Elite Medical Clinic

PERSONAL INJURY / ACCIDENT MEDICAL HISTORY INTAKE FORM

Date: _____

Full Name: _____

Date of Birth: _____/_____/_____ **Date of Accident:** _____/_____/_____

Age: _____ Gender: Male____ Female____ Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced

Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____-_____-_____ Driver's License No.:_____

Cellular Phone.: _____Home/Work Phone: _____

Personal E-Mail: _____

Employer:_____

Emergency Contact: _____ Phone: _____Relation_____

Your Attorney's Name: _____

Case Manager's Name: _____Your Attorney's Email:_____

Your Attorney's Phone: _____ Fax: _____

Your Attorney's Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION:

Insurance Company: _____

ID#: _____ Group #: _____

Insured's Name: _____
(Last) (First) (Init)

Relation to patient: _____ D.O.B.: _____ Soc. Sec. #: _____

ACCIDENT INFORMATION:

Type of Accident: ☐ Car ☐ Motorcycle ☐ Bicycle ☐ Pedestrian ☐ Slip & Fall ☐ Other_____

Location: ☐ Street: Near Which Intersection? _____

☐ Freeway: Which Freeway? _____

☐ Other: _____

If Car Accident:

Where you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger Other_____

Accident type: ☐ Rear ended ☐ Head-on ☐ T-Boned ☐ Broad-sided Other_____

_____

_____

_____

_____

_____

_____

_____

Immediately following the accident did you experience:

☐ Shock ☐ Loss of Consciousness ☐ Anxiety Attack ☐ Nervous ☐ Panicky ☐ Lightheaded

State your emotions and physical state: _____

_____

Did the ambulance arrive on the scene? ☐ Yes ☐ No If yes, did they transport you to the hospital? ☐ Yes ☐ No

Did you go to the Emergency Room/Hospital? ☐ Yes ☐ No If yes, which one?_____

When did you go? _____

What test(s) were performed? _____

Did you have any surgery performed? _____

What medication(s) were you prescribed, if any?_____

Did you go to the Urgent Care? ☐ Yes ☐ No If yes, which urgent care? _____

When did you go? _____

What tests were performed? _____

What medication(s) were you prescribed, if any?_____

Did you go to see your Primary or General Doctor? ☐ Yes ☐ No If yes, name of your doctor_____

When did you go? _____

What tests were performed? _____

What medication were you prescribed, if any?_____

Have you seen a chiropractor or physical therapist? ☐ Yes ☐ No

If yes, when was your first treatment? _____ Are you still being treated? ☐ Yes ☐ No

How any times a week?_____ How many weeks total?_____

Have you seen any other provider? (circle all that apply)

Orthopedic Neurologist Acupuncturist Pain Management Other_____

What tests have been performed? ☐ Xray ☐ CT Scan ☐ MRI ☐ Other_____

_____

What Medications have you taken for the pain? Has it helped? _____

_____

HEAD (mark all that apply)

On a scale of 0 – 10, rate your pain *NOW or RECENTLY*: (Please ○ the number that best describes your pain)

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Did you have any injury to your head? ☐ Yes ☐ No Did you have any loss of consciousness? ☐ Yes ☐ No

Please describe the headaches: ☐ Sharp ☐ Pulsating ☐ Dull ☐ Pressure ☐ Comes & Goes ☐ Constant

What Area? ☐ All over ☐ Front ☐ Right Side ☐ Left Side ☐ Back ☐ On Top

Do you experience any? ☐ Dizziness ☐ Vertigo ☐ Nausea ☐ Vomiting ☐ Visual changes

☐ Slurred speech ☐ Local weakness ☐ Seizures ☐ Ringing in your ear(s)

NECK

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Any Neck Pain? ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement

Tingling in your hand(s)? ☐ Yes ☐ No Numbness in your hand(s)? ☐ Yes ☐ No

Does the pain radiate to: *Right Arm / Left Arm / Chest / Upper Back / Right Shoulder / Left Shoulder*

(circle all that apply) *Pain does not radiate*

RIGHT SHOULDER

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

What area hurts? ☐ Front ☐ Back ☐ Side ☐ On Top

LEFT SHOULDER

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

What area hurts? ☐ Front ☐ Back ☐ Side ☐ On Top

UPPER BACK

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement ☐ Worse with sitting long period

LOWER BACK

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Pressure ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement ☐ Worse with sitting long period

Any tingling/numbness in your foot or toe(s)? ☐ Yes ☐ No Any loss of bowel or bladder control? ☐ Yes ☐ No

Any difficulty walking ☐ Yes ☐ No Any numbness in your buttock? ☐ Yes ☐ No

Does the pain radiate to: *Upper Back* *Right Buttock / Right Leg / Right Hip / Right Knee*

(circle all that apply) *Pain does not radiate* *Left Buttock / Left Leg / Left Hip / Left Knee*

RIGHT HAND / WRIST / ELBOW

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Any **Right Hand** pain? ☐ Yes ☐ No Any **Right Wrist** pain? ☐ Yes ☐ No Any **Right Elbow** pain? ☐ Yes ☐ No

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

LEFT HAND / WRIST / ELBOW

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Any **Left Hand** pain? ☐ Yes ☐ No Any **Left Wrist** pain? ☐ Yes ☐ No Any **Left Elbow** pain? ☐ Yes ☐ No

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

RIGHT HIP

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

LEFT HIP

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

RIGHT KNEE

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

Any difficulty going up and down stairs? ☐ Yes ☐ No Does your knee lock on you? ☐ Yes ☐ No

LEFT KNEE

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Describe the pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Stiffness ☐ Other_____

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

Any difficulty going up and down stairs? ☐ Yes ☐ No Does your knee lock on you? ☐ Yes ☐ No

RIGHT FOOT / ANKLE

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Any **Right Foot** pain? ☐ Yes ☐ No Any **Right Ankle** pain? ☐ Yes ☐ No

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

LEFT FOOT / ANKLE

No Pain ***Severe Pain***

0 1 2 3 4 5 6 7 8 9 10

Any **Left Foot** pain? ☐ Yes ☐ No Any **Left Ankle** pain? ☐ Yes ☐ No

Is the pain: ☐ Constant ☐ Comes and Goes ☐ Worse with movement (check all that apply)

ANY OTHER PROBLEMS/PAIN?: (Please detail below)

☐ Chest Pain ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Eye Pain ☐ Ear Pain ☐ Other_____

_____

_____

_____

_____

ANY CUTS? If yes, please list where: _____

ANY BRUISES? If yes, please list where:_____

_____

WHERE DOES IT BOTHER YOU THE MOST? _____

_____

Do you experience any of the following after the accident? (circle all that apply)

Depression Anxiety Panic Attacks Insomnia Suicidal thoughts Recurrent flashbacks

Loss of Appetite _____

Any Allergies to Medication? ☐ None ☐ Yes, please list _____

Current Medication: ☐ None (please list any and all of your current medications)

_____ _____

_____ _____

List Past Medical History: ☐ No known major medical problems

☐ Diabetes ☐ High Blood Pressure ☐ High cholesterol ☐ Depression ☐ Anxiety ☐ Heart disease

☐ Stroke ☐ Cancer ☐ Thyroid disease ☐ Other_____

_____

List Past Surgeries: ☐ No past surgeries

☐ Appendectomy ☐ Tubal Ligation ☐ Gallbladder removal ☐ C-Section ☐ Tonsil ☐ Hysterectomy

_____

_____

List previous back, neck and musculoskeletal problems: _____

_____

Do you currently use: Tobacco ☐ Yes ☐ No Alcohol ☐ Yes ☐ No Illegal drug use ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Family History: List conditions that run in your family: ☐ None _____

Any possibility of being pregnant? ☐ Yes ☐ No **Last Menstrual Period:** _____ ☐ N/A

_____ _____

Patient's Signature Date

Elite Medical Clinic

2214 S Hoover Street, Los Angeles, CA 90007
Office: (213) 622-3100 Facsimile: (213) 622-3132

To: _____

_____

_____

Re: Medical Reports and Doctor's Lien

I authorized the above doctor and/or their authorized representatives to furnish my attorney, any attorney or attorneys who subsequentialy are either associated with the said attorney or substituted in their place, with a full report of my examination, diagnosis, treatment, prognosis, itemized bill of charges incurred, etc. in regard to the accident in which I was involved on _____, and hold the above doctor free and harmless from any liability in such transfer of information.

Out of the proceeds of the settlement and/or judgment in my claim for personal injuries, I hereby assign, set over and transfer to the above doctor such monies due and owing to him or the group for medical, chiropractic, x-rays, physical therapy, supplies and/or laboratory fees rendered to me, either by reason of the above accident or otherwise. I further give to the above doctor a lien on any and all funds received by me or in my behave in association with the settlement or satisfaction of judgment arising from claims presented on my behalf.

I fully understand that I am directly responsible to said doctors/group for all medical bills submitted by them for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive said fee. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. It is acknowledged by the undersigned that this assignment and lien is further consideration for the services rendered by the above doctor in addition to the obligation to pay for the medical services.

Patient's personal injury claim medical payments are hereby assigned and will be paid directly from the insurance company to **Houman M Kashani, MD APC**

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT AND LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby acknowledge receipt of a copy of the assignment and lien, and said attorney acknowledges that he/she obligates themselves to the terms of the assignment and lien in consideration for the rendering of medical services to their client by the above doctor and rendering of a report and bill to said attorney. In the event legal action shall be brought in order to enforce this lien, then the prevailing party shall be entitled to reasonable costs and attorney fees in addition to any judgment rendered. A photographic reproduction of this authorization may be used in place of the original. No charges or alterations of the monies billed herein will be accepted unless confirmed in writing by the doctor. Please date, sign and return on copy as soon as possible to the above referenced medical provider of service in order that treatment can continue on the herein contained lien basis.

_____ _____

ATTORNEY'S SIGNATURE DATE

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 provides for judicial review of arbitration proceedings; and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whither in tort, contract, punitive damages, or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or service provided by the physician and his medical clinic or association, partners, substitute physician or physician assistant, independent contractors, associates, associations, corporations, partnership, employees, agents 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 any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. The undersigned also consents to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this agreement. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for the loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. Following the assertion of any claim against physician, any fee dispute, whether or not the subject of any existing court action, shall be resolved by arbitration.

Article 3: **Voluntary Submission to Arbitration**: I voluntarily agree to submit to arbitration any and all claims involving persons bound by this agreement, as set forth herein, whether these claims are brought in tort, contract, for punitive damages or otherwise. This includes, but is not limited to, suits for personal injury, breach of contract, actions to collect debts, or **any kind of civil actions**.

Article 4: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing by U.S. mail, postage and 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. 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 arbitration shall be governed pursuant to code of civil procedure §§ 1280-1295 and Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties agree that provisions of California law applicable to health care providers shall apply to dispute with this arbitration, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. The parties shall bear their own costs, fees and expenses, along with pro rata share of the neutral arbitrator's fees and expenses, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counseling fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nor supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

Article 5: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 6: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature, and if not revoked will govern all medical services received by the patient. Upon timely revocation of agreement, the undersigned physician will cease providing me any services, other than emergency services or those services necessary to avoid abandonment. Proof of revocation should be set with certified mail with return receipt. Will

Article 7: **Retroactive Effect**: this agreement is retroactive and governs all past and future services the undersigned physician has previously performed or may later perform for the patient. The patient intends this agreement to cover all services rendered by the physician not only after the data design (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 8: **Severability Provision**: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the agreement and forced in accordance with California law. By my signature below I acknowledge that I have received a copy of this agreement.

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

_____	_____	_____
Patient/Representative's Name PRINTED	Date	Physician's/Authorized Representative's Signature
		Houman M. Kashani, MD
_____		
Patient/Legal Guardian Signature		2214 S Hoover St, Los Angeles, CA 90007