INTERVENTIONAL SPINE CARE & ORTHOPEDIC REGENERATIVE EXPERTS

NEW PATIENTS' INFORMATION SHEET

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Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name _____

Date of Birth: _____ Sex: _____ Marital Status: _____

(Street) (City) (State) (ZIP)

Address: _____

Phone #: _____ Social Security #: _____

Employer: _____ Work #: _____

Employer's Address: _____

If Student, School Name: _____ Full / Part Time _____

Primary Emergency Contact
Name: _____ Number: _____
Relationship: _____

Email: _____

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name: _____

Address: _____ Phone #: ( ) -

Adjuster Name: _____ Adjuster Phone #: ( ) -

Date of Injury or Accident: _____ Claim #: _____

Type of Injury: ☐Back ☐Leg ☐Hip ☐Neck ☐Shoulder ☐Arm ☐Head ☐Other: _____

Place of work during time of accident: _____ Phone #: ( ) -

In Litigation: ☐Yes ☐NO Amount of Medical Benefits: _____ Notice of Compensation Payable: ☐Yes ☐NO

Attorney Information
Law Office Name: _____ Attorney Name: _____
Law Office Address: _____ City: _____ State: _____
Law Office Telephone: _____ Law Office Fax: _____
Law Office E-Mail: _____ Law Office Contact Name: _____

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Patient Name: _____ **DOB:** _____

DOS: _____

PAIN SCORES (Scale 0 - 10)

0 = No Pain ⟶ 10 = The most pain you have ever felt in your life

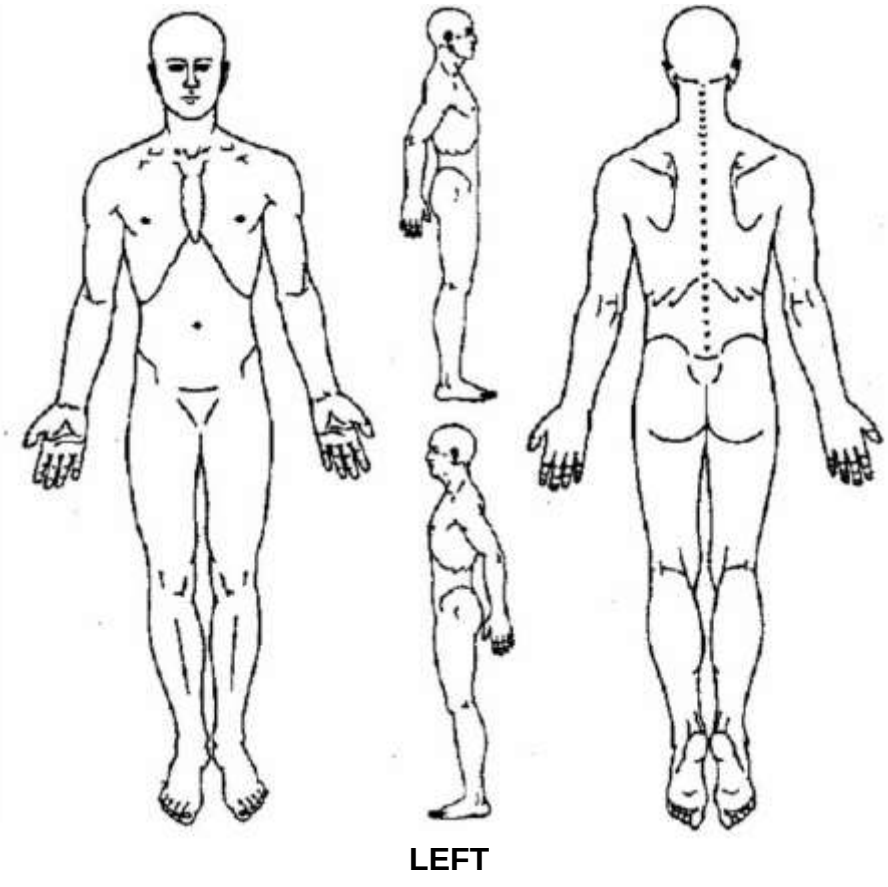
CURRENT pain level (today / now): _____

HIGHEST pain level over the last week: _____

LOWEST pain level over the last week: _____

PAIN DIAGRAM

FRONT **RIGHT** **BACK**



LEFT

Please mark the figure with the location of your symptoms. Do not use circles.

Pain = ✖ ✖ ✖ ✖

Numbness/Tingling = # # # #

Characteristic(s) of pain
(Check all that apply)

- ☐ DULL
- ☐ ACHING
- ☐ BURNING
- ☐ SHARP
- ☐ SHOOTING
- ☐ THROBBING
- ☐ SPASMS
- ☐ OTHER: _____

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NEW PMR & INTERVENTIONAL PAIN MANAGEMENT INTAKE QUESTIONNAIRE

Name:_____ Age:_____ Weight:_____ Height:_____

What is your reason for visit?:_____
How did it begin (suddenly, gradual, accident)? _____
How long has this been going on? _____
Is it constant or occasional? _____
Is it getting worse, same, or better? _____
Does the pain/discomfort go into the arms or legs? Which one? _____
If pain/discomfort goes into arms or legs, is there numbness, tingling, or weakness? _____
_____
What makes it worse (examples - lifting, bending, sitting, walking)? _____
What makes it better (examples - resting, sitting, standing, nothing)? _____
Have you: (please circle)

Lost control of bowel or bladder because of this? ☐YES ☐NO. Explain: _____
Had prior x-rays, CT, MRI, bone scans for this? ☐YES ☐NO. Explain: _____
Had previous spine surgery for this problem (what type)? ☐YES ☐NO. Explain: _____
Had any spinal injections for this? ☐YES ☐NO. Explain: _____
When?_____ Did they help?_____

What other conservative treatments have you tried?

☐ Physical Therapy/Exercise	☐ TENS/E-Stim	☐ Opioid Medications	☐ Cast/Boot/Walker/Cane
☐ Massage/Ultrasound	☐ Traction	☐ Anti-Inflammatories	☐ Orthotics
☐ Chiropractic	☐ Acupuncture	☐ Muscle Relaxants	☐ Other _____

What other medical problems do you have? (eg Asthma, Diabetes, High Blood Pressure, etc)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to any medications? Check box if No Known Drug Allergies → ☐

Medication:	Reaction:	Medication:	Reaction:

Family medical problems? (eg Asthma, Heart disease, Diabetes, Cancer, etc)

Father:_____
Mother:_____
Sibling: _____

Do you **smoke?** ☐ current everyday smoker ☐ current some days smoker ☐ former smoker ☐ never smoked
Use **drugs?** ☐ never ☐ in the past ☐ currently ☐ type of drug: _____
Drink **alcohol?** ☐ never ☐ rarely ☐ socially ☐ frequently (more than twice per week) ☐ alcoholic

What medications are you currently taking? (You may attach a list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

What surgeries have you had in the past? Approximate date of surgery:

_____ _____
_____ _____
_____ _____

Patient Name _____ Patient DOB _____

Patient DOS _____

Please check off any of the following symptoms you have been recently experiencing:

General:	☐ Chills	☐ Fever	☐ Weight Gain	☐ Weight Loss
Skin:	☐ New Lesions	☐ Rash	☐ Hair Loss	☐ Itching
HEENT:	☐ Blurred Vision	☐ Double Vision	☐ Hearing Loss	☐ Discharge
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of Breath	☐ Sputum
Cardiovascular:	☐ Chest Pain	☐ Abnormal Blood Press.	☐ Palpatations	☐ Arrhythmia
Gastrointestinal:	☐ Abdominal Pain	☐ Constipation	☐ Nausea	☐ Vomiting
Muskuloskeletal:	☐ Neck Pain	☐ Dec. Range of Motion	☐ Joint Pain	☐ Muscle Pain
	☐ Mid-Back Pain	☐ Swelling of Extremities	☐ Joint Stiffness	☐ Muscle Spasms
	☐ Low-Back Pain	☐ Deformities	☐ Joint Swelling	☐ Fatigue
Neurological:	☐ Headaches	☐ Fainting	☐ Unsteadiness	☐ Numb/Tingling
	☐ Head Injury	☐ Poor Coordination	☐ Stroke	☐ Weakness
		☐ Trouble Walking		☐ Incontinence
Psychiatric:	☐ Anxiety	☐ Depression	☐ Flashbacks	☐ PTSD
Endocrine:	☐ Cold Intolerance	☐ Heat Intolerance	☐ Excessive Sweating	☐ Diabetes
Hematology:	☐ Blood Clots	☐ Abnormal Bleeding	☐ Easy Bruising	☐ Blood Thinners
Genito-Urinary:	☐ Bleeding	☐ Discharge	☐ Urinary Incontinence	☐ UTI

☐ **None of The Above Apply**

Your primary medical (family) doctor? Name:_____ Tel #_____

Address:_____

City:_____ State:_____ Zip: _____

Did a doctor refer you here, and if so who? Name:_____ Tel # _____

Address:_____

City:_____ State:_____ Zip: _____

OFFICE USE ONLY BELOW THIS LINE: Vital Signs:

Physical Exam: (pertinent positives)

Symptom Evaluation
Concussion/Traumatic Brain Injury
(from SCAT 5)

☐ If not applicable, please check this box and skip this page.

SCORE: Choose a whole number per symptom.

0 1 2 3 4 5 6

None **Severe**

Symptom	SCORE
Headache	
"Pressure in head"	
Neck Pain	
Nausea or Vomiting	
Dizziness	
Blurred Vision	
Balance problems	
Sensitivity to light	
Sensitivity to noise	
Feeling slowed down	
Feeling like "in a fog"	
"Don't feel right"	
Difficulty concentrating	
Difficulty remembering	
Fatigue or low energy	
Confusion	
Drowsiness	
Trouble falling asleep	
More emotional	
Irritability	
Sadness	
Nervous or Anxious	
OFFICE USE ONLY BELOW THIS LINE	STOP HERE
Total # of symptoms	
Symptom Severity Score	

Name: _____

DOB: _____

Date: _____

OFFICE USE ONLY

Previous Test ☐ N/A

Date: _____

Total # of Symptoms: _____

Symptom Severity: _____

PHYSICAL EXAMINATION

Consent for Treatment with Controlled Substances

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of opioid pain medication, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the risk of developing an addiction disorder and uncertainty regarding the extent to which they provide long-term benefit.

These drugs are monitored by the State of California and the Drug Enforcement Agency because these drugs have potential for abuse or diversion. Therefore strict accountability is required. For this reason the following policies are agreed to by you, the patient, as a condition for the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Controlled substances must come from the physician who signs below or, during his or her absence, by the covering physician. Exceptions apply only when a controlled substance is being prescribed in a routine manner by another provider who is aware of all medications.
2. All controlled substances must be obtained at the same pharmacy, notwithstanding pharmacy-related issues made known by you to the practice.
3. You will inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take, or if you change pharmacies.
4. The prescribing physician has permission to discuss treatment details with dispensing pharmacists, or other professionals who provide you health care, to maintain accountability.
5. Unannounced urine, serum, or saliva toxicology screens may be requested and your cooperation is required.
6. You may not use any illicit substances while taking controlled substances including, but not limited to cocaine, heroin, methamphetamine, ecstasy, etc.
7. You may not share, sell, or otherwise permit others to have access to these medications.

Initial below

8. You will take these medicines as prescribed or you will otherwise notify the physician.

_____ 9. **Original containers of medication will be brought to each visit for which a medication refill is being requested with the remaining corresponding medication inside.**

_____ 10. **You will maintain a journal of your medication use and bring it to each visit for which a medication refill is being requested**. An example will be provided to you. Maintain a blank original and make copies for use.

11. If your medication has been damaged, misplaced, or stolen you must complete a police report regarding the theft and provide a copy to this office.
12. Renewals are contingent on keeping scheduled appointments no less than 3 days in advance of the end of your current medication cycle. Urgent appointment requests for this purpose will not be honored and it is your responsibility to plan accordingly. Phone calls for prescriptions after hours or on weekends are not compliant with this requirement.
13. Early refills will generally not be given. You may not run out of your medications before an appointment for medication refill.
14. It is understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit and safety.
15. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation). You agree to not operate heavy machinery while under the influence of these medications.
16. If the legal authorities have questions concerning your treatment all confidentially is waived and these authorities may be given full access to our records of controlled substance administration.
17. You understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Violation of any component of this contract may be met with one warning and repeat review of this agreement. No further warnings will be given. Final violation of this agreement indicates that safe outpatient management using these medications has not been demonstrated and therefore results in immediate termination of controlled substance prescribing. A referral to a detoxification program will be provided at that time.

Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Physician Signature: _____ Date: _____

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Patient Telephone: _____ Patient E-Mail: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Address of Pharmacy: _____

_____

* If Address unknown, please mention cross streets

Telephone of Pharmacy: _____

Fax Number of Pharmacy: _____

ADDITIONAL PHARMACY INFORMATION (If Applicable)

Name of Pharmacy: _____

Address of Pharmacy: _____

_____

* If Address unknown, please mention cross streets

Telephone of Pharmacy: _____

Fax Number of Pharmacy: _____

Consent to Receive Text Message Appointment Reminders

By signing below, I authorize iSCORE to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by iSCORE under my cell phone plan. My text/mobile phone number is: _____

Initials _____

I know that I am under no obligation to authorize iSCORE to send me text messages. I may opt-out of receiving these communications at any time by calling the office at 626-460-1096 or 818-338-6860. Please allow 2-3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from iSCORE.

Patient Name: _____

Signature: _____

Date: _____ Date of Birth: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

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Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Patient's or Patient Representative's Signature Date

By: _____ _____

Physician's or Authorized Representative's Signature Date

By: _____

Print Patient's Name

MAXIM MORADIAN, MD

Print or Stamp Name of Physician or Authorized Agent of Medical Group

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

Facility Name: _____ Fax No.: _____

Facility Address: _____ Tel No: _____

The information you may release subject to this signed release form is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes
□ Care Plan	□ Lab Reports	□ Radiology Reports
□ Pathology Reports	□ Treatment Record	□ Operative Reports
□ Hospital Reports	□ Medication Record	□ Other (please specify)

Release my protected health information to the following entity:

iSCORE (Interventional Spine Care and Orthopedic Regenerative Experts)

Address: 317 S. Brand Blvd., Suite 103, Glendale, CA 91204

51 N. 5th Ave, Suite 301, Arcadia, CA 91006

Tel: (818) 338-6860 & (626) 460-1096; Fax: (888) 425-9079

Email: medicalrecords@iscoreinc.com

_____ _____

Patient Name Signature of Patient or Personal representative

_____ _____

Patient Date of Birth Printed Name or patient or Personal representative

_____ _____

Date Description of Personal Representative's Authority

Medication Reconciliation Consent

I hereby certify that I am providing authorization to my physician/medical provider/health care professional to obtain electronic prescription history information as part of direct health care services. I am authorizing this information to be shared via all applicable federal, state, local, and common laws, rules, regulations, directives, and guidelines. This includes, but is not limited to, HIPAA and related regulations; the Health Information Technology for Economic and Clinical Health Act and related regulations; the Anti-Kickback provisions of the Social Security Act and related regulations; the federal Physician Self-Referral Prohibition provisions of the Social Security Act and related regulations; and state and federal pharmacy laws and regulations.

Disclaimer: I understand that certain information may not be available or accurate in this report, including items I have requested not to be disclosed due to privacy concerns, over-the-counter medications, low-cost prescriptions, prescriptions paid for out-of-pocket or from non-participating sources, or due to errors in insurance claims data. I will do my best to provide verbal or written medication history to my physician/medical provider/health care professional.

Patient Name: _____

Signature: _____

Date: _____ Date of Birth: _____