

SHAM M. VENGURLEKAR, MD, PC.
 7010 E. CHAUNCEY LANE, SUITE #215
 PHOENIX, AZ 85054

Patient Demographics

Please complete this form in its entirety by providing the requested information. All requested information is necessary to provide you complete care and missing information will cause delays. Please remember to notify our offices to report any changes to the information being provided (e.g. insurance company, phone number, address, primary care physician, etc.).

Last Name	First Name	Middle Initial	Today's Date / /
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Date of Birth / /	Age	Sex M / F	Name of Spouse
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Arizona Address	City	Zip	Marital Status S M W D Sep
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Permanent Address (if different from above)	City	Zip	Social Security Number - -
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Home Phone Number () -	Cell Phone Number () -	Email Address
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Name of Employer	Work Phone Number	Occupation
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Primary Insurer (If not the Primary Insurance Holder) Name	Address (if different than above)	
Phone Number	Date of Birth	Social Security Number

Emergency Contact:	Phone Number:
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Name of Referring Physician	Address	Phone Number Fax Number
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Name of Primary Care Physician (If different from Referring Physician)	Address	Phone Number Fax Number
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Name of Primary Insurance Company	Name of Secondary Insurance Company
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Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____

Date: _____

17. List any medications being taken for **other** medical disorders (also include herbal/supplements/ over the counter medications):

18. Other Treatments: Please circle whether your symptoms (**W**) Worsened, (**I**) Improved, or (**U**) Unchanged

- | | | | |
|---|----------|----------|-----------|
| <input type="checkbox"/> Chiropractic: | Worsened | Improved | Unchanged |
| <input type="checkbox"/> Acupuncture: | Worsened | Improved | Unchanged |
| <input type="checkbox"/> Massage: | Worsened | Improved | Unchanged |
| <input type="checkbox"/> Epidural blocks: | Worsened | Improved | Unchanged |
| <input type="checkbox"/> Trigger point injection: | Worsened | Improved | Unchanged |
| <input type="checkbox"/> Physical Therapy: | Worsened | Improved | Unchanged |

If you have had therapy, when did you go? _____

How many sessions did you have? _____

19. Please provide the physician names that you have seen for this pain problem:

- | | |
|---|--|
| <input type="checkbox"/> Anesthesiologist: _____ | <input type="checkbox"/> Neurologist: _____ |
| <input type="checkbox"/> Physical Medicine / Rehab: _____ | <input type="checkbox"/> Neurosurgeon: _____ |
| <input type="checkbox"/> Orthopedic: _____ | <input type="checkbox"/> Other: _____ |

20. Past medical history: (list **all** medical problems, e.g.: Asthma, High blood pressure, Heart disorders, etc): _____

21. Past surgeries: (list **all** surgeries, e.g.: Appendectomy, Hernia surgery, Hysterectomy, Breast implants, etc): _____

22. Past injuries: (sports, motor vehicle, falls, etc): _____

23. System Review: (please check all that apply)

- a) **Cardiac:** chest pain heart attack high blood pressure irregular heart beat heart murmur
 shortness of breath
- b) **Lungs:** cough blood in sputum asthma bronchitis valley fever tuberculosis
- c) **Neurological:** headaches seizures stroke paralysis dizziness ringing in ears
- d) **Skeletomuscular:** fibromyalgia arthritis lupus connective tissue disorder
- e) **Hormonal:** thyroid sex hormones
- f) **Metabolic:** diabetes elevated cholesterol elevated triglycerides
- g) **Blood Disorder:** increased bleeding thalassemia hemophilia Christmas disease
 sickle cell disorder phlebitis or clots in leg or lung
- h) **Urinary:** burning lack of continence increased frequency kidney stone
 blood in urine prostate problems impotence
- i) **Stomach/Bowel:** ulcer acidity constipation diverticulitis diarrhea blood in stool

24. Menstrual history:

Beginning of Last Menstrual Cycle: _____

Have you had a recent...?

- a) Mammography No Yes Date: _____
- b) Pelvic/Gyn Exam No Yes Date: _____
- c) Hormone replacement therapy No Yes Date: _____
- d) Contraceptive Use No Yes Since: _____
- e) Prostatic / PSA Exam: No Yes Date: _____

25. Tests Performed: (list **all**): _____

Have you brought reports today? No Yes If yes,

- Regular X-Rays of _____ MRI Scan of _____ Nerve Conduction of _____
- CT scan of _____ Discogram of _____ Other: _____
- Myelogram of _____ Bone Scan of _____

26. Psychiatric / Psychological: (Check **all** that apply)

- Depression Memory problem or loss Problems with thinking/thought process
- Concentration difficulty Suicidal thought

27. Past or current exposure to:

- Tuberculosis Rheumatic fever A.I.D.S.
- Valley fever (cocci) Hepatitis (jaundice) Other: _____

28. Please provide your referral source: _____

HABITS

1. SMOKING:

Have you smoked in the past? No Yes

Do you smoke now? No Yes If yes, for how long? _____

Cigarettes: _____ per day Pipe: _____ per day Cigars: _____ per day

2. ALCOHOL:

Do you drink alcohol? No Yes If yes, how much? _____ per day

Have you ever had problems with alcohol? No Yes If yes, please explain: _____

If yes, explain _____

3. CAFFEINATED DRINKS:

Do you consume drinks with caffeine? No Yes If yes,

Coffee: _____ per day Tea: _____ per day Cola: _____ per day

Other _____ per day

4. DRUGS:

Have you used illegal drugs in the past? No Yes

Do you use illegal drugs now? No Yes If yes, for how long? _____

Cannabis: _____ per day Cocaine: _____ per day Ecstasy: _____ per day

Methamphetamine: _____ per day Heroin: _____ per day Other: _____

Have you ever misused prescription drugs? No Yes If yes, are you willing to get help? No Yes

SOCIAL INFORMATION

1. List all the areas you have lived in (e.g.: Phoenix, AZ): _____

2. Marital Status:
 Married Divorced Single
 Separated Widowed
3. Do you live: Alone With spouse With parents Other _____
4. Do you have Children: No Yes If yes, please provide childrens gender and age
Child One: Male Female Age: _____ Child Four: Male Female Age: _____
Child Two: Male Female Age: _____ Child Five: Male Female Age: _____
Child Three: Male Female Age: _____ Child Six: Male Female Age: _____
5. Has your pain problem changed your relationship with your spouse and family? No Yes
If yes, describe _____

FAMILY HISTORY

List any pertinent family history (example: cardiac, strokes, psychiatric history, diabetes, etc.): _____

OCCUPATIONAL HISTORY

1. Please describe your current work status:
 Disabled Homemaker Unemployed
 Retired Employed Other: _____
If you are not working, are you currently receiving wage compensation? No Yes
2. If employed, please describe your current job (if unemployed, your very last job): _____

- a. How long have you held this job? _____
b. How many hours per week do you work? _____
3. Have you missed a lot of work because of your current or previous illness, injury or pain? No Yes
If yes, when was the last day you worked full time? _____

LITIGATION

1. Are you seeing the Physician because of an auto or workplace accident? No Yes
If yes, are you willing to sign lien documents? No Yes
2. Do you have or plan to have an attorney involved? No Yes If yes, please provide name/address of
Attorney. Attorney: _____
Address: _____
Address: _____
3. Will the attorney be managing the process to authorize your treatment? No Yes
4. Have you had any lawsuits in the past? No Yes

TREATMENT GOALS

1. Describe your goals for the treatment:
 Return to work / Be more active and Not be dependent on
Productivity functional medication
 Improve quality of life Participate in sports Other _____

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**CONSENT FOR RELEASE OF INFORMATION, ASSIGNMENT OF
MEDICAL BENEFITS, FINANCIAL POLICY, INSURER DISCLOSURE, AND PATIENT
RESPONSIBILITY**

I hereby give my consent to Sham Vengurlekar, M.D., P.C. as holder of my protected health information (PHI), to release information to my insurance carrier or any agency or representative of my insurance carrier for obtaining payment for services provided. In addition, I authorize the payment of insurance benefits to be made on my behalf directly to Sham Vengurlekar, M.D., P.C. for medical services provided. In the event that payment of benefits is made directly to me, as payee, I will endorse and release payments to Sham Vengurlekar, M.D., P.C.

I understand that per my insurance plan, I may have a co-payment, co-insurance, and deductible amount which I will be required to pay at the time of service (all contractual discounts will be applied), or my appointment may be cancelled and or rescheduled. If I am a cash pay patient, I am required to pay in full at time of service. I may pay by Cash, Debit, Check, Discover, Visa, or Mastercard. Although, if payment does not clear, or is disputed, then a fee up to \$40.00 will be incurred plus any associated fees. I understand that if I do not comply with my financial obligations, Dr. Vengurlekar's practice, associates, or staff have no further obligation and or responsibility to continue care, and that my care will be terminated.

I understand that Sham Vengurlekar, M.D., P.C. will make every attempt to collect payment for services from my insurance company(s), or other party in a timely manner. I also agree to stay actively involved with my insurance carrier to ensure Dr. Vengurlekar and affiliated companies are reimbursed for services provided. I am fully aware that I will be billed for any services that have been deemed "not a covered benefit or not medically necessary" by my insurance company(s), (including Medicare patients as long as an Advanced Beneficiary Notice (ABN) has been completed for each date of service). I understand that I am responsible for any balances on my account after my insurance, or other payer has processed my claim and agree to pay this balance in full (e.g. denials, co-pay, deductible, etc.). I also understand that if my patient balance becomes delinquent, further action will be taken and I'm responsible for all costs to collect the debt including and not limited to, assignment to collections agency, reporting to credit bureaus, and legal ramifications.

I give my consent to use or disclose my PHI as needed for treatment, payment or medical operations in support of my medical care.

I understand that Sham Vengurlekar, M.D., P.C. requires a fee for copying patient records (when requested by attorney) of \$70.00 (up to 20 pages) plus .75 cents per page. I have also been advised that if I fail to appear for a scheduled appointment in the office and do not provide written cancellation two business days in advance, I will be personally charged a fee of \$125.00. If I fail to appear for a scheduled procedure and do not provide written cancellation two business days in advance, I will be personally charged a fee of \$250.00.

I understand that any general or other specific health issues, beyond the scope of interventional procedures, will need to be addressed by my primary care physician or another appropriate medical specialist. If I currently do not have a primary care physician, I will be responsible to locate the appropriate physician and seek the appropriate advice. By signing below, I verify that I have read and understand the content of this form. I also agree to be personally responsible for any of the above fees (if applicable).

Date: _____

Patient/Patient's Representative Name: _____

Patient/Patient's Representative Signature: _____

Relationship to Patient: _____

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CANCELLATION / NO SHOW POLICY

Thank you for choosing Dr. Vengurlekar to assist you in meeting your healthcare needs. We strive to provide the very best care to all our esteemed patients and look forward to serving you. Please remember, the work needed to prepare for your appointment begins 3-5 days before your appointment. Therefore, we ask that you call the practice 24-48 hours in advance, or as soon as possible when an appointment needs to be cancelled / rescheduled.

Failure to notify the office of your cancellation will result in a patient no-show. No-show fees are based upon the scheduled appointment. The fee applied to a patient's account for a missed office visit is \$125.00. The fee for missing a scheduled procedure is \$250.00. These charges are not covered by your insurance company and are payable by you.

Your signature below verifies that you have read and understand our no-show / cancellation policy and that you agree to be personally responsible for notifying the office in the event of a cancellation. In the event the office is not notified, you agree to pay the above fees. If unavailable due to an emergency, please contact the office and speak with a patient representative about rescheduling.

Date: _____

Patient / Patient Representative Name: _____

Patient / Patient Representative Signature: _____

ADDITIONAL QUESTIONNAIRE FOR HEADACHE PATIENTS ONLY

(If you do not have headaches, please skip this section.)

1. When did you first develop headaches? _____
2. Do you have more than one type of headache? No Yes
3. Where is your headache located?
 Neck Back of the head Eyes Face Temples Other _____
4. Where does your headache start?
 Neck Back of the head Behind eyes Other _____
5. How often and what time of the day do you have headaches? _____
6. Which of the following words do you use to describe your headache?
 Throbbing Pounding Splitting Pulsating
 Piercing Dull Aching Tight Other: _____
7. How long does one episode of headache last?
Shortest _____ Longest _____
8. What physical or environmental factors trigger the headache or make it worse?
 Bright light Tobacco Alcohol Exercise Loud noises
 Sex Changes in weather Travel Increased physical activity
 Other _____
9. Have you noticed if any foods trigger your headaches? No Yes
If yes, list _____
10. Do you have any craving for any specific foods prior to a headache occurrence?
 No Yes If yes, list _____
11. If female, do you get headaches before, during, or after your menstrual cycle? No Yes
 - a) Have you had: Hysterectomy Ovaries removed
 - b) Do you have problems with hormones? No Yes
 - c) Do you take hormones? No Yes
12. How is your headache controlled? _____
13. Do you experience any of the following? (only mark those that apply).

	Before Headache	During Headache	After
Headache			
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sound Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Can you tell when you are going to have a headache? No Yes
If yes, explain _____
15. Do you have neck pain associated with headaches? No Yes
If so, when do you have the neck pain? Before During After

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Medical Power of Attorney for Health Care Acknowledgment and Assignment

A Power of Attorney for Health Care allows you to name a health agent, someone who will make health decisions for you if you cannot. Your health care agent will ensure that your health care providers give you the care you wish to receive. You may also require that your health care agent communicate in any manner with you about any specific proposed health care.

Please check the appropriate box:

- I do not have a medical power of attorney and I'll make all health care decision for myself.
- I have a medical power of attorney (please attach medical power of attorney) and my Agent is as follows:

Agent's Full Name

Agent's Street Address

City

State

Zip Code

Agent's Daytime Phone

Agent's Other Phone

Agent's Email Address

SIGNATURE

I understand the contents of this document and the effect of granting powers to my Agent.

Date: _____

Principal's Full Name: _____

Principal's Signature: _____

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Authorization for the Release of Medical and/or Billing Information

Many of our patients allow a family member or a friend to request medical or billing information. Under the requirements of HIPAA, we are not permitted to release information to anyone but the patient without the patient's direct approval, in writing. Please take a moment to complete the below section if you'd like to approve the release of medical and/or billing information to someone other than yourself.

I DO NOT authorize the offices of Sham M Vengurlekar, MD to release my Medical and/or Billing Information.

I authorize the offices of Sham M Vengurlekar, MD to release my Information as follows:

Recipient Name: _____ Information: Medical Information
 Billing Information

Recipient Name: _____ Information: Medical Information
 Billing Information

Recipient Name: _____ Information: Medical Information
 Billing Information

Recipient Name: _____ Information: Medical Information
 Billing Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or request a copy of my record to review the information disclosed. I understand that the information being disclosed to any of the above recipient(s) is not protected information as the recipient may disclose the information to others.

Date: _____

Patient Name: _____

Patient Signature: _____

Revocation of Approval for the Release of Medical and/or Billing Information

I am revoking my approval for my personal information to be disclosed. I understand that no information will be given to the recipient unless another authorization is completed and signed by me.

I am revoking my approval for the above recipient(s) to receive my Medical and/or Billing Information.

Date: _____

Patient Name: _____

Patient Signature: _____

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CERTIFICATION BY PATIENT

Providing accurate information is vital to the potential outcomes resulting from your medical care. Therefore, we ask that patients provide honest and complete answers to the questions asked. Please take a moment to certify the below information is accurate by providing your initials before each statement.

- 1) _____ (Initials) certify that I have truthfully answered all the questions asked and have not knowingly withheld any information concerning any of the information provided either past or present.

- 2) _____ (Initials) I acknowledge that if I have withheld any information from this record or if I am non-compliant with medical advice or medications, Sham Vengurlekar, M.D., P.C. will exercise the right to terminate my care.

- 3) _____ (Initials) I consent to receive care from Sham Vengurlekar, M.D., P.C., or associate to take my medical history, conduct physical examination and to order any tests, including but not limited to, consultations, x-ray exams, laboratory exams, functional testing, cardiac testing, or other test that supports the approved treatment plan.

Date: _____

Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____

Witness: _____