Neurosurgical Specialists of El Paso, PLLC
Dr. Neda Jafari
(915) 351-1444

Date:_____/_____/_____ **E-mail**: _____ **Cell Phone**: (_____) _____-_____

(FECHA DE HOY) (CORREO ELECTRONICO) (TELEFONO CELULAR)

Patient's Name: _____ **SS#:** _____-_____-_____
(NOMBRE DEL PACIENTE) (SEGURO SOCIAL)

Address: _____ **Home Phone:** (_____) _____-_____ **DOB:** _____/_____/_____
(DOMICILIO) (TELEFONO DE CASA) (FECHA DE NACIMIENTO)

City, State: _____ **ZIP:** _____ **Gender:** ☐ Female ☐ Male
(CIUDAD Y ESTADO) (CODIGO)

Employer: _____ **Work Phone:** (_____) _____-_____ **Occupation:** _____
(EMPLEADOR) (TELEFONO DE EMPLEADOR) (OCUPACION)

Work Address, City, State: _____
(DOMICILIO DE EMPLEADOR, CIUDAD, Y ESTADO)

WHO REFERRED YOU HERE:
Brochure/Family/YellowPages/Newspaper/Hospital/Doctor: _____
QUIEN LE REFIRIO AQUI:
Folleto/Familia/Pagina Amarillas/Periodico/Hospital/Doctor: _____

Date of Accident or Injury: ____/_____/_____ **Hurt on the Job** ___Yes/Si ___ No **MVA** ___ Yes/Si ___ No
(FECHA DE ACCIDENTE) (FUE LASTIMADO EN EL TRABAJO) (ACCIDENTE DE VEHICULO DE MOTOR)

Emergency Contact Name: _____ **Phone Number:** (_____) _____-_____
(EN CASO DE EMERGENCIA A QUIEN NOTIFICAMOS) (TELEFONO DE CASA/CELULAR)

Emergency Contact Relationship to Patient: _____
(RELACION AL PACIENTE)

PRIMARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**
(INFORMACION DE ASEGURANZA PRIMARIA)

Insurance Company: _____ **Phone Number:** (_____) _____-_____
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: _____ **Patient Relationship to Insured:** _____
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): _____ **Group ID:** _____ **Social Security:** _____/_____/_____
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: _____ **Date of Birth** _____/_____/_____ (FECHA DE NACIMIENTO)

SECONDARY INSURANCE INFORMATION **(provide your insurance card to the front desk at check-in)**
(INFORMACION DE ASEGURANZA SECUNDARIA)

Insurance Company: _____ **Phone Number:** (_____) _____-_____
(COMPANIA DE ASEGURANZA Y TELEFONO DE ASEGURANZA)

Name of Insured: _____ **Patient Relationship to Insured:** _____
(NOMBRE DE LA PERSONA ASEGURADA) (RELACION AL PACIENTE)

Subscriber ID (Policy #): _____ **Group ID:** _____ **Social Security:** _____/_____/_____
(IDENTIFICACION DE POLIZA) (NUMERO DE GRUPO) (SEGURO SOCIAL)

Effective Date: _____ **Date of Birth** _____/_____/_____ (FECHA DE NACIMIENTO)

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.
(ESTOY DE ACUERDO EN QUE LA INFORMACION FACILITADO EN ESTE FORMULARIO ES PRECISA Y HASTA LA FECHA A LO MEJOR DE MI CONOCIMIENTO.
Patient Signature _____ Date: _____

Neda Jafari, DO

NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

Neurosurgical Specialists of El Paso, PLLC
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1. I authorize **Neurosurgical Specialists of El Paso, PLLC** to file insurance forms on my behalf. I request that payment under Medicare or any other health insurance be made directly to **Neurosurgical Specialists of El Paso, PLLC**. In the event the policy requires payment to the patient, the check must be mailed to the patient in the care of **Neurosurgical Specialists of El Paso, PLLC, 1700 N. Oregon St., Suite 660 El Paso, TX 79902.**

   Yo autorizo a este centro interno del paso a los formularios de seguros de archive en mi nombre. Solicito que el pago en virtud de Medicare o de cualquier otro seguro de salud se haga directamente al centro interno de **Neurosurgical Specialists of El Paso, PLLC.** En el caso de la politica de exigir el pago al paciente, el cheque debe enviarse por correo al paciente en el cuidado de **Neurosurgical Specialists of El Paso, PLLC, 1700 N. Oregon St., Suite 660 El Paso, TX 79902.**

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

2. I hereby authorize **Neurosurgical Specialists of El Paso, PLLC,** to file Medicare or other health insurance forms on my behalf with assignment of benefits as indicated.

   Yo autorizo el centro interno del **Neurosurgical Specialists of El Paso, PLLC,** en el archive de Medicare o de otros formularios de seguros en mi nombre con la asignacion de beneficios, como se indica.

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

3. I hereby authorize **Neurosurgical Specialists of El Paso, PLLC,** to furnish or disclose any information in regard to my illness or treatment to any insurance company, government agency, employer, health professional, or attorneys.

   Yo autorizo **Neurosurgical Specialists of El Paso, PLLC,** para proporcionar o reveler cualquier informacion con respeto a mi enfermedad o tratamiento a cualquier compania de seguros, Agencia gubernamental, empleador, profesionales de la salud, o abogados.

   Signature: _____ Date: _____/_____/_____
   (FIRMA) (FECHA)

Neda Jafari, DO

NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC

Neurosurgical Specialists of El Paso, PLLC
Dr. Neda Jafari
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Notice of Form Fee

There will be a $20.00 charge for completion of each disability (or other) forms, which is due at the time the form is brought into the office. Please allow 1 week from the time the form is brought in (and/or the time of the last office visit) for completion of the form so that the insurance clerk has all the necessary information to complete the form.

Thank you,
Management

Aviso De Cobro Para Formas

Habra un cargo de $20.00 para la realizacion de cada forma de discapacidad y de cualquier otra forma, que es debida en el momento en que el formulario se pone en la oficina. Por favor permita una semana desde el momento en que el formulario es traido en (y/o el momento de la ultima visita de oficina) para la realizacion de la forma para que el empleado de seguro tiene toda la informacion necesaria para llenar el formulario.

Gracias,
Administracion

Signature: _____ Date: _____/_____/_____
(FIRMA) (FECHA)

Neda Jafari, DO

NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC

Neurosurgical Specialists of El Paso, PLLC
Dr. Neda Jafari
(915) 351-1444

Thank you for choosing **Neurosurgical Specialists of El Paso, PLLC.** We shall do our best to provide you with quality and courteous care of your neurological needs.

Gracias por elegir el **Neurosurgical Specialists of El Paso, PLLC.** Haremos nuestro major para proporcionar con calidad y amable atencion de su problema neurological.

Appointment Cancellation Policy

In order to best serve our patients, we respectfully request that appointments be kept as scheduled. Cancellations are accepted in advance of the appointment by telephone. We respectfully request 24 hour advance notice if you need to cancel your appointment.

Poliza de Cancelacion de Cita

Con el fin de servir major a nuestros pacientes, solicitamos respetuosamente que se mantengan las citas como estaba previsto. Las cancelaciones se aceptan antes de la cita por telefono. Respetuosamente solicitamos las 24 horas de antelacion si necesita cancelar su cita.

Medication Refill Policy

A 48 hour notice is needed for refill of medication. If appointments have been missed or cancelled or treatment is not current, medication may not be renewed. Pain medication needs to be filled from your Primary Physician or your Pain Management Physician. Medication will not be renewed when requests are called to the answering service after office hours or on weekends and holidays.

Poliza de Repuesto de Medicamentos

Un aviso de 48 horas es necesaria para el respuesto del medicamento. Si las citas se han perdido o cancelado o tratamiento no es actual, no se podra renovar su medicamento. No se renovara la medicacion cuando se llaman a las solicitudes para el servicio de contestadores despues de horas de oficina o en los fines de semana y dias festivos.

Signature: _____ Date: _____/_____/_____
(FIRMA) (FECHA)

Neda Jafari, DO

NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC

Neurosurgical Specialists of El Paso, PLLC
General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Printed Name of Witness	Employee Job Title
_____	_____
Signature of Witness	Date

Neda Jafari, DO

NEUROSURGICAL SPECIALISTS OF EL PASO, PLLC

Medical Questionnaire

Patient Name: _____

Date of birth: _____ ☐ **M** ☐ **F** **Today's date:** _____

Chief complaint: _____

_____

Referring doctor: _____

Primary care doctor: _____

HISTORY OF PRESENT ILLNESS/CONDITION

Were you in a motor vehicle accident? **Yes** **No**

Were you injured at work? **Yes** **No**

Please describe the problem, how did it happen? _____

_____

How bad is it? (1 to 10) _____ **How long have you had this?** _____ **When does it get worse/better?** _____

What makes it get worse? standing sitting lying down walking bending exercise

What helps it get better? Pain reliever rest heat/ice exercise physical therapy

Do you have any problems controlling your bladder or bowel? Yes No **Have you had back or neck surgery?** Yes No

Have you had steroid injections? Yes No **What diagnostic tests have you had done?** MRI CT X-ray EMG/NCV

WORK HISTORY

Employer: _____ Occupation: _____

Duties: _____

_____

CONDITIONS - Check (✓) YES OR NO the conditions you currently have or have had in the past year

Y	N		Y	N		Y	N		Y	N	
		Alcoholism			Chemical dependency			Hepatitis			Pneumonia
		Anemia			Diabetes			Injuries			Prostate problems
		Anesthesia complications			Epilepsy			Hypertension			Rheumatic arthritis
		Arthritis			Fibromyalgia			Kidney disease			Seizures
		Asthma			Gout			Liver disease			Stroke
		Bronchitis			Headaches			Migraines			Thyroid disorder
		Cancer			Heart Disease			pacemaker			

PAST SURGICAL HISTORY: List surgeries you have had and what year

1.	3.
2.	4.

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MEDICATION: List medication you are currently taking, (including vitamins and herbs)	
1.	5.
2.	6.
3.	7.
4.	8.
ALLERGIES: To medication or substances	
1.	3.
2.	4.
Social History: Check (✓) the substance you use and describe how much you use.	**Family History: List any illnesses that run in your family.**
Caffeine Yes ☐ No ☐ How much:	1.
Tobacco Yes ☐ No ☐ How much:	2.
Alcohol Yes ☐ No ☐ How much:	3.
Other _____ Yes ☐ No ☐ How much:	4.

SYMPTOMS - Check (✓) YES OR NO the symptoms you currently have or have had in the past year.

Y	N	**General**
		Chills
		Dizziness
		Fainting
		Fever
		Loss of Weight
		Numbness
		Sweats

Y	N	**Eye, Ear, Nose, Throat**
		Bleeding Gums
		Blurred vision
		Crossed eyes
		Difficulty swallowing
		Double vision
		Earache
		Ear discharge
		Hay fever
		Hoarseness
		Loss of hearing
		Nosebleeds
		Persistent cough
		Ringing in the ears
		Sinus Problems

Y	N	**Cardiovascular**
		Chest pain
		high blood pressure
		Irregular heart beat
		Low blood pressure
		Poor circulation
		Rapid heart beat
		Swelling in ankles

Y	N	**Respiratory**
		Cough
		Shortness of breath
		Decreased in exercise capacity

Y	N	**Gastrointestinal**
		Abdominal pain
		Appetite poor
		Bloating
		Bowel changes
		Constipation or diarrhea
		Gas
		Heartburn or indigestion
		Hemorrhoids
		Nausea or vomiting

Y	N	**Genitourinary**
		Blood in urine
		Frequent urinating
		Lack of bladder control
		Painful urination

Y	N	**Muscle/Joint/Bone Pain, weakness, or numbness:**
		Arms
		Back
		Feet
		Hands
		Hips
		Legs
		Neck
		Shoulders

Y	N	**Skin**
		Bruise easily
		Hives
		Itching
		Change in moles
		Rash
		Scars
		Sore that won't heal

Y	N	**Neurological**
		Dizziness lightheadedness
		Weakness
		Fainting
		Seizures

Y	N	**Psychiatric**
		Depression
		Headache
		Loss of sleep
		Nervousness
		Stress
		Trouble concentrating

Y	N	**Endocrine**
		Diabetes
		Hypertension
		Thyroid disease

Y	N	**Hematological**
		Anemia
		Bleeding disorder

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

Physician Signature_____ Date reviewed_____

Physician:

FOR CLINICAL OFFICE USE ONLY

**PHYSICIAN MUST DOCUMENT

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System/Body Area		**Elements of Examination
Cardiovascular		• Exam of carotid arteries (e.g. pulse amplitude, bruits)
		• Auscultation of heart with rotation of abnormal sounds and murmurs.
		• Exam of peripheral vascular system by observation (e.g. swelling, varicosities) and palpation (e.g. pulses, temperature, edema, tenderness)
Constitutional		• Measurement of any 3 of the following vital signs: blood pressure, pulse, respiration, temperature, height, weight.
		• General appearance of patient (e.g. development, nutrition, deformities, attention to grooming)
Eyes		• Ophthalmoscopic exam of optic discs (e.g. size, C/D ratio, appearance) and posterior segments (e.g. vessel changes, exudates, hemorrhages)
Musculoskeletal (includes extremities)		• Exam of gait and station
		Assessment of motor function including: • Muscle strength in upper and lower extremities
		• Muscle tone in upper and lower extremities (e.g. flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (e.g. fasciculation, tardive dyskinesia)
Neurological		*Evaluation of higher integrative functions including*: • Orientation to time, place and person
		• Recent and remote memory
		• Attention span and concentration
		• Language (e.g. naming objects, repeating phrases, spontaneous speech)
		• Fund of knowledge (e.g. awareness of current events, past history, vocabulary)
		Test the following cranial nerves: • 2nd through 12 cranial nerve
		• Examination of sensation
		• Examination of deep tendon reflexes in upper and lower extremities with notation of pathologic reflexes
		• Test coordination

RADIOLOGIC STUDIES:

MDM:

Physician: _____

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OF EL PASO, PLLC

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Rate the severity of your pain on this scale *(Circle One):*

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

(1 = mild and 10 = intense/severe/worst pain of your life)

DOCTOR OR ASSISTANTS NOTES ONLY:

_____
_____
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Toe/Heel + --- SLR + --- RLE LLE ELE