Armin Afsar-Keshmiri, M.D., M.S.
Board Certified In Orthopaedic Surgery
Fellowship Trained Spine Surgeon

INITIAL PATIENT VISIT:

Name: _____ DOB: _____
Address:_____
Age: ____ Sex: ____ Weight: _____ Height: _____

Phone: Home: _____Work: _____ Mobile: _____
Social Security Number:_____
Email address:_____
Local Pharmacy Name _____Address_____
Mail Order Pharmacy_____
Employer_____ Occupation _____

How did you find us? __ Referring MD __ Friend/Family Member __ Website __ Facebook __ Commercial
__ Other (describe)_____

Referring Physician Name _____ Referring Physician Telephone #_____

Who is your Primary Care Physician? _____

CURRENT MEDICAL CONDITION:

Please describe your main problem/complaint:

Do you have: ___ Only Back Pain ____Back And Leg Pain ____ Only Leg Pain
___ Only Neck Pain ____Only Shoulder/Arm Pain
___ Neck, Shoulder and Arm Pain ___ Other _____

Which is worse: ___Back Pain ___Leg Pain ___ Neck Pain ____ Shoulder/Arm Pain

I have had back/neck pain: ____Less than 1 month ___1-3 Months ____ 3-6 Months ___ 6 Months- 1 Year
____1-3 Years ___3-5 Years ____ Greater than 5 Years

My pain came on: ____Gradually, over time ____Quickly

My pain was brought on by: ____No specific incident ____Following an accident or incident at work
____ Following an accident or incident **NOT** at work
Date of MVA/Injury: _____
Describe the accident/incident: _____
_____

My Pain pattern is: ___A single attack of pain ___Attacks of pain with pain free intervals
___Continuous Pain ___Continuous pain with attacks of serve pain

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Do you have: ____Numbness: Where_____Tingling: Where_____
____Weakness: Where_____
What time of the day is your pain worse ____Morning ___Late in the day ___The middle of the night

I experience pain: ___The entire day ___A fair amount of the day (2-7 hours)
___Most of the day (16-20 Hours) ___A small amount of the day (1 hour or less)
___A good part of the day (8-15 Hours) ___Less than once a day

How long does the pain attack last: ____Seconds ___Minutes ___Hours ___Constant
For how long can you walk: ___ <15 minutes ____15-30 Minutes ___ 30-60 Minutes ___NO Restrictions
How long can you stand: ___< 15 minutes ___15-30 Minutes ___30-60 Minutes ___ NO Restrictions

What position/activity make the pain worse or better?

	Standing	Sitting	Walking	Stairs	Lying Down	Bending	Lifting	Coughing	Bowel Mov't	General Activity
Better:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Worse:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Pain Rating Scale: How would you rate your pain today: **(Circle One Number)**

0 - 1 - 2 – 3 - 4 – 5 – 6 – 7 – 8 – 9 – 10
None Mild Moderate Severe Worst Possible Pain

Name, Date, and Location of office you have sought help for your pain: (check all that apply)

Family Doctor: _____
Orthopaedist: _____
Spine Surgeon: _____
Physical Therapist:_____
Chiropractor: _____
Pain Management: _____
Physiatrist:_____
Neurologist:_____
Psychiatrist/Psychologist: _____

Have any of the above treatments decreased your pain: ____ NO
____YES, describe:_____

Which medications do you take for your pain:
_____
My pain now seems to be: ___Getting better ____Staying the same ____Getting Worse
Have you noticed any change in your bowel or bladder habits?
____NO ____YES, Describe: _____

Has any other Surgeon recommend surgery? _____NO ____YES, who: _____

Have you had previous Spine Surgery?
___NO ___YES ⟶ When: ___/___/_____ Doctor:_____
Type of surgery:_____

If you had previous spine surgery, did the surgery make the pain better: ____YES ____NO

Have or are you planning to apply for Disability or Worker's Compensation:
____YES, Date of Injury_____ ____NO
Is there a lawsuit or litigation pending in relationship to your pain? ____YES ____NO

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REVIEW OF SYSTEMS:

Primary Reason for Today's Visit:

_____

Do you presently have any problems with the following areas? If YES, give explanation and date

FEVER ____YES ____NO
CHILLS ____YES ____NO
WEIGHT LOSS ____YES ____NO
EYES ____YES ____NO

EARS, NOSE, MOUTH, THROAT ____YES ____NO
CARDIOVASCULAR, (heart, blood vessels) ____YES ____NO
RESPIRTORY (lungs/breathing) ____YES ____NO
GASTROINTESTINAL (stomach/intestines) ____YES ____ NO
GENITOURINARY (genitals/kidney/bladder) ____YES ____NO
MUSCULOSKELETAL (muscles/joints) ____YES ____NO
INTEGUMENT (skin/breast) ____YES ____NO
NEUROLOGICAL ____YES ____NO
PSYCHIATRIC (depression, anxiety, bipolar, substance abuse, etc) ____YES ____NO
ENDOCRINE (hormones, glands) ____YES ____NO

HEMATOLOGIC/IMMUNOLOGIC (blood) ____YES ____NO
CLOT NORMALLY AFTER CUTS? ____YES ____NO
EXCESSIVE BLEEDING? ____YES ____NO
BLOOD LOSS DURING SURGERY? ____YES ____NO
SEASONAL ALLERGIES (hay fever, etc) ____YES ____NO

PAST MEDICAL HISTORY:

Check below if you have had any of the following:

_____ Heart Disease _____ High Blood Pressure ____ Diabetes
_____Asthma _____ Kidney Disease ____ Tuberculosis
_____Migraine Headaches _____ Hepatitis ____ Epilepsy
_____Emotional Disorder _____ Cancer ____ HIV
Other_____

PAST SURGERIES: (Procedure and date): _____
_____

CURRENT MEDICATIONS: (Dates started meds and include non-prescription)

_____
_____
_____

MEDICINE/SUBSTANCE/LATEX ALLERGIES: (Include reaction)

_____

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SOCIAL HISTORY:

Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed

Highest Education Level Completed:
____ Grade school ____ High School ____ College, Technical ____ Graduate, Professional

Do you currently use Tobacco? ___Yes ___No _____ Started Age/Total years _____Stopped
Indicate quantity per day: Cigarettes____ Cigars____ Chewing Tobacco_____

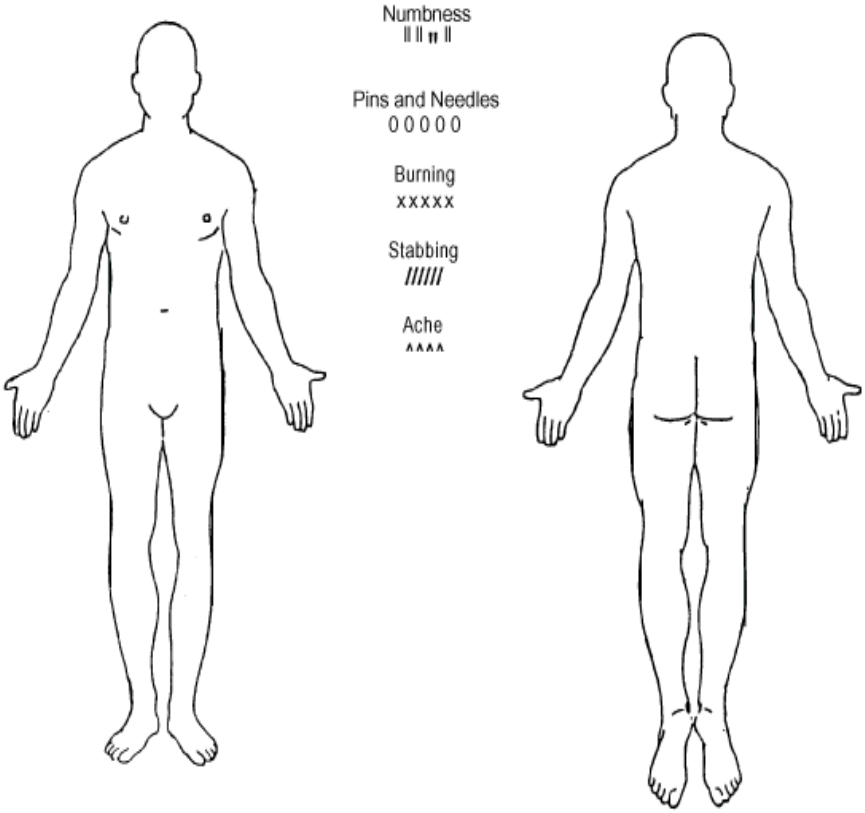
Do you currently consume Alcohol? _____Yes _____No
Indicate quantity per day: Beer_____ Wine_____ Distilled Sprits_____

WORK STATUS:

Employer Name and Address_____

Occupation_____
Are you currently? _____ Working Full Time _____Working Part time
_____ Unemployed _____ Retired
_____ Disabled, Temp _____ Disabled, Perm
_____ Housewife _____ Other _____

If you are currently NOT working:
How long have you been off work due to your back/neck pain? _____



PAIN DIAGRAM:
Please use the following diagrams to show us where you are experiencing pain and numbness:

Please circle all of the following adjectives which describe your pain:

DULL BURNING
COLD SHOOTING
TIGHT THROBBING
ELECTRIC TINGLING
OTHER_____

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Patients with known Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS/ KYPHOSIS

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis / Kyphosis: ____ Parent _____Brother/Sister
____Cousin _____None
____Other_____

Previous non-operative treatment: _____None _____Observation Only
_____ Exercise _____Brace ___ Other _____

First operative event: ___/___/_____ Second operative event: ___/___/_____

Current concerns: ____ None ____Feel imbalance
____ New or increased back pain ____Painful rod
____ Unhappy with my appearance

If you have back pain, then where: ___Upper Back ___Mid Back ___Lower Back

Do you feel that your curves have increased or decreased over time: ___Yes ___No

Do you feel you have lost height in the last few years: ___Yes ___No

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INSURANCE

Name of person responsible for this account_____
Relationship to patient:_____
Birthdate: _____ SS#: _____
Primary Insurance company name: _____
ID# _____ Group #: _____
Secondary Insurance company name: _____
ID#: _____ Group #: _____

Is patient covered by No-Fault insurance? _____ (If yes, Please Complete the Following)
Is patient covered by Workers Compensation? _____ (If yes, Please Complete the Following)
Insurance company name: _____ WC or NF Case # _____
ID#/Case # : _____
Case worker's name and phone/fax #: _____
_____
Employer_____Phone # _____
Occupation:_____
_____

I certify that I have insurance with the above company (ies) and assign Dr. John C. Herzog and/or Dr. Armin Afsar-Keshmiri all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize use of my signature on all insurance submissions.
The offices of Drs. John C. Herzog and Armin Afsar-Keshmiri may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits and the benefits payable to related services.
MEDICARE AUTHORIZATION:
I request that payment of authorized Medicare benefits be made to Drs. John Herzog and Armin Afsar-Keshmiri for their services. I authorize any holder of medical or other information about me to be released to Medicare or Medicaid services and their agents any information needed to determine these benefits related to services**.**

Signature of Beneficiary, Guardian or Personal Representative _____
Print Name of Beneficiary, Guardian or Personal Representative _____

_____ _____
Date Relationship to Beneficiary

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILTY TO INFORM SARATOGA SPINE IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN ANY OF THE ABOVE AREAS.

Signature of Patient, Parent or Guardian _____Date_____

Patient Name_____ DOB_____

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HIPPA PRIVACY STATEMENT

This notice describes how health information about you, if you decided to become a patient of this practice, may be used, disclosed and how you can get access to your health information. This is required by the Privacy Regulations used as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
Commitment to your privacy:

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the integrity of your health information. We realized these laws are complicated, but we must provide you with the following information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court order.
3. If required to to so by low enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or of another individual of the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the US Military forces and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

Rights regarding your health information:
You can request that our practice communication with you about your health in a particular manner. We will accommodate reasonable requests.

1. You can request a restriction in our use or disclosure of your health information for treatment and payment of health care operations.
2. You have the right to inspect and obtain a copy of your health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician's name to 7 Murray Street, Glens Falls, NY 12801. We will respond within ten (10) business days.
3. You may ask to amend your health information if you believe it is incorrect or incomplete, as longs as the information is kept by our practice. To request and amendment, your request must be made in writing and submitted to this office. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice.
5. Right to file a complaint if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosure that are not identified by this notice or permitted by applicable law.

This practice shares an electronic medical record database. We do cover each other and your medical records will be accessed when necessary.

Additional person(s) authorized to speak with regarding appointment messages and/or medical information:

Name:_____ Name:_____
Signature_____Date_____

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Financial Responsibility

I understand that the above named Dr(s) may or may not be a participating provider with my insurance company and that I am financially responsible for all charges whether or not paid by my insurance company. I give my permission to bill my insurance carriers with the understanding that I am financially responsible for all charges whether or not paid by my insurance carrier. Above named Dr(s) may use my healthcare information in any way for the purpose of obtaining payment for services rendered. I authorize the use of my signature on all insurance submissions.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at (518) 743-1010.

Acknowledgment that I have received that above policy:

Name_____
Signature_____Date_____