

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
(INFORMACION DE ASEGURANZA PRIMARIA)

(provide your insurance card to the front desk at check-in)

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
(INFORMACION DE ASEGURANZA SECUNDARIA)

(provide your insurance card to the front desk at check-in)

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: _____



NEUROSURGICAL
SPECIALISTS
OF EL PASO, PLLC

Neda Jafari, DO

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

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)



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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 traído 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: _____
(FIRMA)

Date: ____/____/_____
(FECHA)



**NEUROSURGICAL
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Neda Jafari, DO

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 mayor 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 mayor 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: _____
(FIRMA)

Date: ____/____/_____
(FECHA)



Neda Jafari, DO

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



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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 | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | Chemical dependency | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Injuries | <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Anesthesia complications | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Gout | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Migraines | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | |

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 <input type="checkbox"/> No <input type="checkbox"/> How much: | 1. |
| Tobacco Yes <input type="checkbox"/> No <input type="checkbox"/> How much: | 2. |
| Alcohol Yes <input type="checkbox"/> No <input type="checkbox"/> How much: | 3. |
| Other _____ Yes <input type="checkbox"/> No <input type="checkbox"/> How much: | 4. |

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

| Y | N | General |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chills |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Weight |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweats |

| Y | N | Respiratory |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased in exercise capacity |

| Y | N | Skin |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in moles |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Scars |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore that won't heal |

| Y | N | Eye, Ear, Nose, Throat |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in the ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |

| Y | N | Gastrointestinal |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Appetite poor |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel changes |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation or diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn or indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting |

| Y | N | Neurological |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | lightheadedness |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |

| Y | N | Genitourinary |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |

| Y | N | Psychiatric |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Stress |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble concentrating |

| Y | N | Cardiovascular |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | high blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling in ankles |

| Y | N | Muscle/Joint/Bone Pain, weakness, or numbness: |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Arms |
| <input type="checkbox"/> | <input type="checkbox"/> | Back |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips |
| <input type="checkbox"/> | <input type="checkbox"/> | Legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders |

| Y | N | Endocrine |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |

| Y | N | Hematological |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | 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:



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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 | <i>Evaluation of higher integrative functions including:</i> • 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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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:

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

