California NeuroInstitute, Inc. – Fahd R Khan, MD

2512 Samaritan Ct. Suite H – San Jose, CA 95124

(All information MUST be completed in order to bill your insurance company)

Patient Name Last: ______________________________ First: ______________________________ MI: ______

Date of Birth: ____________________________ Age: ___________

Street Address: ____ Apt #: __________

City: ____ State: ___________ Zip: ____________________

Phone # - Home: _____________________ Cell: _______________________ Work: _______________________

Email: ____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐

Sex : Male ☐ Female ☐

Primary Language Spoken: _______________________________________

Ethnicity (Check one): Hispanic/Latin American ☐ Not Hispanic or Latino ☐ Other ☐ Refuse to Report ☐

Race: (Check all that apply): American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific ☐

White ☐ Black or African American ☐ Hispanic ☐ Other Race ☐ Refuse to Report ☐

Employer: ____

Person to notify in an Emergency: ______________________________ Relation: ________________________

Phone number: ____

Preferred Pharmacy: Name: ________________________________ Phone Number: _____________________

Pharmacy Address: ____

City: ___________________________________ State: ________________ Zip: _____________________

Primary Insurance Company (Please Provide Copy of Card) :_________________________________

Subscriber (If other than patient, otherwise you may leave it blank)

Last Name: _____________________________ First: ___________________________ MI:_______

Subscriber's Birth date: _________________

Subscriber's Employer : ____

Subscriber's Identification Number: ________________________________

Group Number: ______________________________________

Relationship to Patient: ____

I understand that I am liable for expenses incurred which are not covered under my plan. I understand that all co-payment, deductibles and/ or non-covered services are to be paid in full at the time of service. I hereby authorize the release of any information to my insurance company necessary claims. I hereby authorize my insurance company to make payments directly to the physician. I have read and agree to the policies and will abide by them.

Signed: ____ Date: ______________________

Reason for today's visit:

____

____

Is this the result of a specific injury or accident? Yes ☐ No ☐

Are you involved in litigation or potential litigation regarding this condition? Yes ☐ No ☐

Date of accident: ____________________ Type of accident: __________________________________

It is important for us to communicate with your physician about the result of your evaluation. Please provide the names and **full addresses** of all your individuals authorized to receive reports from us.

If you wish to revoke your authorization to send copies of this evaluation and subsequent visits to any or all individuals listed below, please send a written letter to the clinic revoking consents to release this information and specify which individuals you are referring to.

1. Referring Physician: ____

Street Address: ____

City, State, Zip: ______________________________ Phone #: ____________________

2. Primary Care Physician: ____

Street Address: ____

City, State, Zip: ______________________________ Phone #: ____________________

3. Name: ______________________________ Indicate subspecialty: ________________

Street Address: ____

City, State, Zip: ______________________________ Phone #: ____________________

4. Name: ______________________________ Indicate subspecialty: ________________

Street Address: ____

City, State, Zip: ______________________________ Phone #: ____________________

Past Medical History:

Have you ever been **diagnosed** with any of the following conditions or had any of the procedures listed below? *Check Yes or No. If yes, please give details.*

System	YES	NO		YES	NO
CARDIOVASCULAR			***OTHER***		
Atrial fibrillation	☐	☐	Alcohol dependency	☐	☐
Blood clotting disorder	☐	☐	Cancer	☐	☐
Carotid artery disorder	☐	☐	Diabetes	☐	☐
Congestive heart failure	☐	☐	Drug abuse	☐	☐
Elevated cholesterol	☐	☐	Immune system disorder	☐	☐
Heart murmur	☐	☐	Thyroid disease	☐	☐
Heart attack/angina	☐	☐	Toxic exposure	☐	☐
Heart surgery/angioplasty	☐	☐	Sexually transmitted disease	☐	☐
High blood pressure	☐	☐			
Prosthetic/artificial heart value	☐	☐			
Blockage of arm or leg blood vessels	☐	☐			
GASTROINTESTINAL/ GENITOURINARY/RESPISTORY			**Other Medical Problems/History:** (Please list all medical conditions not listed above)		
Stomach ulcers	☐	☐	______________________________		
Liver disease/hepatitis	☐	☐	______________________________		
Kidney/bladder disease	☐	☐	______________________________		
Lung disease	☐	☐	______________________________		
Tuberculosis	☐	☐	______________________________		
Asthma	☐	☐	______________________________		
COPD	☐	☐	______________________________		
NEUROLOGICAL			***Physician Comments:***		
Brain Tumor	☐	☐			
Seizure disorder/Epilepsy	☐	☐			
Head injury	☐	☐			
Migraine headaches	☐	☐			
Parkinson's disease	☐	☐			
Essential Tremor	☐	☐			
Stroke or TIA	☐	☐			
Nerve or muscle disease	☐	☐			
Other neurological disease	☐	☐			

Previous Operations/Hospitalizations

Date	Hospital	Problem/Operation
________________	___________________________	_____________________________
________________	____________________________	_____________________________
________________	_____________________________	_____________________________
________________	_____________________________	_____________________________
________________	_____________________________	_____________________________
________________	_____________________________	______________________________

Current Medications

Please list any mediation (prescriptions and non-prescription) you are currently taking (including vitamins & aspirin)

Medications	Dosage	Number taken daily
___________________________________	______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________

List of Herbal medications & Vitamins:

___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________
___________________________________	_______________________	__________________________

Are you taking any blood thinners? (Coumadin/Warfarin, Plavix, Aspirin, Eliquis, Xarelto etc.) ☐ Yes ☐ No

Please list, including dosage: ____

Allergy History

Have you ever had an allergic reaction to any medication? ☐ YES ☐ NO if yes, please list medication & reaction.

____

Are you allergic to latex, x-ray dye or iodine? ☐ YES ☐ NO If yes, please explain? ___________________________

Other Treatments

Please list other recent treatments for pain or other medical condition. (e.g., physical therapy, acupuncture, hypnosis, psychiatric, counseling, etc.): ____

____

____

Social History

Birthplace: ______________________________ Highest grade completed in school: ___________________________

Are you currently working? **YES** ☐ **NO** ☐

Employer: ____

Occupation: ____

Who currently lives with you? ____

Have you ever smoked cigarettes? **YES** ☐ **NO** ☐

If yes, how much do you currently smoke per day? ☐ **None** ☐ **½ pack** ☐ **1 pack** ☐ **>1pack**

If you previously smoked, how long ago did you quit**?** ☐ **<1 yr.** ☐ **1-5 yrs.** ☐ **>5 yrs.**

How many years did you smoke? ________________________________

Have you had significant exposure to: Pesticides? **YES** ☐ **NO** ☐ Toxic Waste? **Yes** ☐ **NO** ☐

Do you drink alcohol? **YES** ☐ **NO** ☐ Type: __________________________

How often/much do you drink alcohol? _____________________________________

Do you exercise? **YES** ☐ **NO** ☐

If yes how much? **Rarely** ☐ **Occasionally** ☐ **More than 3 times per week** ☐

Family History

Family Members		Age (or age at death):	Sex:		Living: *(Please check)*		Medical Problems:
Grandparents –	**Paternal:**	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
	Paternal:	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
	Maternal:	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
	Maternal:	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
	Father:	_______________			**Yes** ☐	**No** ☐	______________________
	Mother:	_______________			**Yes** ☐	**No** ☐	______________________
	Siblings:	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
		_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
		_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
		_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
	Children:	_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
		_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________
		_______________	**M**	**F**	**Yes** ☐	**No** ☐	______________________

PAIN SCALE

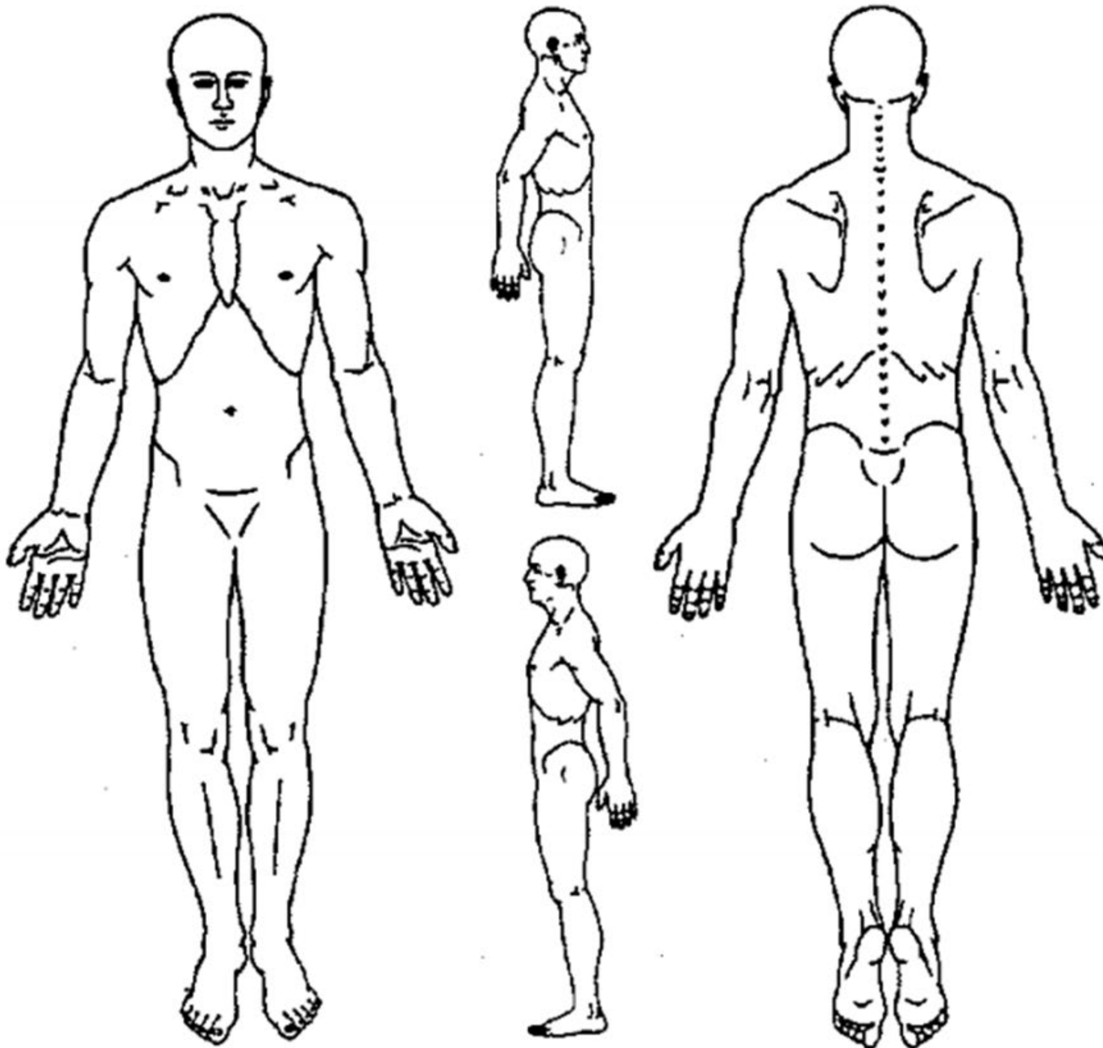
Rate the severity of your pain by checking one box on the following scale.

NO PAIN										WORST POSSIBLE PAIN
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: **A** – ACHE **B** – BURNING **N** – NUMBNESS
P – PINS & NEEDLES **S** – STABBING **O** - OTHER



If **Other** please explain?

____

____

____

REVIEW OF SYSTEMS: Have you experienced any of the following symptoms? Please check yes or no.

ALLERGY/IMMUNOLOGY	YES	NO	HEMATOLOGICAL/LYMPHATIC	YES	NO
Low resistance to infection	☐	☐	Easy bruising	☐	☐
Environmental allergies	☐	☐	Frequent bleeding	☐	☐
CARDIOVASCULAR			Enlarged lymph nodes	☐	☐
Chest pain or angina	☐	☐	**INTEGUMENTARY (SKIN & BREAST)**		
Irregular heart rhythm	☐	☐	Unusual or prolonged rashes	☐	☐
CONSTITUTIONAL			Breast pain or lump	☐	☐
Recent weight change	☐	☐	Change in hair or nails	☐	☐
Good general health lately	☐	☐	**MUSCULOSKELETAL**		
Recurrent fevers, chills, sweats	☐	☐	Joint swelling	☐	☐
Extreme fatigue	☐	☐	Difficulty walking	☐	☐
Frequent nausea, vomiting	☐	☐	**NEUROLOGICAL**		
Difficulty sleeping	☐	☐	Headaches	☐	☐
EARS, NOSE, MOUTH, THROAT			Numbness/tingling sensation	☐	☐
Change in hearing	☐	☐	Weakness or paralysis	☐	☐
Ringing in the ears	☐	☐	Convulsions or seizures	☐	☐
Recent nose bleeds	☐	☐	Change in memory/concentration	☐	☐
Chronic sinus problems	☐	☐	Loss or blurry vision/double vision	☐	☐
Voice changes	☐	☐	Black outs/dizziness	☐	☐
EYES			Memory loss or confusion	☐	☐
Change in vision	☐	☐	Other neurological problems	☐	☐
Glaucoma	☐	☐	**PAIN**		
ENDOCRINE			Joint stiffness or pain	☐	☐
Heat or cold intolerance	☐	☐	Muscle pain	☐	☐
Excess thirst or urination	☐	☐	Neck pain	☐	☐
GASTROINTESTINAL			Back pain	☐	☐
Change in appetite	☐	☐	Other pain (please specify)	☐	☐
Severe heart burn	☐	☐	**PSYCHIATRIC**		
Vomiting blood	☐	☐	Anxiety/Nervousness	☐	☐
Frequent diarrhea	☐	☐	Depression	☐	☐
Constipation	☐	☐	Other	☐	☐
Black or bloody stools	☐	☐	**RESPIRATORY**		
Abdominal pain	☐	☐	Breathing problems/shortness of breath	☐	☐
GENITOURINARY			Coughing up blood	☐	☐
Blood in urine	☐	☐	Chronic cough	☐	☐
Burning with urination	☐	☐			
Difficult/frequent urination	☐	☐			
Lack of bladder control	☐	☐			
Sexually transmitted disease	☐	☐			
Change in sexual function	☐	☐			

Please read this portion carefully.

California NeuroInstitute, Inc.

requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. **TERM OF AGREEMENT**. I understand that the terms and conditions in this outpatient agreement will remain in effect as long as I am under the care of Dr. Khan. I understand I will be asked to confirm that my demographic and insurance information is correct at each clinic visit. If my insurance or demographics information has changed, I will inform the clinic staff.
2. **MEDICAL CONSENT.** I, the undersigned, consent to the general treatment and procedures that may be limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I also authorized California NeuroInstitute to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during an operation, procedure or treatment, for research that maybe conducted by California NeuroInstitute or unaffiliated academic or commercial third parties if allowed under legal requirements and California NeuroInstitute policies. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.
3. **PHOTOGRAPHY.** I consent to the taking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment, and the use of the pictures, videotapes or electronic reproductions, for purposes permitted by law. Under specific circumstances, I may be asked for separate consent prior to the talking of pictures, videotapes or other electronic reproductions of the patient's medical or surgical condition or treatment and the use of those pictures, videotapes or electronic reproductions. If the image could be directly used to identify the patient, I will be asked for authorization to use or disclose the image, unless it is for treatment, internal teaching activities, institutionally approved research in specific cases, or limited other activities consistent with applicable privacy laws.
4. **FINANCIAL AGREEMENT.** For the services to be rendered, I agree to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of California NeuroInstitute. This includes financial responsibility for all deductibles and co-payment that may be required by the patient's insurance or health plan, including Medicare and Medi-Cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection. I further agree to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraph 6 (Contracted Health Plan Patients and Other Sources) and/or 7 (Assignment of Insurance Benefits will also apply).
5. **NOTICE REGARDING DISCLOSURE OF PHYSICAN OWNERSHIP INTERESTS.**
   Dr. Fahd Khan is a shareholder at Spine Sports Surgery Center, LLC in Campbell, CA. Your surgery may be performed at this center, but patients can also elect to have their surgeries performed at multiple local hospitals instead. You will not be treated differently if you choose an alternative facility. Dr Khan would be happy to discuss this with you if you have any concerns.
6. **CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES.** I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which California NeuroInstitute contracts, or through some other source (e.g., clinical trial sponsor, employer's worker's compensation insurance). I agree to be responsible under paragraph 4 contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other source; (d) for services not covered and/or paid by the patient's health plan or other source to the extent allowed by law or contract.
7. **ASIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** I authorize direct payment to California NeuroInstitute of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services at a rate not to exceed the actual institutional and professional charges. I understand and agree that I am financially responsible under paragraph 4 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to California NeuroInstitute to assist the patient in applying for payment under Medicare or Medi-Cal is correct.

The undersigned certifies that he/she has read both pages of the Terms and Conditions of Services and is the patient or responsible person is duly authorized by or on behalf of the patient to execute and accept its terms.

______________________________	______________________________	________________
Patient or Responsible Person Signature	Print Name	Date/Time

Please indicate relationship of person signing this document if someone else helped filling out Intake forms:

☐ Patient Authorized Consent ☐ Patient with Legal Custody ☐ Legal Guardian/Temporary Legal Guardian

Explain type of guardianship: ____

☐ Person with written Authorization (e.g. Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney)

☐ Explain type of written authorization: ____

☐ Documentation of written authorization received.

If interpreted: ________________________ ________________________ ________________

Interpreter Signature Print Name Language

____________________________________ ________________________

Position/Relationship to patient Date/Time

FINANCIAL RESPONSIBITIES AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTITIVE

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (4) and, if applicable, Contracted Health Plan and Other Sources (6) and Assignment of Insurance Benefits (7) above.

____________________________________	________________________	________________
Financial Responsible Party	Relationship to Patient	Date/Time