Premier Brain & Spine Institute, Inc.
(All information MUST be completed in order to be seen)

Patient Name Last: _____ First: _____ MI: _____

Date of Birth: _____ Age: _____ Patient Social Security: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone # - Home: _____ Cell: _____ Work: _____

Email: _____

Marital Status (Circle One): Married Single Divorced Widowed Separated

Sex (Circle One): Male Female

Primary Language Spoken: _____

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

Race: (Circle all that apply) American Indian or Alaska Native Asian Native Hawaiian or Other Pacific White Black or African American Hispanic Other Race Other Pacific Islander 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)

Last Name: _____ First: _____ MI: _____

Subscriber's Birth date: _____ Social Security Number: _____

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 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. Please also sign the space below to indicate your consent to release your medical information to these individuals.

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 primary care or subspecialty: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

4. Name: _____ Indicate primary care or 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? *Circle Yes or No. If yes, please give an explanation.*

System	Patient Comments	Physician Comment
CARDIOVASCULAR		
Atrial fibrillation	YES NO	
Blood clotting disorder	YES NO	
Carotid artery disorder	YES NO YES NO	
Congestive heart failure	Level_____ Date_____	
Elevated cholesterol	YES NO	
Heart murmur	YES NO	
Heart attack/angina	YES NO	
Heart surgery/angioplasty	YES NO	
High blood pressure	YES NO	
Prosthetic/artificial heart value	YES NO	
Blockage of arm or leg blood vessels	YES NO	
GASTROINTESTINAL/ GENITOURINARY/RESPISTORY		
Stomach ulcers	YES NO	
Liver disease/hepatitis	YES NO	
Kidney/bladder disease	YES NO	
Lung disease	YES NO	
Tuberculosis	YES NO	
Asthma	YES NO	
COPD	YES NO	
NEUROLOGICAL		
Brain tumor	YES NO	
Convulsions/seizure disorder/epilepsy	YES NO	
Head injury	YES NO	
Migraine headaches	YES NO	
Parkinson's disease	YES NO	
Stroke or TIA	YES NO	
Nerve or muscle disease	YES NO	
Other neurological disease	YES NO	
OTHER		
Alcohol dependency	YES NO	
Cancer	YES NO Type: _____	
Diabetes	YES NO	
Drug abuse	YES NO	
Immune system disorder	YES NO	
Thyroid disease	YES NO	
Toxic exposure	YES NO	
Sexually transmitted disease	YES NO	

Other Medical Problems/History: (Please list all medical conditions not listed above)

_____

_____

_____

_____

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, 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 Treatment

Please list other recent treatment for pain 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** ☐ **>3 times per week**

Family History

(Please Circle)

Family Members		Age (or age at death):	Sex:		Living:		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

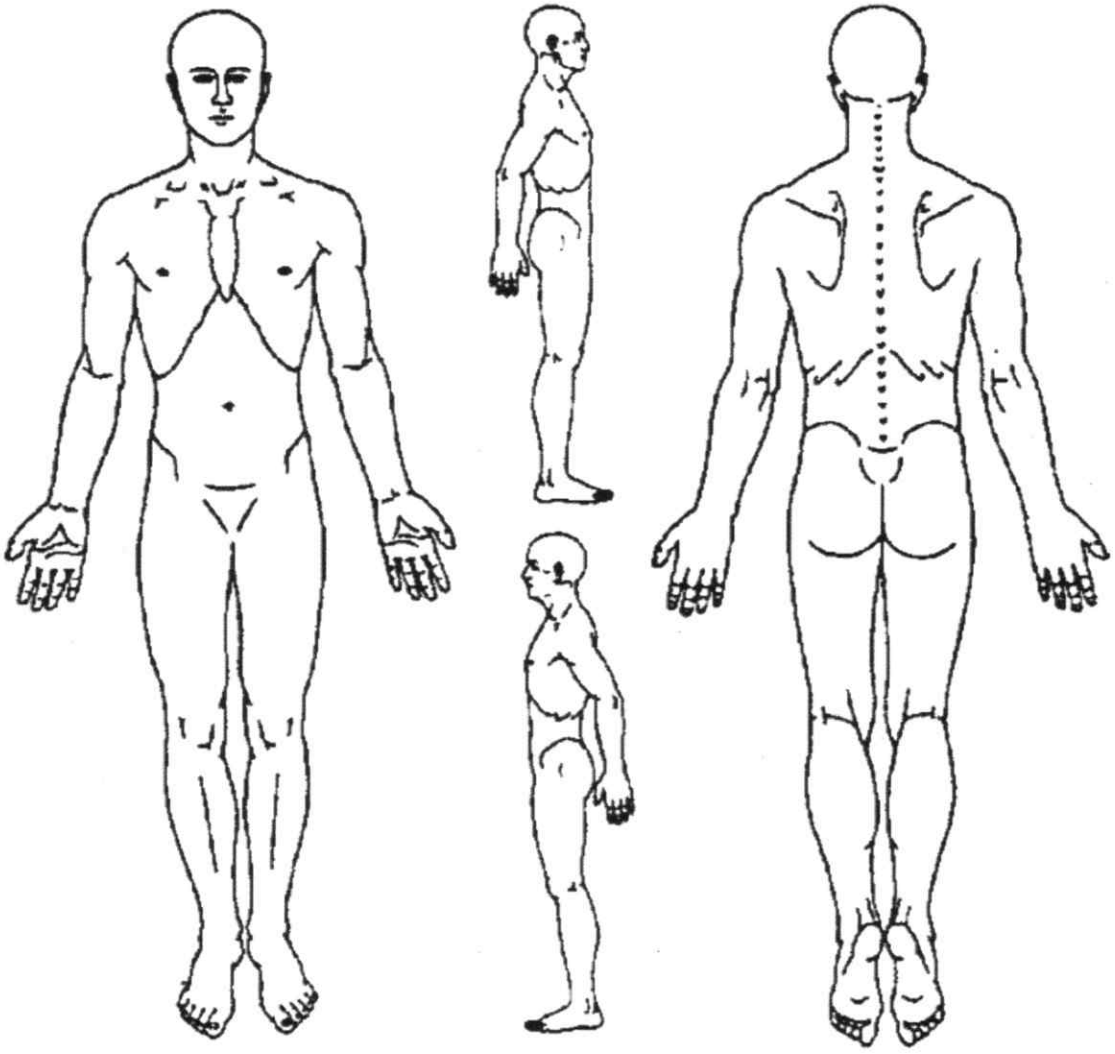
Rate the severity of your pain by checking one box on the following scale.

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 circle yes or no.

ALLERGY/IMMUNOLOGY	*Circle One*	
Low resistance to infection	YES	NO
Environmental allergies	YES	NO
CARDIOVASCULAR		
Chest pain or angina	YES	NO
Irregular heart rhythm	YES	NO
CONSTITUTIONAL		
Recent weight change	YES	NO
Good general health lately	YES	NO
Recurrent fevers, chills, sweats	YES	NO
Extreme fatigue	YES	NO
Frequent nausea, vomiting	YES	NO
Difficulty sleeping	YES	NO
EARS, NOSE, MOUTH, THROAT		
Change in hearing	YES	NO
Ringing in the ears	YES	NO
Recent nose bleeds	YES	NO
Chronic sinus problems	YES	NO
Voice changes	YES	NO
EYES		
Change in vision	YES	NO
Glaucoma	YES	NO
ENDOCRINE		
Heat or cold intolerance	YES	NO
Excess thirst or urination	YES	NO
GASTROINTESTINAL		
Change in appetite	YES	NO
Severe heart burn	YES	NO
Vomiting blood	YES	NO
Frequent diarrhea	YES	NO
Constipation	YES	NO
Black or bloody stools	YES	NO
Abdominal pain	YES	NO
GENITOURINARY		
Blood in urine	YES	NO
Burning with urination	YES	NO
Difficult/frequent urination	YES	NO
Lack of bladder control	YES	NO
Sexually transmitted disease	YES	NO
Change in sexual function	YES	NO
HEMATOLOGICAL/LYMPHATIC		
Easy bruising	YES	NO
Frequent bleeding	YES	NO
Enlarged lymph nodes	YES	NO
INTEGUMENTARY (SKIN & BREAST)		
Unusual or prolonged rashes	YES	NO
Breast pain or lump	YES	NO
Change in hair or nails	YES	NO

MUSCULOSKELETAL	*Circle One*	
Joint swelling	YES	NO
Difficulty walking	YES	NO
NEUROLOGICAL		
Headaches	YES	NO
Numbness/tingling sensation	YES	NO
Weakness or paralysis	YES	NO
Convulsions or seizures	YES	NO
Change in memory/concentration	YES	NO
Loss or blurry vision/double vision	YES	NO
Black outs/dizziness	YES	NO
Memory loss or confusion	YES	NO
Other neurological problems	YES	NO
PAIN		
Joint stiffness or pain	YES	NO
Muscle pain	YES	NO
Neck pain	YES	NO
Back pain	YES	NO
Other pain (please specify)	YES	NO
PSYCHIATRIC		
Nervousness	YES	NO
Depression	YES	NO
Other	YES	NO
RESPIRATORY		
Breathing problems/shortness of breath	YES	NO
Coughing up blood	YES	NO
Chronic cough	YES	NO

Please read this document carefully.

Premier Brain & Spine Institute

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 for one year from the date of signature and that I will be asked to sign this agreement annually. 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 Premier Brain & Spine Institute 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 Premier Brain & Spine Institute or unaffiliated academic or commercial third parties if allowed under legal requirements and Premier Brain & Spine Institute 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 Premier Brain & Spine Institute. 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 Physician Ownership Interests.**
   Please be advised that Edward Rustamzadeh, M.D., holds ownership interest in the following and may refer you to one or more of these services in connection with your care and treatment: Advanced EP Diagnostics, Inc. is a California Professional Corporation which is owned in whole or in part by Edward Rustamzadeh, M.D., and provides Neuromonitoring to patients of Dr. Rustamzadeh. Please note that you have the right to obtain Neuromonitoring services from any provider of your choosing unless your ability to choose the provider of such services is limited by the terms of your health insurance coverage. If you do not wish to obtain Neuromonitoring services from Advanced EP Diagnostics, Inc. please let Dr. Rustamzadeh or his staff know and Premier Brain & Spine Institute, Inc. will endeavor to help seek to refer you to another provider of Neuromonitoring services. By your signature below you acknowledge your understanding that Dr. Rustamzadeh holds an ownership interest in Advanced EP Diagnostics, Inc. and your consent to receiving Neuromonitoring services provided by Advanced EP Diagnostics, Inc.

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 Premier Brain & Spine Institute 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. **ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS).** I authorize direct payment to Premier Brain & Spine Institute (Dr. Rustamzadeh) 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 Premier Brain & Spine Institute 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:

☐ 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