Welcome!

Please take a few minutes to answer the following questions so we can better assist you with your heath care needs.

PATIENT REGISTRATION FORM

Date: _____ Soc Sec #: _____ Date of Birth: _____

Name: _____ Home Phone: _____
Last Name First Name Initial

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Sex: ☐M ☐F ☐Minor ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Long term partner

Emergency Contact Name: Phone: Relationship

Employer: _____ Work Phone: _____

Address: _____ Occupation: _____

Who should we thank for referring you?

Primary Insurance

Person Responsible for Account: _____
Last Name First Name Initial

Relationship to Patient: _____ Date of Birth: _____ SSN: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Responsible Party Employer: _____ Business Phone: _____

Employer's Address: _____ Occupation: _____

Medical Insurance: _____

Billing Address: _____

Subscriber I.D. # Group #

Secondary Insurance

Insured Name: _____
Last Name First Name Initial

Relationship to Patient: _____ Date of Birth: _____ SSN: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Insured's Employer: _____ Business Phone: _____

Employer Address: _____ Occupation: _____

Medical Insurance: _____

Billing Address: _____

Subscriber I.D. # _____ Group # _____

Reason for Visit

List your present concern, problem, or symptoms:

Past Medical History

When was your last physical exam: _____

Primary Care Physician's Name: _____ Phone: _____

1. Are you currently under medical treatment?..... ☐ Yes ☐ No

Please describe:

2. Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

Please describe:

3. Are you currently taking any medication?..... ☐ Yes ☐ No

Please List:

4. Do you smoke?..... ☐ Yes ☐ No

5. Do you use alcohol?..... ☐ Social ☐ Yes ☐ No

6. Do you use cocaine or other drugs?..... ☐ Yes ☐ No

7. Have you had any allergic reactions to the following?

Local Anesthetics (eg Novocaine) ……	☐ Yes	☐ No
Penicillin or other Antibiotics……..	☐ Yes	☐ No
Sulfa Drugs……	☐ Yes	☐ No
Barbiturates (sleeping pills)……	☐ Yes	☐ No
Sedatives……..	☐ Yes	☐ No
Iodine……..	☐ Yes	☐ No
Aspirin……..	☐ Yes	☐ No
Other……..	☐ Yes	☐ No

Please describe:

8. Women Only:

Are you currently pregnant?..... ☐ Yes ☐ No

Have you had any of the following?

	Yes	No
Anemia (low blood count……	☐	☐
Anorexia (no appetite)……	☐	☐
Arthritis……	☐	☐
Asthma……..	☐	☐
Back Problems……..	☐	☐
Bleeding tendency……	☐	☐
Blood Disease……..	☐	☐
Cancer……	☐	☐
Chemical dependency or addiction?	☐	☐
Chemotherapy……..	☐	☐
Chickenpox……	☐	☐
Chronic Fatigue Syndrome……	☐	☐
Circulatory Problems……	☐	☐
Congenital Heart Lesions……	☐	☐
Cough – persistent or bloody……	☐	☐
Diabetes.....	☐	☐
Emphysema……..	☐	☐
Epilepsy……	☐	☐
Glaucoma……..	☐	☐

	Yes	No
Heart Murmur……	☐	☐
Heart Disease……..	☐	☐
Hepatitis Type _____.....	☐	☐
Hernia……	☐	☐
Herpes……	☐	☐
High Blood Pressure……	☐	☐
HIV/AIDS……..	☐	☐
Jaundice……	☐	☐
Kidney Disease……..	☐	☐
Latex Sensitivity……	☐	☐
Liver Disease……	☐	☐
Low Blood Pressure……..	☐	☐
Measles……	☐	☐
Migraine Headaches……	☐	☐
Mitral Valve Prolapse……..	☐	☐
Mumps……..	☐	☐
Multiple Sclerosis……	☐	☐
Pacemaker……..	☐	☐
Pneumonia……	☐	☐

	Yes	No
Polio……	☐	☐
Prostate Problem……	☐	☐
Psychiatric Care……..	☐	☐
Respiratory Disease……	☐	☐
Rheumatic Fever……..	☐	☐
Scarlet Fever……	☐	☐
Shortness of Breath……	☐	☐
Sinus Trouble……	☐	☐
Skin Rash……..	☐	☐
Stroke……	☐	☐
Thyroid Problems……	☐	☐
Tonsillitis……	☐	☐
Tuberculosis……..	☐	☐
Ulcer……..	☐	☐
Venereal Disease……	☐	☐
Any other Condition……	☐	☐

Please Describe:

_____

Assignment and Release

I hereby authorize payment directly to Ardavan Aslie, M.D. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize Ardavan Aslie and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____ Date: _____

How and when did your problem begin? (please explain)

Employment Status:

Are you currently working? ☐ Yes ☐ No

☐ Full-time / ☐ Part-time / ☐ Disabled / ☐ Unemployed / ☐ Retired

Employer Name:

Position:

If not working, off since when?

Do you have any of the following symptoms?

Weakness	☐ arms / ☐ hands / ☐ legs / ☐ feet	☐ left / ☐ right	☐ none	
Numbness (loss of feeling)	☐ arms / ☐ hands / ☐ legs / ☐ feet	☐ left / ☐ right	☐ none	
Tingling (falling asleep)	☐ arms / ☐ hands / ☐ legs / ☐ feet	☐ left / ☐ right	☐ none	
Bladder control:	☐ No problem	☐ Can't empty bladder	☐ Loss of urine	
Bowel control:	☐ No problem	☐ Constipation	☐ Loss of control	

Is your pain relieved by bending forward? ☐ No ☐ Yes

Previous Treatments:

Physical Therapy:	☐ No	☐ Yes	Date: _____
Injections:	☐ No	☐ Yes	Date: _____
Chiropractic Treatment:	☐ No	☐ Yes	Date: _____

Previous Tests

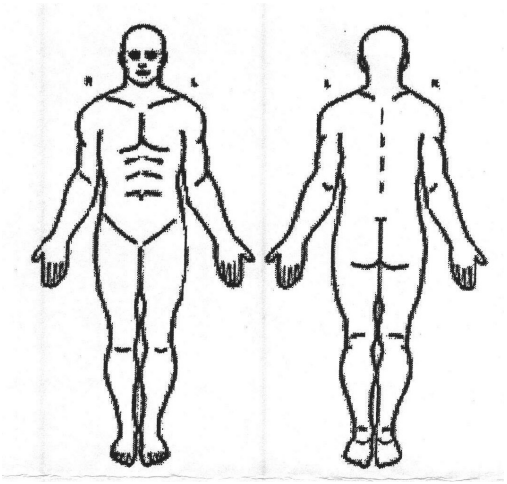
X-rays	☐ No	☐ Yes	Date: _____
MRI	☐ No	☐ Yes	Date: _____
CT	☐ No	☐ Yes	Date: _____
Mylogram	☐ No	☐ Yes	Date: _____
Discogram	☐ No	☐ Yes	Date: _____
Nerve test (EMG/NCS)	☐ No	☐ Yes	Date: _____

Other:

Circle pain level
Pain Scale (0-10)

0 = No pain
1 =
2 = Slight pain
3 =
4 =
5 = Moderate pain
6 =
7 =
8 = Hurts a lot
9
10 = Worst pain

Please shade in your area of pain:



Please check symptoms you have been having:

☐ **NEUROLOGICAL**	☐ **MUSCULOSKELETAL**
☐ Headaches	☐ Neck pain
☐ Fainting spells / “blacking out”	☐ Arm pain
☐ Seizures	☐ Arm weakness
☐ Memory problems	☐ Arm numbness/tingling
☐ Speech difficulties	☐ Back pain
☐ Difficulty concentrating	☐ Leg pain
☐ Double or blurred vision	☐ Leg weakness
☐ Face weakness	☐ Leg numbness/tingling
☐ Poor coordination in arms and/or legs	☐ Joint pain or swelling
☐ Hearing loss or ringing in ears	☐ Arthritis

Family Medical History:

Father’s age: _____ ☐ alive ☐ deceased
If deceased, cause of death: _____

Mother’s age: _____ ☐ alive ☐ deceased
If deceased, cause of death: _____

Sibling’s ages: _____
If deceased, age at time of death and cause: _____

Children’s ages: _____
If deceased, age at time of death and cause: _____

Other significant diseases in the family: _____

Ardavan M. Aslie, M.D.
Orthopedic Spine Surgeon

INFORMATION RELEASE AUTHORIZATION

Due to the HIPPA (Health Insurance Portability and Accountability Act) regulations, Dr. Aslie will not give out any information about your medical treatment to anyone (including your spouse) except as designated by you. This will include appointment times, medication usage, procedures, billing, etc.

If you would like to have this information available to another party please list them below.

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Please send copies to my primary care physician:

Name

Address | Fax Number:

Signature

Ardavan M. Aslie, M.D.
Orthopedic Spine Surgeon

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use of my protected health information by Dr. Aslie's office for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations of Dr. Aslie's office. I understand that diagnosis or treatment to me by Dr. Aslie may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of this practice. Dr. Aslie is not required to agree to the restrictions that I may request, however if Dr. Aslie agrees to a restriction that I request, the restriction is binding on Dr. Aslie.

I may revoke this consent in writing at any time, except to the extent that Dr. Aslie has taken action in reliance on this consent.

My protected health information means information including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer as in the case of Workers' Comp, or a healthcare clearing house. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Dr. Aslie's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Dr. Aslie's office. This Notice of Privacy Practices also describes my rights and Dr. Aslie's duties with respect to my protected health information.

Dr. Aslie reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices and may request a revised copy be sent in the mail or ask for one at the time of my next appointment.

Patient Signature **Date**

Print Name

NAME: ______________________________ **DOB:** ____________________

PHARMACY: ____________________________ **Phone #** __________________

DRUG ALLERGIES:

Please list ALL drug allergies:

CURRENT MEDICATIONS

Please list **ALL** current medications, dosage, and prescribing physician.

DATE	*MEDICATION / DOSAGE*	*INSTRUCTIONS*	*REFILLS*	*PHYSICIAN*