Desert Spine, Sport & Joint Center

Dr. Sohail Ahmad

Orthopedic Surgery & Sports Medicine

Patient Information

First _____ Middle _____ Last _____

Address _____ City _____ State _____ Zip Code _____

Phone/Cell _____ SS# _____ Date of Birth _____

Email Address _____ Emergency Contact: Name and Phone # _____

Gender: Male/Female Referred By: [redacted]

Work Comp Carrier Information

Insurance Name _____ Address _____ City _____ State _____ Zip _____

Claim Number _____ Date of Injury _____ Body Part Injured _____

Adjuster Name _____ Phone # _____ Fax # _____

[redacted]

Employment Information

Name of Employer _____ Telephone Number _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____

Assignment and Release

I, _____ have insurance with the above mentioned carrier and assign directly to Dr. Ahmad all medical benefits. I understand that I am financially responsible for all charges incurred and not covered by my health plan. I understand that a copy of my insurance card (front & back) as well a photo ID is required at the time of services for billing purposes. I hereby authorize Dr. Ahmad to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature Date

HIPAA

I, _____, fully understand that all health information given to the Dr and his staff is personal and confidential. I also understand that absolutely no information will be given to any person without prior written consent from myself and understand that it must be kept on file and updated yearly.

_____ _____

Signature Date

Consent for Treatment

I hereby authorize and consent Dr. Ahmad to interpret/perform any x-ray exam, laboratory tests and all treatment rendered to myself or my children.

_____ _____

Signature Date

Medicare Authorization

I request the payment of authorized Medicare benefits be made either to me or on my behalf to the physician rendering service. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ _____

Signature Date

Sohail Ahmad, MD
Board Certified Orthopedic Surgeon

TO: Attorney

_____
_____
_____

Physician:

_____
_____
_____

RE: _____

DOI: _____ Chart No. _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered to me by reason of this accident, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____ Patient's Name _____

Dated: _____ Physicians' Signature: _____ Physicans Name _____

The undersigned being attorney of record of the above patient does hereby agree to observe all terns of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor named above.

Dated: _____ Attorney's Signature: _____ Attorneys Name _____

DESERT SPINE SPORT & JOINT CENTER

DR. SOHAIL AHMAD MD

BOARD CERTIFIED ORTHOPEDIC SPINE & SPORT SURGEON

DATE:_____ AGE / EDAD_____

PATIENT'S NAME:(NOMBRE) _____

PRIMARY CARE PHYSICIAN _____

Side Involved: Right_____ Left_____ Both_____
Derecho:_____ Izquierdo:_____Ambos:_____

History of Present Illness:

1 . What are been seen for today:_____
Para que te estan viendo hoy:

_____

2. Describe onset symptoms:_____
Describe los sintomas de inicio:

_____

3. Describe current sympotoms:_____
Describe los simtomas actuals:

_____

4. Describe activities that make symptoms worse:_____
Describe actividades que empeoran los sintomas:

_____

5. Describe activities the make symptoms better:_____
Describe actividades que mejoran los sintomas:

_____

6. Have you ever been seen for this injury before:_____
Alguna ves has sido visto por esta lesion:

_____

Past Medical *History Histórico médico*:

1. Medial conditions: Encircle those that apply:
   Condiciones médicas: Encierre en un círculo las que correspondan:

High blood pressure *Hipertensão*	Diabetes	HIV
Heart attack *Ataque cardíaco*	Stroke *acidente* vascular cerebral	
Hepatitis *Hepatite*	Shortness of breath *Falta de ar*	
Irregular Heartbeat Chest *Baú de batimentos cardíacos irregulares*		
Chest Pain *Dor no peito*	Blood Clots *Coágulos de sangue*	
Asthma *asma*	Seizures *Convulsões*	
Blood in Stool *Sangue nas fezes*	Congestive Heart Failure *Insuficiência Cardíaca Congestiva*	
Blood in Urine *Sangre in orina*	Kidney Problems *Problemas Renais*	
Cancer(Type *Modelo*:_ ___)	Other *Outra*:	

2. List all medications with dosages you are currently taking:
   Liste todos os medicamentos com as dosagens que você está tomando atualmente
   ( ) Yes, they include: *Sim, eles incluem* ( ) None *Nenhum*

_____

3. List all allergies you have: *Liste todas as alergias que você tem*
   ( ) Yes, they include: *Nenhum* ( ) None *Nenhum*

_____

4. List all previous surgeries, including dates: Liste todas as cirurgias anteriores, incluindo datas
   ( ) Yes, they include: *Nenhum* ( ) None *Nenhum*

_____

_____

_____

Social History *História Social*:

Occupation *Ocupação*:

Do you smoke *Voce fuma?*	Yes ( )	No (
Do you drink alcohol *Você bebe álcool*	Yes ( )	No (,

What sports or activity do you participate in and how often: _____
De quais esportes ou atividades você participa e com que frequência

_____

Who may we thank for your visit? _____
A quem podemos agradecer a sua visita

Thank You

ACTIVITIES OF DAILY LIVING (ADL'S)

(**Patient:** Please answer each question once with an X in the appropriate column. Note that these questions should be answered as they pertain to your activities of daily living based on your current injury. If the activity does not apply to you please answer N/A)

Name: _____ Date: _____

Are you able to:	Yes	No	N/A	If NO please explain
1. Dress yourself including shoes				
2. Wash and dry yourself				
3. Take a bath				
4. Get on and off the toilet				
5. Cut your food				
6. Lift a full cup to your mouth				
7. Make a meal				
8. Write a note				
9. Type a message on a computer				
10. Use a telephone				
11. Work outdoors on flat ground				
12. Climb up 1 flight of stairs (10 steps)				
13. Stand				
14. Sit				
15. Recline				
16. Rise from a chair				
17. Run errands				
18. Light housework				
19. Feel what you touch				
20. Open car doors				
21. Turn faucets on and off				
22. Get in and out of a car				
23. Sleep				
24. Engage in sexual activity				

(rev 1-2013)

Patient Signature: _____ Date: _____

Provider Initials _____ 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, 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 into it, are giving up their constitutional right to have any such dispute decided 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 whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not 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 any pregnant 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 right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, 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 arbitration shall be governed pursuant to Code of 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 rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: 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 enforced in accordance with California law.

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

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.

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

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

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By _____
Patient's Signature (Date)

_____
Print Patient's Name

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

_____
Print Name and Relationship to Patient

ACUERDO DE ARBITRAJE MÉDICO-PACIENTE

Artículo 1: Acuerdo de arbitraje: Se conviene que cualquier disputa relativa a negligencia médica, es decir, a si cualquiera de los servicios médicos prestados bajo este contrato fueron innecesarios o no autorizados o llevados a cabo de manera impropia, negligente o incompleta, sea determinada por el sometimiento a arbitraje según lo dispuesto por la ley de California, y no por medio de una demanda o el recurso a un procedimiento judicial salvo en lo que la ley de California dispone para la revisión judicial de procedimientos arbitrales. Ambas partes, al celebrar este contrato, están renunciando a su derecho constitucional a que dicha disputa sea decidida en un tribunal frente a un jurado y, en su lugar, están aceptando el uso de arbitraje.

Artículo 2: Todas las reclamaciones deberán ser sometidas a arbitraje: Es la intención de las partes que este acuerdo cubra todas las reclamaciones o controversias contractuales, extracontractuales o de cualquier otro tipo, y vinculará a todas las partes cuyas reclamaciones se deriven o se relacionen de cualquier forma con el tratamiento o los servicios prestados o no prestados al paciente por el médico, el grupo o asociación médica, sus socios, asociados, asociaciones, corporaciones, entidades sociales, empleados, agentes, clínicas y/o proveedores identificado/s más abajo (en adelante, agrupados bajo el nombre de "Médico"), incluido el tratamiento o los servicios prestados o no prestados a cualesquiera cónyuges o herederos e hijos del paciente, nacidos o no nacidos, al tiempo de la aparición de los hechos de los que se deriva la reclamación. En el caso de una madre embarazada, el término paciente en la presente designará tanto a la madre como al futuro hijo o hijos.

El inicio por parte de un Médico de una acción ante un tribunal para el cobro de honorarios no significará la renuncia al derecho a exigir el sometimiento a arbitraje de cualquier reclamación por negligencia. Sin embargo, tras la interposición de una demanda contra el Médico, cualquier disputa por honorarios, esté o no sujeta a un procedimiento judicial, también deberá ser resuelta por arbitraje.

Artículo 3: Procedimiento y ley aplicable: Las peticiones de arbitraje deberán ser comunicadas por escrito a través del correo postal, con el franqueo pagado, a todas las partes, describiendo la reclamación contra el Médico, la indemnización por daños y perjuicios que se pretende, y los nombres , direcciones y números de teléfono del paciente y, en su caso, de su abogado. Después de eso, las partes seleccionarán un árbitro de equidad que haya sido previamente un juez de un tribunal de instancia superior del estado de California, para entienda en la causa. Ambas partes tendrán el derecho de someter separadamente a arbitraje los temas de responsabilidad e indemnización por daños y perjuicios a petición escrita del árbitro. El paciente deberá entablar sus reclamaciones con diligencia razonable, y el arbitraje se regirá de acuerdo a los artículos 1280-1295 del Código de Procedimiento Civil (Code of Civil Procedure) y a la Ley Federal de Arbitraje (artículos 1 a 4 del Título 9.° del Código de los Estados Unidos). Las partes deberán pagar sus propios costos, honorarios y gastos, además de costear una parte proporcional de los honorarios y gastos del árbitro de equidad.

Artículo 4: Efecto retroactivo: El paciente tiene el propósito de que este acuerdo cubra todos los servicios prestados por el Médico no sólo después de la fecha de su firma (lo cual incluye, entre otros, el tratamiento de emergencia), sino también antes de que fuera firmado.

Artículo 5: Revocación: Este acuerdo puede ser revocado por notificación escrita entregada al Médico dentro de los 30 días que siguen a la firma y si no es revocado regirá todos los servicios médicos recibidos por el paciente.

Artículo 6: Disposición de divisibilidad: En caso de que una o varias disposiciones de este acuerdo sea/n declarada/s nula/s y no exigible/s, tal disposición o disposiciones deberá/n considerarse nula/s al efecto y el resto del acuerdo será exigible de acuerdo a las normas del estado de California.

Entiendo que tengo derecho a recibir una copia de este acuerdo. Al firmar abajo, reconozco que he recibido una copia.

ADVERTENCIA: AL FIRMAR ESTE CONTRATO USTED ESTÁ DE ACUERDO CON QUE CUALQUIER PROBLEMA DE NEGLIGENCIA MÉDICA SEA DECIDIDO POR ARBITRAJE DE EQUIDAD Y ESTÁ RENUNCIANDO A SU DERECHO A UN JURADO O A UN PROCEDIMIENTO JUDICIAL. VEA EL ARTÍCULO 1 DE ESTE CONTRATO.

Por : _____
Firma del médico o del representante debidamente autorizado (Fecha)

Por: _____
Coloque el sello o escriba en letra de imprenta el nombre del médico, grupo médico o asociación

Por: _____
Firma del traductor (si corresponde) (Fecha)

_____
Escriba con letra de imprenta el nombre del traductor

Por : _____
Firma del paciente (Fecha)

_____
Escriba el nombre del paciente en letra de imprenta

Por: _____
Firma del representante del paciente (si corresponde) (Fecha)

_____
Escriba con letra de imprenta el nombre y la relación con el paciente

Una copia firmada de este documento deberá ser entregada al paciente. El original será archivado en el expediente médico del paciente.