Patient Information

Please fill out the following sheets in their entirety.

Today's Date: _____

Patient's Name: _____ Age: ___ Date of Birth: _____
Last Name, First Name, MI

Sex: ____ SS#: _____ - _____ - _____ Single____ Married____ Widowed____

Home Address: _____
Street address

_____
City, State, Zip Code

Home Phone Number: ( ) _____ - _____ Cell Phone: ( ) _____

Emergency Contact: Name: _____ Phone #: ( ) _____- _____

Relationship: _____

Referring Source: _____ MD__ DO__ DC__ DDS__ Other_____

Primary Care Physician: _____Phone#:_____

Your Occupation: _____ Employer: _____

Employer Address: _____ Work Phone #: ( ) ____ - _____

Is today's visit related to an on-the-job injury? _____
If yes, date of accident: _____

Is today's visit related to a motor vehicle accident: _____
If yes, date of accident: _____

Are you working now? _____ Last date worked: _____

Other doctors seen for this injury/illness: _____

Do you have an attorney for this injury/illness: _____
If yes, name /address/phone number of attorney: _____

Please describe how this injury / illness occurred: _____

Insurance Information

Patient's Name: _____ Name of Insurance Co: _____
(Please give the front desk person your insurance card so she can make a copy for your chart)

Health insurance is designed to help you meet the cost of medical services however it seldom covers the entire cost of your medical care. Your policy is a contract between you and your insurance company, not between your doctor and the insurance company. The primary responsibility for payment, therefore, rests with you. We will provide you with the necessary information and will assist you whenever possible. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or other balance not paid by your insurance company. Insurance companies offer several different plans and options based on what you choose to purchase from them therefore, it is also your responsibility to know the policies of your plan (deductible, copays, coinsurance and network status) since it is a contract agreed by you and your health insurance carrier. If you wish to be evaluated by Dr. Sean A. Jebraili, you hereby agree to these terms.

I, the undersigned, authorize payment of medical and surgical benefits to Sean A. Jebraili, M.D. and acknowledge that I am responsible for all monies that are or may become due and owing for services rendered to me or to another at my request, by the office of Sean A. Jebraili, M.D. I the undersigned, authorize the release of any medical information necessary to process this claim. In the event that any insurance carrier refuses to cover any claim for said services, I agree to pay the same. I understand that I may be charged a statement fee for unpaid balances beyond twenty-five days. In the event that it becomes necessary for Sean A. Jebraili, M.D. to initiate collection proceedings for payment of said services, I agree to pay all cost of collection, including but not limited to court costs, thirty-three percent attorney collection fees and interest at the rate of 8% of all sums due from the due date thereof. I also understand that should my account be subject to collections proceedings, I may no longer be accepted as a patient in this office.

Patient's Name (Please Print): _____

Patient's Signature: _____

Date: _____/_____/_____

Patient Privacy. Our practice is committed to securing the privacy of your health information. Accordingly, we have posted our practice's Notice of Privacy Practices in the reception area. You are not required to read this Notice. However we would like your acknowledgment that you have been notified that the practice has such a Notice of Privacy Practices.

Signature_____ Date_____

Patient Medical History

THIS FORM IS VERY IMPORTANT TO YOUR TREATMENT AND CARE. PLEASE TAKE THE TIME TO FILL IT OUT FULLY AND ACCURATELY.

Patient Name: _____ Date when illness began: _____

Chief complaint: _____

_____

Have you had an epidural steroid injection? Y / N Did it help? Y / N
Have you had physical therapy? Y / N Did it help? Y / N

Past Major Illnesses: _____

_____

Surgeries/Hospitalizations and Year:

_____

_____

Current Medications – ***include dosage and frequency:***

_____

_____

List any known allergies to medications:

_____

Please describe your use of tobacco (smoking, chewing, etc.):

_____Yes. If yes, how much per day: _____
_____ No, never smoked / used tobacco
_____ No, I quit ____ years/months/days ago

Please describe your alcohol intake:

_____Yes. If yes, how much? _____
_____No, never.
_____No, but I used to.

Family History:

Mother *Alive / Deceased* *Age* *Cause of Death:* _____
Father *Alive / Deceased* *Age* *Cause of Death:* _____

Any family members with significant neurological disease or illness? Please describe: _____

_____

Patient Medical History – Conservative Measures

FORM IS VERY IMPORTANT TO YOUR TREATMENT AND CARE. PLEASE TAKE THE TIME TO FILL IT OUT FULLY AND ACCURATELY.

Patient Name: _____ Date when illness began: _____

What conservative measures/treatments have you taken and for how long?

Physical Therapy Yes or No If Yes – how long? _____
Injections Yes or No If Yes – how many?_____
Activity Modifcation Yes or No If Yes – how long?_____
Medications Yes or No If Yes – which ones and for how long

_____
_____

Please rate your pain level on a scale of 1 – 10 with 1 being the lowest and 10 the highest: 1 2 3 4 5 6 7 8 9 10

Please give specific details about how your ADL (activities of daily living) have been limited

_____
_____
_____
_____
_____

Review of Systems

Please check any description that may apply.

Cardiovascular

- ❑ Chest pain or angina
- ❑ High blood pressure
- ❑ Irregular heart pulse
- ❑ Heart murmur
- ❑ High Cholesterol
- ❑ Swelling in feet or hand

Respiratory

- ❑ Asthma
- ❑ Chronic cough
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Lung cancer
- ❑ Bloody sputum

Gastrointestinal

- ❑ Liver disease
- ❑ Jaundice
- ❑ Stomach ulcers
- ❑ Gastritis
- ❑ Colon cancer

Genitourinary

- ❑ Bladder or incontinence
- ❑ Bladder cancer
- ❑ Prostate cancer

Musculoskeletal

- ❑ Joint pain and swelling
- ❑ Arthritis

Neurological

- ❑ Seizures
- ❑ Poor coordination of arms and/or legs
- ❑ Disorientation
- ❑ Migraine headaches

Psychiatric

- ❑ Anxiety
- ❑ Depression
- ❑ Other, describe _____

Endocrine

- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Hormone problems

Hematological/ Lymphatic

- ❑ Anemia
- ❑ Hemophilia
- ❑ Blood transfusion, If yes, when: _____
- ❑ HIV/AIDS
- ❑ Hepatitis

Reproductive

- ❑ Pregant now
- ❑ Birth control pills
- ❑ Breast cancer

The Patient Medical History is accurate to the best of my knowledge.

Patient's Signature: _____
Date: _____