PAIN & REHAB
orange county

3300 West Coast Highway
Newport Beach, CA 92663
(949) 610-1042

Today's Date: _______________

Patient's Name: ____ Date of Birth: ________________________

Social Security #: _________________________ Single ◯ Married ◯ Divorced ◯ Widow ◯ Sex: M F

Employment Status: Employed ◯ Full Time Student ◯ Part Time Student ◯ Preferred Language:_________

Address: ________________________________ City: ____________________ Zip Code: _________________

Home Phone: ___________________________________ Alt. Phone: _________________________________

Email Address: ____

We are working to improve communication with our valued patients and occasionally send out newsletters with helpful health related articles. We are implementing a new monthly newsletter to improve communication with our valued patients. We'll also keep you informed about new services and upcoming events & programs in our office, any changes to our office hours, and new additions to our team.

Occupation: _________________________________ Employer: _____________________________________

Employer Address:_______________________________ City:_____________________ Zip Code:_________

Employer Phone: ________________________________

Emergency Contact: __________________________________ Phone: ________________________________

Relationship to Patient:______________________________

Primary Insurance Name: ____

I.D. #: ____ Group #: ___________________________________

Primary Insured Name: ___________________________________ Date of Birth: ________________________

Social Security #: ____________________________ Relationship to Insured: ___________________________

Address: _________________________________ City: ____________________ Zip Code: ________________

Home Phone: ___________________________________ Alt. Phone: _________________________________

Secondary Insurance Name: ____

I.D. #: ____ Group #: ___________________________________

Primary Insured Name: _____________________________________ Date of Birth: ______________________

Social Security #: ___________________________ Relationship to Insured: ____________________________

Address: ________________________________ City: _____________________ Zip Code: ________________

Home Phone: ____________________________________ Alt. Phone: ________________________________

PAIN & REHAB
orange county

3300 West Coast Highway
Newport Beach, CA 92663
(949) 610-1042

Patient Last Name: ___________________________

Primary Doctor's Name: ____ Phone: _________________________

Address: ___________________________________ City: _____________________ Zip Code: _________________

Date of Last Visit: __________________________________

CONSENT TO TREAT: (1) I authorize the doctor to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. (2) I authorized the doctor to perform all recommended treatment mutually agreed upon. I also agree the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. (3) I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made. (4) I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

INITIAL HERE: ________

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

INITIAL HERE: ________

LIABILITY/ WAIVER AND RELEASE: I know and agree that Dr. Rahimi is not responsible for loss or damage to personal valuables. I hereby release, discharge and acquit Dr. Rahimi, it's agents, representatives, affiliates, employees, or of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, EMT or Physician services.

INITIAL HERE: ________

AUTHORIZATION OF PAYMENT: Payment is requested at the time of your appointment. I hereby assign all benefits directly to Dr. Rahimi and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive I will be financially responsible for payment. For patients without health insurance, we require payment at the time of your appointment. If you need to make financial arrangements, please let us know. Patients that have an outstanding balance after 90 days will be considered delinquent and will be referred to a collection agency. Collection fees will be added to any patient balance that is referred to a collection agency. Those patients referred to a collection agency will only receive services on a cash basis and payment is due before services are rendered.

INITIAL HERE: ________

INSURANCE: As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance

PAIN & REHAB
orange county

3300 West Coast Highway
Newport Beach, CA 92663
(949) 610-1042

Patient Last Name: ____________________________

policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and Dr. Rahimi. You are responsible for full payment of your account, regardless of the status of your insurance claim. **INITIAL HERE**: ________

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS: Starting with services rendered on January 1, 2013, coverage by Medicare will be limited for outpatient physical therapy (PT) and speech-language pathology (SLP) services combined. The combined limits are $1900 per year. Medicare pays up to 80% of the limits. A law called the Balanced Budget Act of 1997 put these financial limits for therapy services in place. These limits were in effect for 1999, but not in 2000 through 2005 because Congress passed other laws to put a "hold" on the limits. This will further be evaluated by your Physician and Physical Therapist. If you reach the 2013 limits, you may receive more therapy services from a hospital outpatient department. The limits will not apple to these services, but you will have to pay the 20% co-payment. You should expect some delays in service should you choose this route.

I hereby certify that I have read and understand the therapy limits and warrant that: **PLEASE INITIAL ONE BELOW**

I have not received physical therapy or speech-language pathology during the current year.

INITIAL HERE: ________

I have received some of these services from another provider during the current year.

INITIAL HERE: ________

And I therefore elect to:

Receive the therapy from this provider and accept the responsibility for the payment in excess of the Medicare limits.

INITIAL HERE: ________

Receive only covered services from this provider.

INITIAL HERE: ________

I certify that all of the information provided herein is true and correct. By signing below, I acknowledge that I have read and understand the above policies and I give my consent to the terms discussed therein. I authorize the use of this signature on all insurance submissions.

____ ______________________________
Patient Signature Date

____ ______________________________
Witness Signature Date

HEALTH INFORMATION FORM

TODAY'S DATE:____________________

PATIENT'S NAME:____DOB:___________________________

FAMILY DOCTOR:____________________________________REFERRING DOCTOR:_________________________________

CHIEF COMPLAINT: (Please describe your pain including location. Include a description of typical day and limitations.)

____

____

____

HISTORY OF PRESENT ILLNESS:

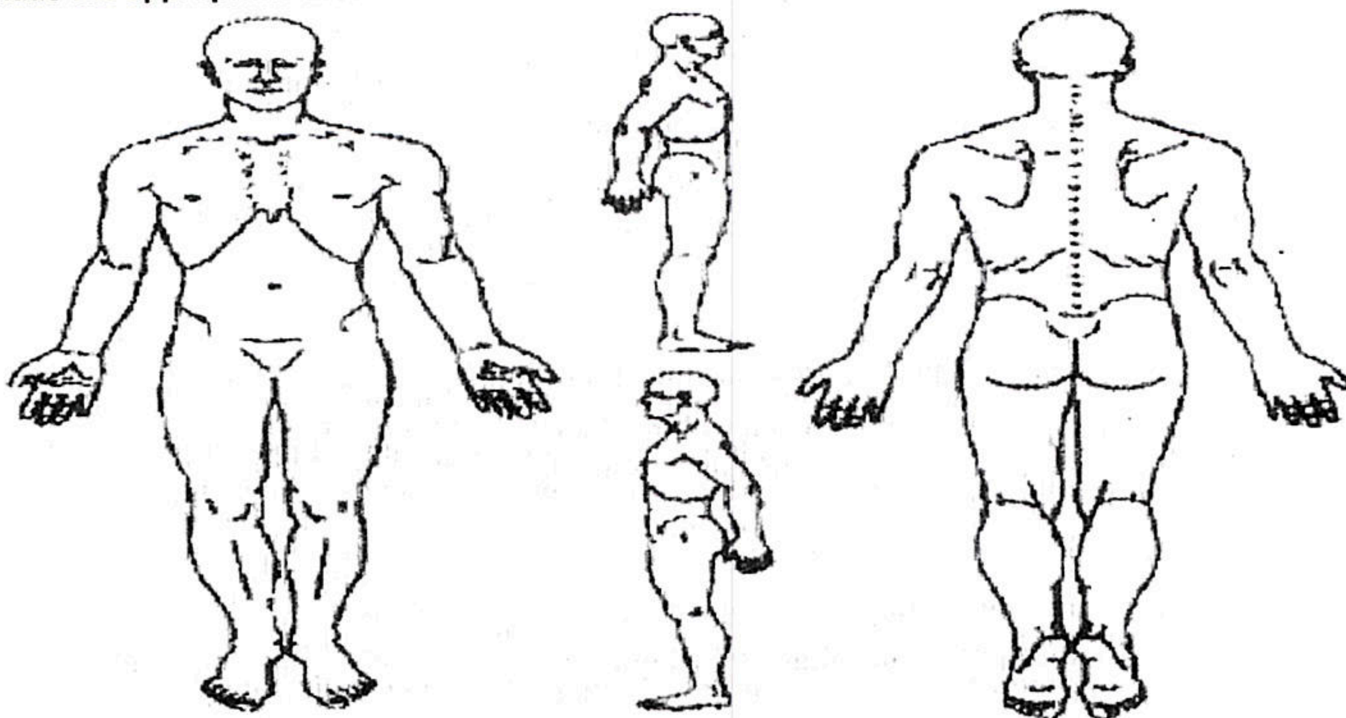
When did you first notice symptoms? __________________________

Was the onset of this: GRADUAL SUDDEN

How often do you experience the pain? AM PM DAILY WEEKLY (circle all that apply)

As the day progresses, do your symptoms increase, decrease or remain the same?____________________________

Shade the appropriate areas of Pain or Abnormal Sensation:



HEALTH INFORMATION FORM

On a scale of 0-10 (10 being emergency room pain) please rate your present level of pain.

1 2 3 4 5 6 7 8 9 10

What is the worse pain you experience on a scale of 0-10? ______

What is the best the pain gets on a scale of 0-10? _____

What is an acceptable level of pain for you on a scale of 0-10, with 10 being the worse?

What aggravates your symptoms? (circle all that apply)

Sitting	Standing	Repetitive Activities	Lying Down
Swallowing	Stress	Household Activities	Up/Down stairs Bending
Squatting	Talking	Reaching overhead	Reaching Behind Back
Walking	Coughing	Others_____	

What relieves your symptoms? (Circle all that apply)

Sitting	Stretching	Cold	Heat	Alcohol
Elevating Limbs	Wearing Splints	Standing	Massage	Traction
Lying Down	Exercise	Whirlpool	Walking	Rest
Medication	Other:__________			

What previous treatments have you had? (Circle all that apply)

None	Exercise	Injection into Spine	Injection into Muscles
Bracing	Oral Medication	Biofeedback	Massage Therapy
Hypnosis	TENS Unit	Traction	Joint Manipulation
Physical Therapy	Acupuncture	Casting	

PAST MEDICAL HISTORY (Circle all the apply)

Diabetes	Emphysema	Deep Vein Thrombus	Arthritis
Rheumatoid Arthritis	Multiple Sclerosis	Osteoporosis	Polio
Hypertension	Stomach Ulcers	Cancer, Type_____________	Other____________

PAST SURGICAL HISTORY:

Surgery & Date:____

SOCIAL HISTORY

Do you smoke/use tobacco products? Y N If yes, how much?____________________________

Do you drink? Y N If yes, how much?____________________________

HEALTH INFORMATION FORM

FAMILY HISTORY: (List all serious illnesses in your immediate family, identifying who has/had the illness)

Example: diabetes, TB, breast cancer, Heart Disease, hypertension, strokes, cancer.

Illness	Family Member	Notes
______________________________	______________________________	__________________________
______________________________	______________________________	__________________________

OCCUPATIONAL HISTORY

Are you currently working? Y N

If NO: Date last worked:________________

Are you retired: Y N

Are you on Disability? Y N

If yes, first date on disability_________________

If YES: Job title/Description:______________________________Hrs worked/day_______Days a wk______

Doses your job require? (circle all that apply)

Bending	Twisting	Pushing	Lifting
Kneeling	Ladder Climbing	Pulling	Overhead Work

REVIEW OF SYSTEMS: (Do you now or have you had any problems related to the following systems?) Circle Yes or No

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other_______________________

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N

Other_______________________

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other_______________________

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Other_______________________

HEALTH INFORMATION FORM

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N

Other______________________

Endocrine

Excessive Thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N

Other______________________

Gastrointestinal

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N

Other______________________

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N

Other______________________

Genitourinary

Painful Urination	Y	N
Urine Retention	Y	N
Urinary Frequency	Y	N

Other______________________

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Other______________________

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting problem	Y	N

Other______________________

Are you currently pregnant? Y N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other__________________________

Are you allergic to any medications? Y N

If yes, please list____

Are you allergic to Bee Stings? Y N

Are you allergic to any foods? Y N

If yes, please list:____

HEALTH INFORMATION FORM

CURRENT PAIN MEDICATIONS (Please list all medication your are currently taking INCLUDING over the counter & supplements)

NAME OF MEDICATION	DOSAGE	WHEN DO YOU TAKE	HOW OFTEN