Middle)

Do you smoke? ☐ Yes ☐ No Packs per day? _____ for _____ years.

Use other nicotine products? ☐ Yes ☐ No ☐ Chew ☐ Gum ☐ Patch ☐ Cigars ☐ Other

Have you quit smoking? ☐ Yes ☐ No How long ago? _____

Drink alcohol? ☐ Yes ☐ No ☐ Daily ☐ 1-2xWeek ☐ 1-2xMonthly ☐ 1x2xYearly ☐ Never

FAMILY MEDICAL HISTORY

	Alive	Deceased	Age	Health Status or Cause Death
Father:	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Brother(s)	☐	☐	_____	_____
Sisters(s)	☐	☐	_____	_____
Son(s)	☐	☐	_____	_____
Daughter(s)	☐	☐	_____	_____

Reviewed by: _____ Date: _____

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REVIEW OF SYSTEM

Patient Name: _____ _____ _____
Last First Middle

CONSTITUTION

Irritability	☐ Yes	☐ No
Chills/rigors	☐ Yes	☐ No
Decreased activity	☐ Yes	☐ No
Decreased appetite	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Increased appetite	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No

Others _____

EYES

Pain	☐ Yes	☐ No
Floaters	☐ Yes	☐ No
Tearing	☐ Yes	☐ No
Visual loss	☐ Yes	☐ No

Other _____

EARS

Discharge	☐ Yes	☐ No
Fullness in ears	☐ Yes	☐ No
Hearing loss	☐ Yes	☐ No
Tinnitus/Ringing in ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Other _____

NOSE & SYNUS

Eplstaxis/Nosebleeds	☐ Yes	☐ No
Facial pain	☐ Yes	☐ No
Nasal congestion	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No
Sneezing	☐ Yes	☐ No

Others _____

THROAD & MOUTH

Change in taste	☐ Yes	☐ No
Post nasal drainage	☐ Yes	☐ No
Voice change	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Tooth pain	☐ Yes	☐ No
Lump in throat	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No

Other _____

RESPIRATORY

Cough	☐ Yes	☐ No
Dyspnea/Shortness of breath	☐ Yes	☐ No
Stridor	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Other _____

CARDIOVASCULAR

Chest pain (cardiac)	☐ Yes	☐ No
Irregular heartbeat/palpitations	☐ Yes	☐ No
Syncope/Fainting	☐ Yes	☐ No

Other _____

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REVIEW OF SYSTEM

Patient Name: _____ (Last) _____ (First) _____ (Middle)

VASCULAR

Cool extremity	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No
Other	_____	

GASTRO INTESTINAL

Heartburn	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Bloating	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Reflux	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Others	_____	

METABOLIC / ENDOCRINE

Change in sleep/awake pattern	☐ Yes	☐ No
Chronically overweight	☐ Yes	☐ No
Chronically underweight	☐ Yes	☐ No
Cold intolerance	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
Heat intolerance	☐ Yes	☐ No
Other	_____	

NEUROLOGICAL

Loss of consciousness	☐ Yes	☐ No
Vertigo/Dizziness	☐ Yes	☐ No
Memory impairment	☐ Yes	☐ No
Focal weakness	☐ Yes	☐ No
Gait disturbance	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Speech changes	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Incoordination	☐ Yes	☐ No
Light-headedness	☐ Yes	☐ No
Visual changes	☐ Yes	☐ No
Others	_____	

PSYCHIATRIC

Difficulty concentrating	☐ Yes	☐ No
Psychiatric/emotional	☐ Yes	☐ No
Other	_____	

DERMATOLOGIC

Contact allergy	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
Nail changes	☐ Yes	☐ No
Rash	☐ Yes	☐ No
Change in mole	☐ Yes	☐ No
Skin lesion	☐ Yes	☐ No
Other	_____	

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Patient Name: _____ _____ _____
Last First Middle

HEMOTOLOGIC

Easy bleeding	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Blood clots	☐ Yes	☐ No
Transfusion	☐ Yes	☐ No

Other _____

IMMUNOLOGICAL

Hay fever	☐ Yes	☐ No
Urticaria/hives	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
"Bee" sting allergies	☐ Yes	☐ No
Environmental allergies	☐ Yes	☐ No
Food allergies	☐ Yes	☐ No

Other _____

ROS Reviewed with Patient: _____ Date: _____

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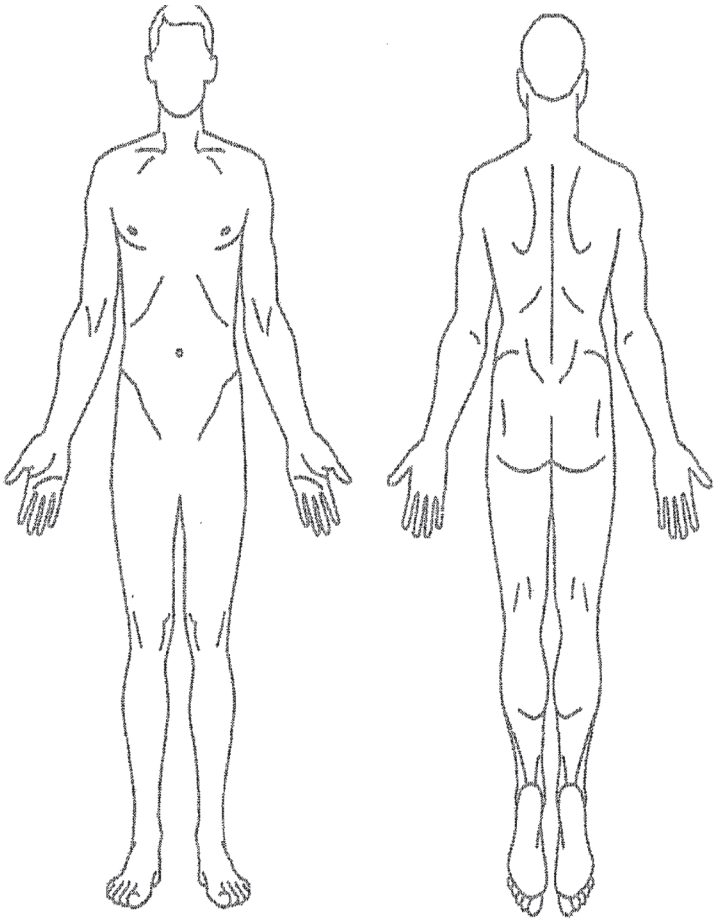
VAS PAIN INDEX

Patient Name: _____ (Last) _____ (First) _____ (Middle)

WHERE JS YOUR PAIN NOW? Does It go anywhere? (Describe):

USE THE BODY DIAGRAM TO SHOW WHERE YOU FEEL THE FOLLOWING SENSATION

- ☐ PAIN: △
- ☐ NUMBNESS: ○
- ☐ BURNING: X
- ☐ STABBING: /
- ☐ PINS & NEEDLES: =



LEG PAIN	____%
ARMPAIN	____%
NECK PAIN	____%
BACK PAIN	____%
TOTAL	100%

☐ ☐

None | Mile | Moderate | Severe | Very Severe | Worst Possible

Please scale your pain by checking appropriate box above which most accuractely describe your overall degree of pain

RESET SAVE PRINT SUBMIT