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 / /

Date of Birth / /	Age	Sex M / F	Name of Spouse

Arizona Address	City	Zip	Marital Status S M W D Sep

Permanent Address (if different from above)	City	Zip	Social Security Number - -

Home Phone Number ( ) -	Cell Phone Number ( ) -	Email Address

Name of Employer	Work Phone Number	Occupation

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:

Name of Referring Physician	Address	Phone Number Fax Number

Name of Primary Care Physician (If different from Referring Physician)	Address	Phone Number Fax Number

Name of Primary Insurance Company	Name of Secondary Insurance Company

Patient/Responsible Party Name: ________________________________
Patient/Responsible Party Signature: _____________________________ Date: ________________

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Patient Questionnaire

Thank you for allowing us to assist you in meeting your healthcare needs. We place a lot of emphasis on the details of your symptoms of pain and other aspects of your medical history. This form will help in arriving at an accurate diagnosis and formulating the appropriate interventional pain therapies tailored to your needs. Please pay close attention to the following items, which you need to fill out completely and accurately.

1. Date of onset pain: ____________________________________
2. Location of primary pain: ______________________________
3. Nature of pain ____ (e.g., sharp, stabbing, stinging, etc.)
4. Continuous or intermittent? _____________________________
5. Did you have a fall, injury, or accident prior to the onset of pain? No ☐ Yes ☐

   If yes, what date? _____________________________________

   Briefly describe: ____
6. Intensity of pain: **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 (**Severe pain)**
7. Activities that increase your pain:

   ☐ Sitting: ☐ Coughing: ☐ Bending: ☐ Lying down

   ☐ Walking: ☐ Sneezing: ☐ Sports Activities:
8. List activity that relieves your pain (excluding medications):

   ☐ Sitting ☐ Lying down ☐ Ice/Heat ☐ Other: _________________________
9. Sleep pattern: ☐ Unchanged ☐ Interference with sleep?

   How many hours of sleep do you get?______________________
10. Ability to pursue activities/occupation____
11. Check side effects that you've experienced and list the medication that caused it:

    ☐ Gastric irritation:_________ ☐ Constipation: ____________ ☐ Jitters: ___________

    ☐ Nausea: ________________ ☐ Drowsiness: _____________ ☐ Other: ___________
12. List drug allergies and type of reaction: ___________________ (e.g.: penicillin, sulfa, itching, rash)
13. List all Food/ Environmental allergies: ____
14. Treatments you have received so far: ____
15. Current Medication: (please list **ALL** pain medications, dosages and frequency)

    ________________ ________________ ________________ ________________

    ________________ ________________ ________________ ________________
16. List **ALL** medications that you have taken in the **past** to control your pain and mark in the ( ) what type of relief you received: e.g. (**R**) relief (**SR**) some relief (**NR**) no relief

    ______________ ( ) ______________ ( ) ______________ ( ) ______________ ( )

    ______________ ( ) ______________ ( ) ______________ ( ) ______________ ( )

For office use only:

Date of Birth: ______ Height: ______ Weight: _____ BP:__________

SpO2: _____________ RR: _________ Pulse: _______ Temp:_______

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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

☐ Chiropractic:	Worsened	Improved	Unchanged
☐ Acupuncture:	Worsened	Improved	Unchanged
☐ Massage:	Worsened	Improved	Unchanged
☐ Epidural blocks:	Worsened	Improved	Unchanged
☐ Trigger point injection:	Worsened	Improved	Unchanged
☐ 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:

☐ Anesthesiologist: _____________________ ☐ Neurologist: ___________________________

☐ Physical Medicine / Rehab: ______________ ☐ Neurosurgeon: _________________________

☐ Orthopedic: ____________________________ ☐ 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

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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

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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 / Productivity ☐ Be more active and functional ☐ Not be dependent on 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 cancelation will result in a patient no-show. No-show fees are based upon the scheduled appointment. The fee applied to a patients 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: ____

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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).

Headache	Before Headache	During Headache	After
Nausea	☐	☐	☐
Vomiting	☐	☐	☐
Dizziness	☐	☐	☐
Abnormal Sensations	☐	☐	☐
Aura	☐	☐	☐
Sound Sensitivity	☐	☐	☐
Light Sensitivity	☐	☐	☐
Other	☐	☐	☐

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: ____

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NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services (I/We) have prescribed are available elsewhere on a competitive basis.

1. DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

   Scottsdale Medical Innovations, LLC: Center for minimally Invasive Interventions to treat complex spinal, sports, joint, and accident pain.

2. ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?

   _X_ Yes ___ No

   If yes, which ones: Minimally Invasive Interventions to treat complex spinal, sports, joint, and accident pain.

3. The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy.

ACKNOWLEDGEMENT: (I/We) have read this “Notice to Patients” form, and (I/We) understand the disclosures that it contains.

Date this_____ Day of_____________, 20___

____
Signature of Patient or Guardian

Rev. 3/05 LM
Retrieved from https://www.azmd.gov/Forms/Files/201707111248_b0eb145622eb4216ae91ba7c418a7687.pdf

Patient Out-of-Network Notice

Thank you for choosing Dr. Vengurlekar as your health care provider. Please take a moment to review the below partners providing your treatment and services. Dr. Sham Vengurlekar, MD, Scottsdale Medical Innovations, LLC, Med Scope, and Omni Medical Solutions are each an individual provider and provided services will be billed to your insurance company separately. In and out-of-network (OON) benefits will be used to determine coverage.

- Dr. Vengurlekar is providing your professional services and is contracted with Humana, Healthnet, BC/BS United Health Care, and Cigna. All other plans may be out-of-network. Please verify contract status with Health Plan.
- Dr. Vengurlekar uses Scottsdale Medical Innovations as the preferred facility. Scottsdale Medical Innovations is not participating as an in-network provider and OON benefits must be utilized for service provided by Provider.
- Dr. Vengurlekar has partnered with Med Scope as the practices preferred lab. Med Scope is out-of-network for many insurance plans.
- Before and after your procedure you may receive functional testing from Omni Medical Solutions. This testing supports the medical necessity for your procedure and Omni Medical Solutions may be OON with your health plan.
- Anesthesia services for Scottsdale Medical Innovations are provided by Cloud 9 Anesthesiology Associates, LLC. Cloud 9 is an OON Provider.

Your services will be billed to your insurance company. Once the insurance company has processed your medical claim, you will receive an Explanation of Benefits (EOB) along with a check for payment. **The EOB is not a bill.** Instead, it is a document that shows how your health insurance company processed the health insurance claim based on your health care benefits. If you receive a check, please endorse to the practice and forward to our offices at 7010 E Chauncey, Suite 215, Phoenix, AZ 85054. As a reminder, you're responsible for all charges and failure to pay for services provided may result in additional action to secure payment.

I acknowledge receipt of the above information and understand that Dr. Vengurlekar has partnered with the above companies to provide services. I further understand that the listed partners may provide additional information regarding contracted services.

____________________________________ ____________________
Patient Name (please print) Date

____
Patient Signature