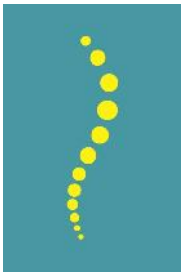

GREG S. KHOUNGANIAN, MD

Minimally Invasive Spine Surgery
Board Certified Orthopedic Surgeon

GENERAL PATIENT INFORMATION FORM

Patient name:_____ Sex:____Birth Date:_____ Age:____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____Cell Phone:_____Driver License #:_____

Email Address:_____Employer:_____Work Phone:_____

Employer's Address:_____

Social Security #:_____Occupation:_____

Name of Spouse:_____Work Phone:_____

Employer of Spouse:_____

Emergency Contact:_____Phone #:_____

Address:_____Relationship: _____

Insurance Carrier:_____Phone #:_____

Insurance Address: _____

Name of Insured:_____Policy #:_____

Member ID #:_____Group #:_____Relationship to Insured: _____

Primary Doctor:_____Phone #:_____

Referred by:_____Phone #:_____

Signature of Patient:_____Date: _____

Signature of parent or guardian:_____Date: _____

Authorization: I hereby authorize payment directly to Greg S. Khounganian M.D. of the medical benefits for services rendered to me or to my dependent. I also authorize my doctor to release information regarding my treatment to my insurance carrier.

I understand that I am financially responsible for all charges.

PATIENT'S PAST MEDICAL HISTORY

Welcome to our practice. Please fill out the Information to the best of your ability.

Today's Date: _____

Patient Name: _____ Age: _____ Date of birth: _____

Chief Complaint: _____

Past medical history

Have you ever had any of the following? Please check all pertinent boxes.

Measles	Arthritis	Glaucoma	Mitral valve prolapse
Mumps	Venereal disease	Stroke	Blood transfusions
Anemia	Chicken pox	Back trouble	Hepatitis
Ulcer	Whooping cough	Diphtheria	Bladder infections
Smallpox	Scarlet fever	Migraines	High blood pressure
Pneumonia	Hemorrhoids	Kidney disease	Low blood pressure
Heart disease	Rheumatic fever	Thyroid disease	Bleeding tendency
Tuberculosis	Epilepsy/seizures	Diabetes	Sleep apnea
Cancer	Aids or HIV	Bronchitis	Infectious mono
Polio	Any or other disorders or disease: _____		

Past surgical history – Please list any/all previous surgeries/hospitalizations

Surgery/hospitalizations_____Date_____Where (Hospital, City, State)

_____

_____

_____

Patient social history:

Marital status	Use of alcohol	Use of tobacco	Living situation	Dominant hand
Single	Never	Never	With family	Right
Married	Rarely	Previosuly quit	With friends	Left
Divorced	Moderate	Currently	Alone	
Widowed	Daily	_____ Packs per day	Other _____	

Family medical history

	Age	Conditions or Disease	If deceased, cause of death
Father:			
Mother:			
Siblings:			

Medications:

Drug name: Dosage: Frequency: Prescribing doctor:

Allergies: (please list any allergies to any medications, tapes, or latex)

Medications: Reactions:

Review of body systems: (please circle yes or no for each of the following:

Musculoskeletal

Joint pain - Yes No
Joint stiffness/swelling- Yes No
Weakness of muscles/joints- Yes No
Muscle pain or cramps- Yes No
Back pain- Yes No
Cold extremities- Yes No
Difficulty walking- Yes No

Constitutional symptoms

Bad general health lately- Yes No
Recent weight change- Yes No
Fever- Yes No
Fatigue- Yes No
Headaches- Yes No

Ear/Nose/Mouth/Throat

Hearing loss/ringing of ears- Yes No
Earaches or drainage- Yes No
Chronic sinus problems- Yes No
Nose Bleeds- Yes No
Bleeding gums- Yes No
Sore throat/voice change- Yes No
Swollen glands in neck- Yes No

Cardiovascular

Heart trouble- Yes No
Chest pain/angina pectoris- Yes No
Swelling of feet/ankles- Yes No

Genitourinary

Frequent Unration- Yes No
Burning/painful urination- Yes No
Blood in urine- Yes No
Incontinence or dribbling- Yes No
Number of pregnancies- _____
Number of pregnancies- _____

Integumentary (Skin/Breast)

Rash or Itching- Yes No
Changes in skin color- Yes No
Varicose Veins- Yes No
Breast pain- Yes No
Breast lump- Yes No

Neurological

Light headed or dizziness- Yes No
Numbness or tingling- Yes No
Tremors- Yes No
Paralysis- Yes No

Endocrine

Excessive thirst- Yes No
Heat or cold Intolerance- Yes No
Dry skin- Yes No
Bleeding/bruising tendency- Yes No
Anemia- Yes No
Enlarged Glands- Yes No

Psychological

Memory loss- Yes No
Nervousness- Yes No
Depression- Yes No
Insomnia- Yes No

Gastrointestinal

Loss of appetite- Yes No
Nausea or vomiting- Yes No
Frequent diarrhea- Yes No
Constipation- Yes No
Rectal Bleeding- Yes No
Blood in stool- Yes No

Respiratory

Chronic/frequent cough- Yes No
Spitting up blood- Yes No
Shortness of breath- Yes No
Wheezing- Yes No

Eyes

Eye disease or Injury- Yes No
Wear glasses or contacts- Yes No
Blurred or double vision- Yes No

Food/Environmental Allergies

_____
_____
_____
_____

**** To the best of my knowledge, these questions have been answered Accurately. I understand that providing incorrect information can be dangerous To my health. It is my responsibility to inform the doctor of any changes in my Medical status. I also authorize the health care staff to perform the necessary services I may need

Signature Date

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____
Address of Provider: _____
_____

Fax Number: _____

Recipient and Address for Delivery of Records:

Purpose: I understand that the specific purpose of this Authorization is

---

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-ray's, HIV/AIDS status, genetic testing, psychotherapy notes and other mental information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (Insert dates of treatments, types of treatment or other designation.)

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Re-disclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____	_____	_____
Signature	Date	Signature of Witness

Name: _____
(Please Print)

If Individual is unable to sign this Authorization, please complete the information below.

_____	_____	_____	_____
Signature of Personal Representative	Legal Relationship	Date	Witness Signature

Name: _____
(Please Print)

ASSIGNMENT OF BENEFIT FORM

Name of Insured (print) _____

Social Security Number _____

I request payment of authorized Insurance benefits (Including Medicare), If I am a Medicare beneficiary, be made on my behalf to Greg S. Khounganian, M.D.

I authorize the release of any medical or other Information necessary to determine these benefits or the benefits payable for related equipment or services to Greg S. Khounganian M.D., the health care financing administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the health care financing administration, my insurance company or other entity requested. The original will be kept on file by Greg S. Khounganian M.D.

I understand that I am financially responsible to Greg S. Khounganian M.D. for any charges not covered by health care benefits. It is my responsibility to notify Greg S. Khounganian M.D. of any changes in my insurance company receiving the claim. I am responsible for the entire bill or balance of the bill as determined by Greg S. Khounganian M.D. and/or my health care insurance carrier if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payments for products and services received.

I the undersigned, herby agree that in the event of default in payment of any amount due, if this account is placed in the hands of an attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. I hereby accept full responsibility for any charges incurred as a result of medical legal testimony provided by doctors in this office, whether requested by my attorney or another party. The charges incurred will be billed at the rate in effect at the time when services where rendered. I understand that such charges will not be covered by insurance and that I am responsible for them.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

The notice of Privacy Practice Describes how medical Information about you may be used and disclosed and how you can get access to this information. Please review it carefully…..

We understand the importance of privacy and are committed to maintaining the confidentiality of you Medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information. This notice describes how we may use and disclose your medical information.

I acknowledge that I have access to the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request and at the office website WWW.GSKSPINE.COM

Print Name _____ Date _____

Sign _____