



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?

	<u>Standing</u>	<u>Sitting</u>	<u>Walking</u>	<u>Stairs</u>	<u>Lying Down</u>	<u>Bending</u>	<u>Lifting</u>	<u>Coughing</u>	<u>Bowel Mov't</u>	<u>General Activity</u>
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: _____
 Psychiatrist: _____
 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 _____ NOCHILLS _____ YES _____ NOWEIGHT LOSS _____ YES _____ NOEYES _____ YES _____ NOEARS, NOSE, MOUTH, THROAT

_____ YES _____ NO

CARDIOVASCULAR, (heart, blood vessels)

_____ YES _____ NO

RESPIRATORY (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

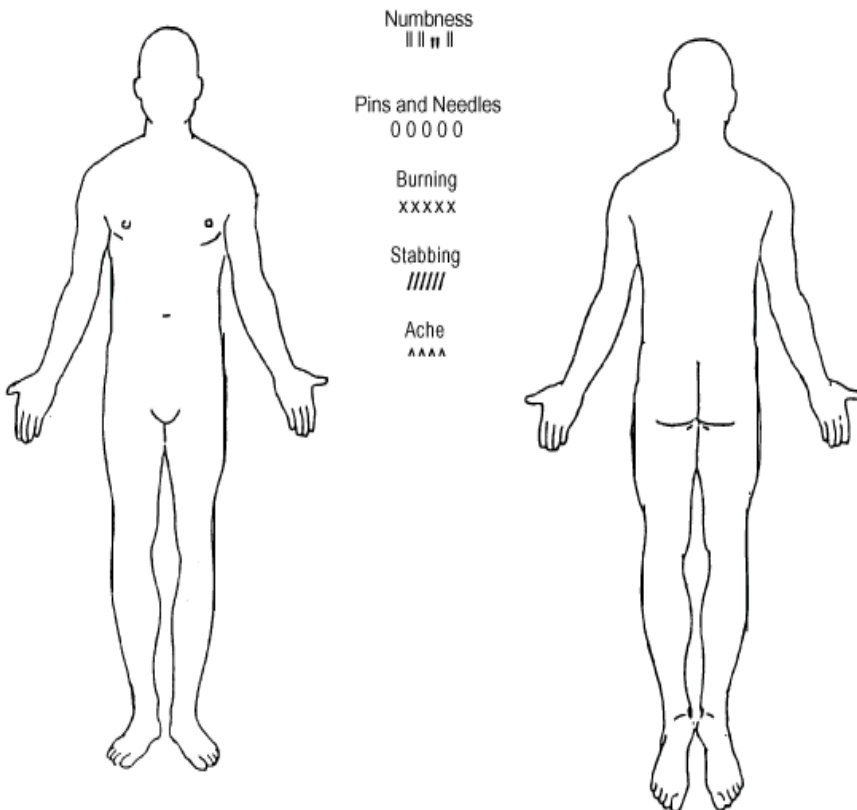
☐ Disabled, Perm

☐ 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

Patient Name _____ DOB _____

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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 RESPONSIBILITY 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 _____

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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 do so by law 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 long as the information is kept by our practice. To request an 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:

Patient Name _____ DOB _____

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Name: _____ Name: _____

Signature _____ Date _____

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 _____