UNIVERSAL PAIN MANAGEMENT
Palmdale, Valencia, Apple Valley, CA

PERSONAL INJURY
PATIENT REGISTRATION FORM

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ SS#: _____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home #: ( ) _____ Work#: ( ) _____

Cell#: ( ) _____ Email: _____

Medical Insurance – Primary

Ins Co Name: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Guarantor's Name: _____ Guarantor's SS#: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical Insurance – Secondary

Ins Co Name: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Guarantor's Name: _____ Guarantor's SS#: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Auto Insurance Company (only if auto accident):

Auto Ins Name: _____ Phone Number: _____

Agent's Name: _____ Policy Number: _____

Insurance Policy Limits: _____ Med Pay: ☐ YES ☐ NO _____

Emergency Contact:

Name: _____ Phone Number: _____

Relationship to Patient: _____

UNIVERSAL PAIN MANAGEMENT
Palmdale, Valencia, Apple Valley, CA

PERSONAL INJURY QUESTIONNAIRE

Date: _____

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Age: _____ SS#: _____ ☐ Male ☐ Female

Please answer the questions below:

Nature of Accident: ☐ Auto ☐ Slip and Fall ☐ Assault ☐ Other

Date of Accident: _____ Time of Day: _____ a.m./p.m. State: _____

Were police notified? ☐ YES ☐ NO Was there a police report? ☐ YES ☐ NO

Where were you taken after the accident? ☐ Home ☐ Work ☐ Hospital ☐ Dr ☐ Other

By whom? _____

Did you have any physical complaints BEFORE THE ACCIDENT? ☐ YES ☐ NO

If Yes, please describe: _____

_____

_____

_____

If Auto Accident:

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Number of people in your vehicle: _____ Other Vehicle: _____

Which direction were you headed? ☐ North ☐ South ☐ East ☐ West

Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side

Were you knocked unconscious? ☐ YES ☐ NO If Yes, for how long? _____

Were you wearing your seatbelt? ☐ YES ☐ NO

Have you been involved in a previous auto accident? ☐ YES ☐ NO

Describe how you felt:

Immediately after the accident: _____

_____

Later that day: _____

_____

The next day: _____

_____

What are your present complaints? _____

_____

Are you: ☐ Improving ☐ Same ☐ Worse

Do you have any congenital (from birth) factors which relate to this problem? ☐ YES ☐ NO
If Yes, please describe: _____

_____

Have you been treated by another physician since the accident? If Yes:

Physician's Name: _____

Address and Phone: _____

Have you ever been hospitalized? ☐ YES ☐ NO
Year: _____ Reason: _____
Year: _____ Reason: _____

Have you ever had any broken bones? ☐ YES ☐ NO If Yes, when? _____

Are you/Could you be pregnant? ☐ YES ☐ NO If Yes, how many months? _____

Please mark to indicate if you have ever had the following:

☐ Bleeding Disorders ☐ Heart Disease ☐ Hypertension

☐ Cancer ☐ Osteoporosis

☐ Diabetes ☐ Stroke

Please mark to indicate if the following habits apply to you:

☐ Smoking Packs/Day _____

☐ Alcohol Drinks/Week _____

☐ Coffee/Caffeine Drinks Cups/Day _____

☐ High Stress Level Reason _____

Have you lost time from work as a result of this accident? ☐ YES ☐ NO

Describe: _____

Do you notice any activity restrictions as a result of this injury?

Describe: _____

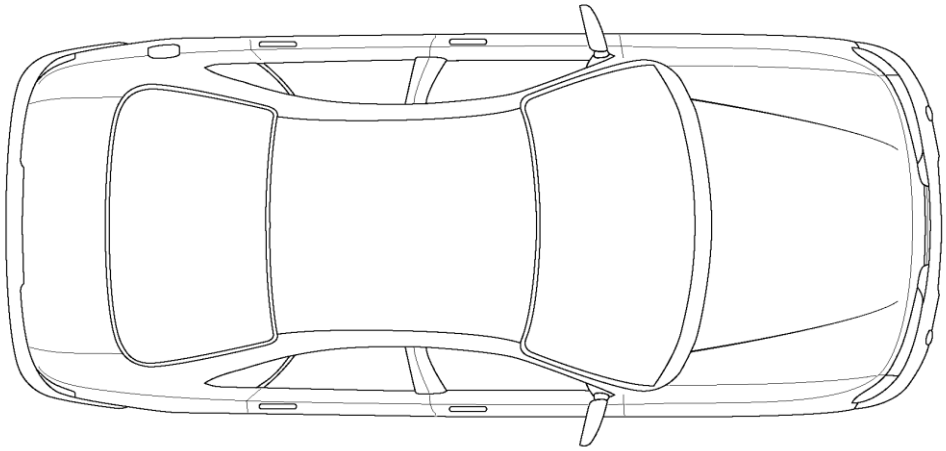
Please list all medications which you are currently taking: _____

In your own words, please describe the accident: _____

Site of Impact:

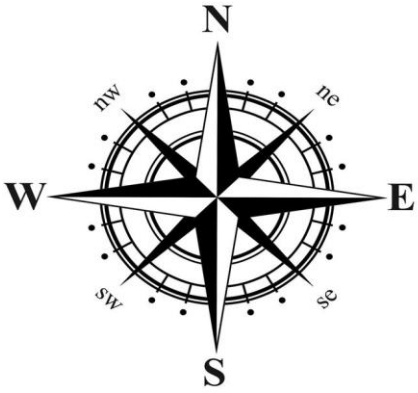
Please mark the diagram below using the following:

"P" = primary "S" = Secondary



Direction:

What direction was the vehicle was traveling:



Force of Impact:

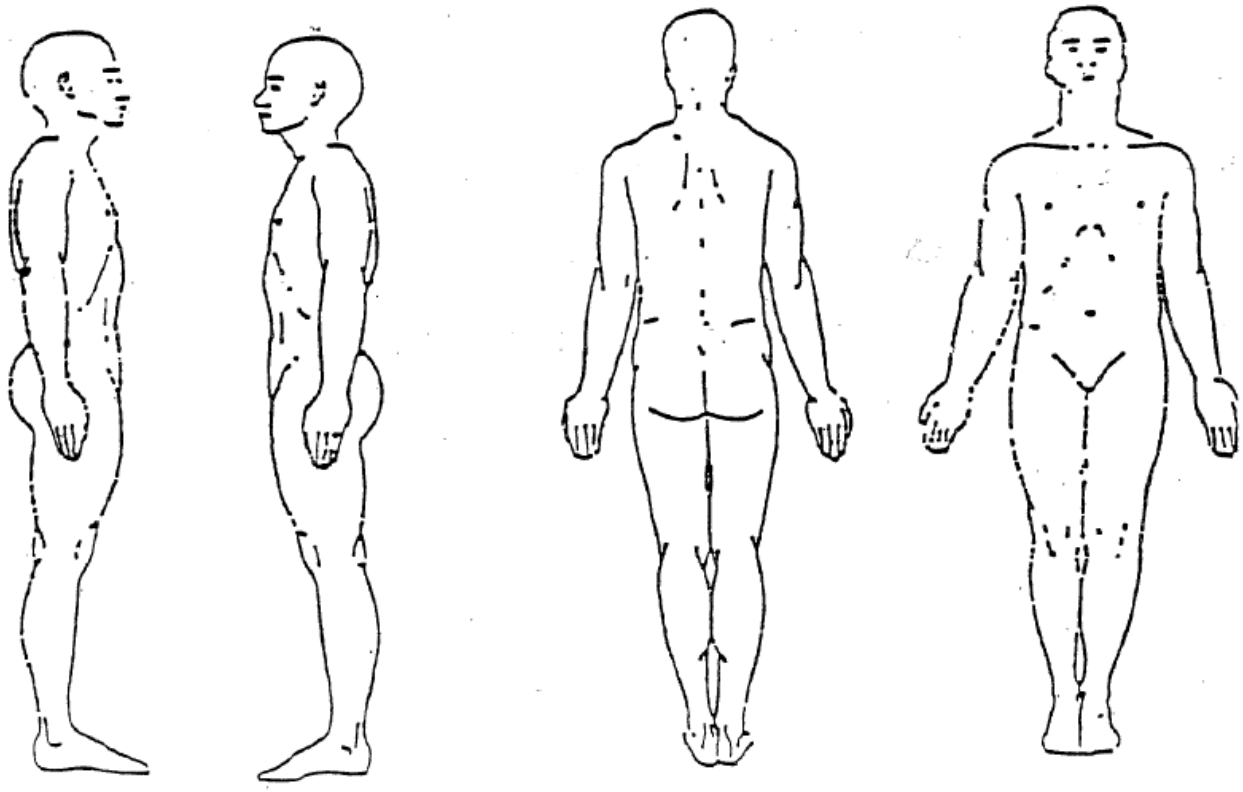
Please choose one:

☐ Low

☐ Moderate

☐ High

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



Patient or Representative's Signature: _____ Date: _____

Employee Witness Signature: _____ Date: _____

FUNCTIONAL LIMITATIONS / ACTIVITIES OF DAILY LIVING

PATIENT REPORTED THAT PAIN HAS THE FOLLOWING AFFECTS OF DAILY LIVING:

0 = **NO** INTERFERENCE WITH ACTIVITY
1-3 = **SLIGHT** INTERFERENCE WITH ACTIVITY
4-7 = **MODERATE** INTERFERENCE WITH ACTIVITY
8-10 = **SEVERE** INTERFERENCE WITH ACTIVITY

SELF – CARE/ PERSONAL HYGIENE

Bathing	0 1 2 3	4 5 6 7	8 9 10
Defecating	0 1 2 3	4 5 6 7	8 9 10
Dressing	0 1 2 3	4 5 6 7	8 9 10
Personal Hygiene	0 1 2 3	4 5 6 7	8 9 10
Getting on/off the toilet	0 1 2 3	4 5 6 7	8 9 10

PHYSICAL ACTIVITY

Walking	0 1 2 3	4 5 6 7	8 9 10
Climbing Stairs	0 1 2 3	4 5 6 7	8 9 10
Standing	0 1 2 3	4 5 6 7	8 9 10
Squatting / kneeling	0 1 2 3	4 5 6 7	8 9 10
Sitting	0 1 2 3	4 5 6 7	8 9 10
Reclining	0 1 2 3	4 5 6 7	8 9 10
Raise from chair	0 1 2 3	4 5 6 7	8 9 10
Carrying Groceries	0 1 2 3	4 5 6 7	8 9 10
Lifting/ Pushing / Pulling	0 1 2 3	4 5 6 7	8 9 10
Household chores	0 1 2 3	4 5 6 7	8 9 10
Getting in / out of bed	0 1 2 3	4 5 6 7	8 9 10

TRAVEL

Getting in / out of the car	0 1 2 3	4 5 6 7	8 9 10
Driving	0 1 2 3	4 5 6 7	8 9 10
Being a passenger in a vehicle	0 1 2 3	4 5 6 7	8 9 10

SEXUAL ACTIVITIES	0 1 2 3	4 5 6 7	8 9 10

SLEEP

Restful nocturnal sleep pattern	0 1 2 3	4 5 6 7	8 9 10

SPORTS/RECREATION ACTIVITY	0 1 2 3	4 5 6 7	8 9 10

NAME: _____ **DATE:** _____

Patient's Name: _____

DOB: _____

READ CAREFULLY BEFORE SIGNING:

MEDICAL CONSENT: The patient is under the care of the attending physicians. The patient or patient's representative consent to any medical treatments or procedures, including invasive procedures (upon special consent), x-ray examinations, taking of medical photographs and laboratory procedures.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as the patient, that in consideration of services to be rendered to the patient, he/she hereby individually obligates himself to pay the account of Universal Pain Management and all treating physicians in accordance with the regular posted rates and the terms of Universal Pain Management.

ASSIGNMENT OF BENEFITS: I do hereby assign irrevocably to Universal Pain Management, to the full extent permitted by law, all rights and benefits payable under any insurance policies providing coverage for medical services costs in an amount not to exceed the charges I incur to my Universal Pain Management account for services during the period of my treatment. I fully understand that I am primarily responsible to Universal Pain Management/physicians for the charges in addition to those charges not paid for under the assignment, and in the event the money is due or the benefits are not paid within sixty (60) days from the date of billing for payment. I will promptly make arrangements to pay the outstanding accounts in full.

A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I do hereby give my permission and consent to release any and all medical records to Universal Pain Management, upon request, and requested records be sent to Universal Pain Management within seven (7) days.

Signature	Witness
Signature of Patient's Representative	Relationship to Patient
Financial Guarantor	Name of Insurance Subscriber

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PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

DOB: _____

I acknowledge that I have received information regarding Universal Pain Management's Patient Rights and Responsibilities & Notice of Privacy Practices:

_____ _____

Patient/Parent/Legal Guardian **Date**

_____

Relationship to Patient

Documentation of Good Faith and Effort

The patient identified below was provided with information regarding UPM's Patient Rights and Responsibilities & Notice of Privacy Practices. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the above-mentioned documents; however, acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign because: _____

☐ There was a medical emergency. UPM will attempt to obtain acknowledgement as soon as practical.

☐ Other reason: _____

Employee Signature: _____ Date: _____

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Palmdale, Valencia, Apple Valley, CA

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide *all i*nformation requested may invalidate this Authorization.

PATIENT INFORMATION

Patient's Name: Last	**First**	**Middle Initial**	**Birth Date**

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of protected health information about the above patient as follows:

Authorized to USE or DISCLOSE information: (Name of person or organization you are REQUESTING information from)			
Address	City	State	Zip Code

Authorized to RECEIVE information: (Name of person or organization who will RECEIVE the information)
UNIVERSAL PAIN MANAGEMENT

☐ **819 Auto Center Drive**
Palmdale, CA 93551
(661) 267-6876 – Phone
(661) 538-9483 – Fax

☐ **16179 Siskiyou Road**
Apple Valley, CA 92307
(760) 241-0350 – Phone
(760) 243-0738 – Fax

☐ **28212 Kelly Johnson Pkwy, #155**
Valencia CA 91355
(661) 367-9788 – Phone
(661) 367-9789 – Fax

DISCLOSE:

- ❑ All health information pertaining to any medical history, mental or physical condition and treatment received.
- ❑ All prescription history.
- ❑ Only the following records or types of health information: _____

_____

Dates of Services:

❑ All ❑ Specific dates: _____

Method of use or disclosure:

❑ Mail ❑ Pick up Review/ Inspect ❑ Fax to #_____ ❑ Other

PURPOSE: The protected health information is being used or disclosed for the following purpose(s):

❑ Personal Use ❑ Continued Care

❑ Other:

EXPIRATION:

This authorization expires on (insert date or event): ❑ Date_____ ❑ Event_____

NOTICE OF RIGHTS AND OTHER INFORMATION:

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization. I may refuse to sign this authorization. I have a right to receive a copy of this authorization. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

NOTE: There will be a charge for copying services.

SIGNATURE

Date:	**Signature (Patient, Parent, Legal Guardian or Authorized Representative)**	**If other than patient, indicate relationship**

Print Name:	**Address:**	**Phone:**

Witness Signature:	**Print name and title:**	**Date:**

SHAHIN A. SADIK, M.D., Q.M.E.
Board Certified-Pain Management and Anesthesiology
Assistant Clinical Professor of USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
Board Certified-Pain Management and Anesthesiology
Assistant Clinical Professor of USC

RAY H. d'AMOURS, M.D.
Board Certified-Pain Management and Anesthesiology
Assistant Clinical Professor of USC

DANIEL ALVES, M.D., Q.M.E.
Board Certified-Pain Management and PM&R

KEVIN KOHAN, D.O., Q.M.E.
Board Certified-Pain Management and PM&R
Assistant Clinical Professor of Western University
Assistant Clinical Professor of USC

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C.
OMID MAHGEREFTEH, D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to, fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral stains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck. Leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all of the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose, and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my best interest to undergo Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intent this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Printed name(s) of the doctor treating this patient:

Omid Mahgerefteh, D.C.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

_____ _____

Printed name of patient Date

_____ _____

Signature of patient Date