NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

PATIENT REGISTRATION FORM

Location:_____

Patient Information : (Please use full legal name)
Informacion del Paciente (Utilize el nombre legal completo)

Last Name:_____ Apellido | **First Name**:_____ Primer Nombre | **Middle Name Initial**: _____ Inicial del Segundo Nombre

Date of Birth:/ Fecha de Nacimiento: _____ | **Age:** / Edad: _____ | **Sex:** / Sexo **Male**/ Masculino _____ Female/Femenino _____

Marital Status: ☐ **Single** ☐**Widowed** ☐ **Married** ☐**Divorced**
Estado Civil: Soltero Viudo/a Casado/a Divorciado/a

Address;/Domicilio:_____

City:/Ciudad_____ | State:/Estado_____ | Zip:/Codigo Postal_____

Home:/ de casa (_____)_____ | Cell:/ Celular (_____)_____ | Work:/ Trabajo (_____)_____ | Social Security /(Seguro Social) _____

Guarantor Information: (List person or insured name responsible for the bill-use legal name, no nickname)
Información del Garante: (indique la persona o el nombre del asegurado responsable de la factura; use el nombre legal, sin apodo)

Relationship of Guarantor to patient: Relacion del Garante con el paciente: | **Self**_____ Uno Mismo | **Spouse**_____ Esposo/a | **Parent**_____ Padre/Madre | **Other:**_____ Otro

Last Name:_____ Apellido | **First Name:**_____ Primer Nombre

Address:/ Domicilio:_____

City:/ Ciudad_____ | **State:/** Estado**:**_____ | **Zip:**/Codigo Postal**:** _____

Home:/ de casa (_____)_____ | **Cell:/** Celular (_____)_____ | **Work:/** Trabajo (_____)_____ | **Social Security** /(Seguro Social) _____

Date of Birth:/ Fecha de Nacimiento: _____ | **Age: /** Edad: _____ | **Sex: /** Sexo **Male/** Masculino:_____ Female/Femenino _____

Employer Name and Address:/ Nombre Y Domicilio de Empleador: _____ | **Work Phone#/**Numero del Trabajo**:** (_____)_____

Emergency Contact Information

Contact Telephone: (_____)_____ Telefono de Contacto | **Name:**_____ Nombre | **Relationship:**_____ Relacion

Insurance/Payment Information:/ Aseguranza /Informacion de Pago:
Type of Payment:/ Tipo de Pago:
☐**Insurance**/Aseguranza ☐**Cash**/Efectivo ☐ **WorkComp**/Compensacion de Trabajo ☐ **Private**/Privado

Primary Insurance:_____ **Policy:**_____ **Policy Holder:**_____
Aseguranza Primaria Poliza Titular de Poliza
Secondary Insurance:_____ **Policy:**_____ **Policy Holder:**_____
Seguro Secundario Poliza Titular de Poliza

Cancellation Policy:
If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty-five-dollar ($35) fee; this will not cover by our Insurance Company.
Poliza de Cancelacion:
Si una cita no se cancela con al menos twenty-four horas de anticipacion, se le cobrará una tarifa de treinta y cinco dólares ($35); esto no será cubierto por nuestra compañía de seguros.

Signature:_____ **Date:**_____

PRIMARY DOCTOR_____ **DOCTOR PRIMARIO**

PHARMACY:_____ **FARMACIA**

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

Medical Records Release Form

To:_____ Date: _____

Address: _____

City, State, Zip: _____

Phone:_____ Fax: _____

Description of Requested Records:

☐ All records that pertain to patients neurologic or pain problems

☐ Recent MRI and/or X-ray reports

☐ Recent H&P or discharge summaries

☐ Pain evaluations

☐ Other _____

_____

_____

Records must be received on or before appointment: _____

I hereby authorize you, the above addressed physician, hospital, or medical facility to release medical records or the information listed, for use by the staff or doctors of the Neuro Spine and Headache Pain Management Center.

Please mail or fac records to :
The Neuro Spine and Headache Pain Management Center

☐	☐	☐
195 West Legion Road Brawley, CA 92227 Phone: (760) 351-8669 FAX: (760) 351-8894	2402 Imperial Business Park Dr. Ste 101 Imperial, CA 92251 Phone : (760) 355-5248 Fax: (760) 355-5237	1501 Ocotillo Suite B, El Centro, CA 92243 Phone: (760) 592-4137 Fax: (442) 271-4099

Patients Name: _____ DOB: _____

Signature: _____ Date:_____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I AUTHORIZE SAYED MONIS, M.D. TO RELEASE TO MY INSURANCE CARRIER OR OTHER CATEGORY OF THIRD PARTY PAYOR, MEDICAL REVIEW PROGRAMS/AGENCIES CONTRACTING WITH THE THIRD PARTY PAYOR, THE SOCIAL SECURITY ADMINISTRATION UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT, CHARGES, THE FOLLOWINFG INFORMATION FOR THE PURPOSE OF SECURING PAYMENT OF MY MEDICAL CHARGES, THE FOLLOWING INFORMATION, DIAGNOSIS AND OTHER MEDICAL INFORMATION FOR THE PURPOSE OF SECURING PAYMENT OF MY MEDICAL TRATMENT, I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. I UNDERSTAND THAT IF I REFUSE TO CONSENT TO THIS RELEASE OF INFORMATION, I WILL BE HELD PERSONALLY RESPONSIBLE FOR PAYMENT OF ALL MEDICAL CHARGES RELATED TO THE EVALUATION AND/OR TREATMENT. I HEREBY REPRESENT AND WARRANT TO SAYED MONIS, M.D. THAT I HAVE COMPLIED WITH ALL OF THE REQUIREMENT AND WARRANT TO SAYED MONIS, M.D. THAT I HAVE COMPLIED WITH ALL OF THE REQUIREMENTS OF MY MEDICAL INSURANCE CARRIER, OR THE HEALTHCARE SERVICE PROVIDER, PRIOR TO HAVING THE PROCEDURE SET FORTH AT THE PARAGRAPH 1, INCLUDING OBTAINING ANY PRECERTIFICATION OR PERMISSION NECESSARY. IN THE EVENT THAT I HAVE NOT COMPLIED, I EXPRESSIVELY AGREE TO PAY SAYED MONIS M.D. ALL CHARGES , FEES, AND COSTS NOT PAID BY MY INSURER OR OTHER HEALTHCARE SERVICE PROCIDERS.

AUTHORIZATHION FOR ASSIGNMENT OF BENEFITS:
I AUTHORIZE PAYEMENT OF ALL MEDICAL BENEFITS TO WHICH I AM OR MAY BE ENTITLED TO BY A PRIVATE OR PUBLIC PAYOR DIRECTLY TO SAYED MONIS M.D. I UNDERSTAND THAT I WILL BE FULLY RESPONSIBLE FOR A PAYMENT OF ANY AND ALL CHARGES NOT COVERED BY MEDICAL INSURANCE .

CANCELLATION/NO SHOW POLICY:
PLEASE BE ADVISE THAT WHEN YOU SCHEDULE AN APPOINTMENT WITH OUT OFFICE YOU ARE MAKING A RESERVATION WITH A LICENSED PROFESSIONAL. THEREFORE, SAME DAY CANCELLATION AND NO SHOW WILL BE SUBJECT TO A $50.00 FEE PER INCIDENT.

FEES NOT COVERED BY INSURANCE:
I HAVE READ AND REVIESED THE INFORMATION PROVIDED CONCERNING FEES OR PATIENT SERVICES NOT COVERED BY INSURANCE.

PRIVATE PRACTICES ACKNOWLEDGEMENTS:
I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN GIVEN OPPROTUNITY TO REVIEW IT.

I HAVE READ AND REVIEWED THE ABOVE INFORMATION:

PATIEND NAME: (PRINT)_____ DATE OF BIRTH:_____

PATIENT/PARENT/LEGAR GUARDIAN SIGNATURE:_____

WITNESS SIGNATURE:_____ DATE :_____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering it, are giving up their constitutional right to have any such dispute decided in a court of law beforea jury, and instead are accepting the use of binding arbitration.

Article 2: **All claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may ariseout of or in any way relate to treatment or services provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers hereinafter collectively referred to as ("Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of anypregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the rightto compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitrator shall be governed pursuant to Code Civil Procedure §1280-1295 and the Federal Arbitration Act (9 U.S.C § 1-4) . The parties shall bear their own costs, fees, and expenses, along with a pro rate share of the neutral arbitrator's fee and expenses.

Article 4: **Retroactive Effect**: The patient intends this agreement to cover all services rendered by Physician not only after the date is signed (including but not limited to, emergency treatment), but also it before the date it is signed, Patient should initial the following: Effective as of the date of first medical services: _____[Patient/Patient Representative Initials Here]

Article 4: **Revocation**: This agreement may be revoked by written notice delivered to Physician within 30 days of signatureand if not revoked will govern all medical services received by the patient.

Article 5: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable,such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I havereceived a copy.

NOTICE: BY SIGINGING THIS SCONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURYOR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Physician or Duly Authorized Representative Signature (Date)

By:_____
Patient's Signature (Date)

By:_____
Print or Stamp Name of Physician, Medical Group or Association Name

By:_____
Print Patient's Name

By:_____
Signature of Translator applicable) (Date)

By:_____
Patient's Representative's Signature (Date)(if

_____
Print Name of Translator

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

Using Opioid Pain Medication in Chronic Pain

This is an agreement between_____(the patient) and Dr. Sayed Monis M.D. concerning the Use opioid analgesics (narcotic painkillers) for the treatment of chronic pain problem.

The medication will probably not completely eliminate my pain but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and I. have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable but not a life-threatening condition. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids, and withdrawal can be life- threatening for a baby.
3. Overdose on this medication may cause death by stopping my breathing; emergency medical personnel can reverse this if they know I have taken narcotic painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
6. I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing to me.
7. I agree that only one doctor will prescribe the opioids, and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
9. I agree not to sell, lend, or in any way give my medication to any other person.
10. I agree not to drink alcohol or take mood altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.
11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued, and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the prescriber may discontinue this form of treatment.

Patient's Signature:_____ Date:_____

Prescriber's Signature:_____ Date:_____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you, our patient. The Notice contains a Patient Rights section describing your right under the law. You have the right to review and receive a copy of our notice before signing the consent form. The terms of our notice may change and if we do so, you may obtain a revised copy by contacting our office.

With my consent, Sayed Monis, M.D., and staff may use and disclose protected healthcare information (PHI) about me to carry out treatment, payment, and healthcare operations to Third Party Organization (TPO). Please refer to out office's Notice of Privacy Practices for more complete description of such used and disclosures.

With my consent, Sayed Monis, M.D., and staff may call my home or other designated location and leave a message on voice mail or in person in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, and advertisements for our services.

With my consent, Sayed Monis, M.D., and staff may email or mail to my home or other designated location that assist the practice in carrying out TPO such as appointment reminders cards, patient statements, and advertisements for our services.

I have the right to request that Sayed Monis, M.D., and staff restrict how it used or disclose my PHI to carry out the TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to by agreement.

By signing this form, you consent to the use and disclosure of protected health information about you for treatment, payment, health care operations. You have the right to revoke this consent at any time, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance to your former consent.

If I do not sign this consent form, Sayed Monis, M.D., and staff may decline to provide treatment to me.

The patient understands that:

- Protected health information may be disclosed or sued for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and I have had the opportunity to review this notice .
- The practice reserves the right to change The Notice of Privacy Practices at any time.
- The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke the Consent and any time in writing with a verifiable signature on file, at anytime and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

Signature of Patient or legal guardian _____ Date _____

Print Name or Relation to Patient _____ Witness by: _____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT,
AND HELATHCARE OPERATIONS

I _____hereby states that by signing this Consent I acknowledge and agrees as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and /or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out in health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with the applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:

    a) A post card mailed to me at the address provided by me; and

    b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided for the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out a treatment, payment, and or/ health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

Patient Name:_____

Patient Signature:_____ Date:_____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Practice privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing I understand I have the right to request how protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If does agree to my restrictions on PHI use, it is bound by the agreement.

Consent for Care:

I, with my signature, authorize (th*is* practice), and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the Identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status, function of the body and the sale *or dispensing* of drugs, devices, equipment, or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for are and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/ responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductible, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that If I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. Consultants in Neuro Spine and Headache Pain Management Center, Inc. are not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.

Consultants in NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER is a physician owned and operated facility.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care. I have read and understand the Consents and financial policy stated above and agrees to accept full responsibility as described above.

_____ _____

Patient/Responsible Party **Date**

Patient Name if different from Responsible Party: _____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

TIA/Stroke Evaluation

Patient Name:_____Date:_____

High Blood Pressure	YES	NO
Diabetes Mellitus	YES	NO
High Cholesterol	YES	NO
Stroke	YES	NO

1.	H/O Dizziness or Light Headedness lasting few seconds or few minutes:	YES	NO
2.	H/O Weakness lasting few seconds of few minutes:	YES	NO
3.	H/O Numbness lasting few seconds of few minutes:	YES	NO
4.	Difficult speaking lasting few seconds or few minutes:	YES	NO
5.	Slurred Speech lasting few seconds or few minutes:	YES	NO
6.	Blurry vision lasting few seconds or few minutes :	YES	NO
7.	Difficult with balance lasting few seconds of few minutes	YES	NO
8.	Confusion lasting few seconds or few minutes:	YES	NO

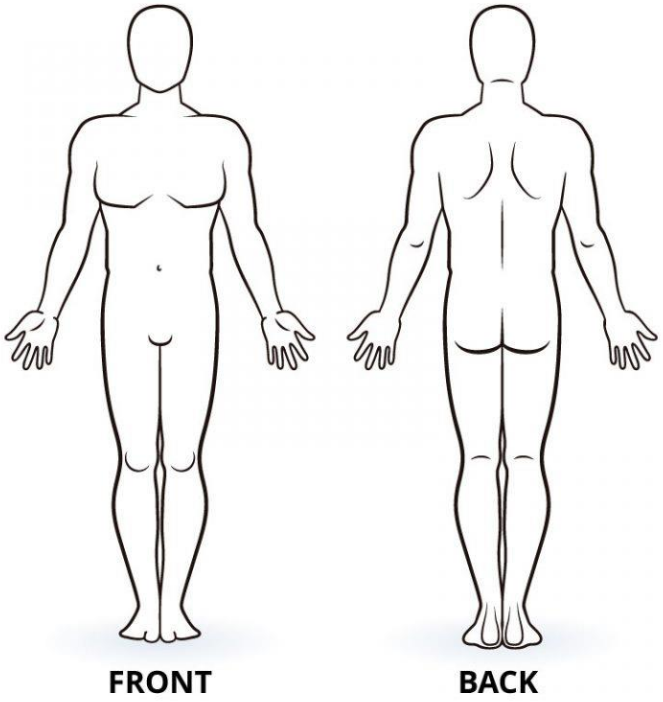
NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

PAIN DIAGRAM

BELOW IS A DIAGRAM OF A BODY. PLEASE CIRCLE THE AREAS THAT HAVE CHRONIC PAIN (LONGER THAN 6 MONTHS)

A CONTINUACIÓN SE ENCUENTRA UN DIAGRAMA DE UN CUERPO. MARQUE CON UN CÍRCULO LAS ÁREAS QUE TIENEN DOLOR CRÓNICO (MÁS DE 6 MESES)

DE FRENTE DE ESPALDAS



FRONT **BACK**

Numbness XXX
Entumecimiento

Pins/Needles 000
Alfileres/Agujas

Burning ---
Arde

Stabbing ///
Punzante

Ache/Stiff >>>
dolor/rigidez

On a scale of 0-10 where would you rank your pain now? Please circle the appropriate Paint Rating scale.

En una escala del 0 al 10, ¿dónde clasificaría su dolor ahora? Encierre en un círculo la escala de clasificación de dolor adecuada.

PAIN RATING SCALE

ESCALA DE CALIFICACIÓN DEL DOLOR

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

MEDICAL HISTORY

Check all that apply

Past Medical History:

☐High Blood Pressure	☐ Heart Failure	☐ Heart Attack/MI	☐Atrial Fibrillation
☐High Cholesterol	☐Diabetes	☐Thyroid Disorder	☐Asthma
☐Chronic Bronchitis	☐ Emphysema/COPD	☐Pneumonia	☐ Tuberculosis
☐Sleep Apnea	☐Blood Clots	☐Pulmonary Embolism	☐Liver Disorder
☐Hepatitis (type):_____	☐GERD/Reflux	☐Stomach Ulcer	☐Lupus/SLE
☐Ulcerative Colitis/Crohn's	☐kidney Stones	☐Kidney Failure/Dialysis	☐Polio
☐Neuropathy	☐Charcot-Marie-Tooth	☐Seizure Disorder	☐Stroke/TIA
☐Cataracts	☐Glaucoma	☐ Psoriasis	☐ Osteoarthritis
☐Rheumatoid Arthritis	☐ Lyme disease	☐ HIV/AIDS	☐Osteoporosis
☐Depression	☐ Anxiety	☐Fibromyalgia	☐ Gout

☐Cancer (specify):_____

☐Other (specify)_____

Are you/could you be pregnant? ☐Yes ☐No

Past Surgical History (List ALL surgeries - example: appendix, tonsils, etc., and date of surgery)

_____

_____

_____

Anesthesia Problems? ☐ No ☐Yes, describe: _____

Check all that apply

Family History:

☐Diabetes ☐ heart disease ☐Blood Clots/Pulmonary Embolism ☐Mayor Anesthesia Problems

☐Chariot-Marie-Tooth ☐Cancer (type): _____

Social History: Occupation:_____

☐Student ☐Homemaker ☐Retired ☐Unemployed ☐On Disability

Whom do you live?

☐Mother ☐Father ☐Spouse ☐Partner ☐Children ☐Siblings ☐Roommate/s ☐Alone

Exercise:

☐Never Rarely/Monthly ☐Weekly ☐Daily

What type of exercise?_____

Hobbies: _____

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

Do you smoke? ☐No ☐Yes ☐Quit (When?) _____

What is the most you ever smoked on a regular basis?_____

How many years have you/did you smoke in your life?_____

Do you drink alcohol? ☐No ☐ Yes ☐Quit (when?) _____

How much do you drink per week? _____

Recreational drugs? Current use: ☐Yes ☐No Past use: ☐Yes ☐No

What type? _____

Check all that apply

Review of Systems: Hematologic: ☐Anemia ☐Bleeding Tendency ☐Easy Bruising

Constitutional: ☐Fevers ☐Chills ☐Night Sweats **Unplanned:** ☐Weight Gain ☐ Weight Loss

Cardiovascular: ☐Chest Pain ☐Palpitations ☐Heart Murmur ☐Swollen Legs ☐Leg Cramps

Pulmonary: ☐Chronic Cough ☐Wheezing ☐Shortness of Breath

GI: ☐Nausea/Vomiting ☐Constipation ☐Chronic Diarrhea ☐Blood in Stool

GU: ☐ Incontinence ☐Problems Urinating **Endocrine**: ☐ intolerance of ☐heat ☐cold

Eyes : ☐Double Vision ☐Blindness **Head/Neck/Ears:** ☐Deafness ☐Sinus Problems

Neurologic: ☐Frequent Headaches ☐Dizziness ☐Balance Problems ☐Numbness/Tingling ☐Weakness

Skin: ☐Ache ☐Rash **Immunologic:** ☐Swollen Glands ☐Hay fever

Musculoskeletal: ☐Stiffness ☐Joint Pain ☐Joint Swelling ☐Neck or Back Problems

GM: ☐Menstrual Problems ☐Breast Masses **Psychiatric:** ☐Anxiety ☐Depression

Other: _____

This information is correct to the best of my knowledge.

Patient Signature:_____ **Date/Time:** _____

(Have Reviewed this new patient history form, including the list of allergy and medications.

_____ _____

Physician Signature Date/Time

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

Have you tried and failed any of the following NSAID's?
Has intentado y fallado cualquierea de los siguiente Anti-Inflamatorios

CELEBREX	☐YES/SI	☐NO
IBUPROFEN (MOTHRIN)	☐YES/SI	☐NO
NAPROXEN(ALEVE)	☐YES/SI	☐NO
ASPIRIN	☐YES/SI	☐NO
DICLOFENAC(VOLTAREN)	☐YES/SI	☐NO
INDOMETHACIN(INDOCIN)	☐YES/SI	☐NO
KETOPROTEN	☐YES/SI	☐NO
KETOROLAC(TORADOL)	☐YES/SI	☐NO
NABUMETOME(DAYPRO)	☐YES/SI	☐NO
OXAPROXIN (DAYPRO)	☐YES/SI	☐NO
PIROXICAM(FELDENE)	☐YES/SI	☐NO

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

MEDICATION LIST/ LISTA DE MEDICAMENTOS

PATIENTS NAME/Nombre Del Paciente: _____

DOB/FECHA DE NACIMIENTO:_____

MEDICATION/Medicamentos	STRENGTH/Concentracion	DOSAGE/ Dosis

NEURO SPINE AND HEADACHE PAIN MANAGEMENT CENTER
Sayed Monis, M.D.

Neuro Spine and Headache Pain Management Center
Cancellation Policy / No Show Policy
For Doctor Appointments and Tests

1. ***Cancellation Policy / No Show Policy for Doctor's Appointment***
   We understand that there are occasions when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't call to cancel an appointment, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise when another patient is unable to cancel and we are unable to schedule you for a visit, due to a seemingly "complete" appointment book.
   If an appointment is not cancelled at least 24 hours before, you will be charged a fee of thirty-five dollars ($35): this will not be covered by your company.

2. ***Scheduled appointments***
   We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patience is 15 minutes late from his schedule appointment, we will have to re-schedule the appointment.

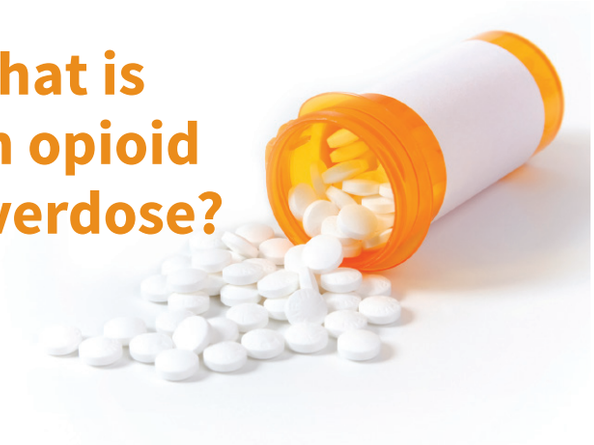
3. ***Cancellation / no-show policy for testing***
   Due to the large block of time needed for testing, last minute cancellation can cause problems and additional expenses for the office.
   If the test is not cancelled at least 3 days in advance, you will be charged a fee of two hundred and ffifty ($250) dollars: this will not be covered by your insurance company. For No Show you will be charged a quota of three hundred ($300) dollars.

4. ***Account Balances***
   We require that these fees mentioned above be paid before receiving additional services for our practice.
   Patients who have questions about their billing to who wish to discuss their account, or any concerns can call and ask to speak with our Chief Operating Officer Veronica Urbina with whom they can review their account and concerns.
   Patients with balances of more than one hundred ($100) dollars, must make arrangements before future appointments are made.

_____ _____ _____

Patient Name Signature/Guardian Date

What is an opioid overdose?



Opioids can cause bad reactions that make your breathing slow or even stop. This can happen if your body can't handle the opioids that you take that day.

TO AVOID AN ACCIDENTAL OPIOID OVERDOSE:

- Try not to mix your opioids with alcohol, benzodiazepines (Xanax, Ativan, Klonopin, Valium), or medicines that make you sleepy.
- Be extra careful if you miss or change doses, feel ill, or start new medications.

Now that you have naloxone…

Tell someone where it is and how to use it.

Common opioids include:

GENERIC	BRAND NAME
Hydrocodone	Vicodin, Lorcet, Lortab, Norco, Zohydro
Oxycodone	Percocet, OxyContin, Roxicodone, Percodan
Morphine	MSContin, Kadian, Embeda, Avinza
Codeine	Tylenol with Codeine, TyCo, Tylenol #3
Fentanyl	Duragesic, Actiq
Hydromorphone	Dilaudid
Oxymorphone	Opana
Meperidine	Demerol
Methadone	Dolophine, Methadose
Buprenorphine	Suboxone, Subutex, Zubsolv, Bunavail, Butrans

* Heroin is also an opioid.

For patient education, videos and additional materials, please visit
www.prescribetoprevent.org

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

2016

Opioid safety and how to use naloxone

A GUIDE FOR PATIENTS AND CAREGIVERS

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

In case of overdose:

1 Check reponsiveness

Look for any of the following:

- No reponse even if you shake them or say their name
- Breathing slows or stops
- Lips and fingernails turn blue or gray
- Skin gets pale or clammy

2 Call 911 and give naloxone

If no reaction in 3 minutes, give second naloxone dose

3 Do rescue breathing and/or chest compressions

Follow 911 dispatcher instructions

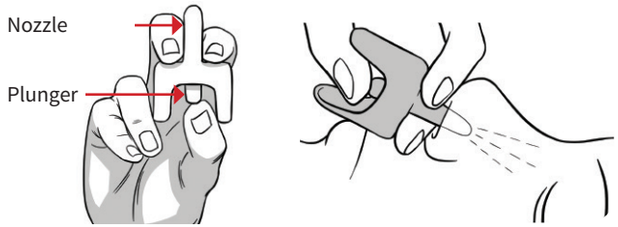
>> STAY WITH PERSON UNTIL HELP ARRIVES.

How to give naloxone:

There are 4 common naloxone products. Follow the instructions for the type you have.

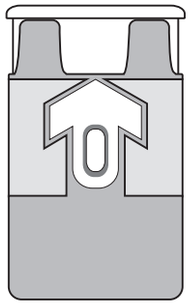
Nasal spray

This nasal spray needs no assembly and can be sprayed up one nostril by pushing the plunger.



Auto-injector

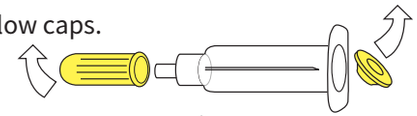
The naloxone auto-injector needs no assembly and can be injected into the outer thigh, even through clothing. It contains a speaker that provides step-by-step instructions.



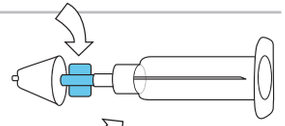
Nasal spray with assembly

This requires assembly. Follow the instructions below.

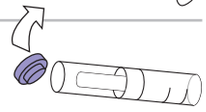
1 Take off yellow caps.

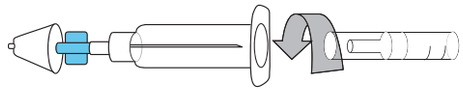


2 Screw on white cone.

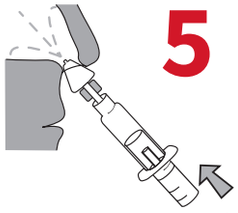


3 Take purple cap off capsule of naloxone.





4 Gently screw capsule of naloxone into barrel of syringe.



5 Insert white cone into nostril; **give a short, strong push** on end of capsule to spray naloxone into nose: **ONE HALF OF THE CAPSULE INTO EACH NOSTRIL.**

Push to spray.

6 If no reaction in 3 minutes, give second dose.

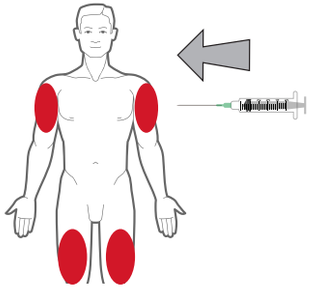
Injectable naloxone

This requires assembly. Follow the instructions below.

1 Remove cap from naloxone vial and uncover the needle.

2 Insert needle through rubber plug with vial upside down. Pull back on plunger and take up 1 ml.

3 Inject 1 ml of naloxone into an upper arm or thigh muscle.



4 If no reaction in 3 minutes, give second dose.