DR. ZESHAN HYDER

11055 Broadway, Crown Point, IN 46307
Phone: 219-797-7463 **Fax:** 219-310-8951

Patient Information (Please Print)

Today's Date MRN#

Last Name	First Name & Middle Initial		
Patient SS#	Sex	DOB	Marital Status
Preferred Language	PCP		
Referring Physician			
Address		City	State Zip
Primary Contact Home Ph		Work Ph	Cell Ph
Email Address			
Employer Name		Employer Address	
Occupation		Employment Status	
Spouse's Name			
Spouse's Home Ph		Work Ph	Cell Ph

Ethnicity	☐ Hispanic	☐ Not Hispanic
Race	☐ American Indian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other	☐ Alaskan Native ☐ White or Caucasian ☐ Asian ☐ Patient Refused

Name of Primary Insurance

Policy Holder Name		Relationship	
Address		Contact Phone	
Policy Holder SS#	Sex	Policy Holder DOB	
Employer	Employer Phone		Ext
Employer Address			

Name of Secondary Insurance

Policy Holder Name		Relationship	
Address		Contact Phone	
Policy Holder SS#	Sex	Policy Holder DOB	
Employer	Employer Phone		Ext
Employer Address			

Emergency Contact Info

Nearest Relative or Friend Not Living With		Relationship
Address		
Primary Contact Home Ph	Work Ph	Cell Ph

You must read and sign the other side of this form.

Authorization for treatment: I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Records Diagnosis: I hereby authorize the physician(s) providing service and any other authorized person to release to it's authorized billing agents, any physicians who treated me, my insurance carrier, employer's workman's compensation insurance, or other category or third party payor, the Social Security Administration unter Title IVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by given written notice. I understand that I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

I give permission to NWI Spine Institute and all clinical providers who have provided care for me, along with any billing services, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits/Financial Obligation: In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to insufficient funds.

Co-Payments: I understand that if my medical insurance requires a co-pay or encounter fee, the payment is due AT THAT TIME OF SERVICE.

No Show Policy: Each time a patient misses an appointment withiout providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments, we have instituted a **$35 no show fee. You must give 24 hours advance notice to cancel appointments. Failure to do so will result in a $35 fee charged to your account. By signing below, you acknowledge that you have read and understand this policy.**

Precertification: If my insurance requires precertification, it is my responsibility to make sure it is obtained. I will be held financially responsible of the precertification is not obtained.

Advance Directive: Information regarding advance directives is provided in the Patient Information Guide.

H.H.S. Pursuant to Health Insurance Portability and Accountability Act of 1996. I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	

(SECTION 1) I give consent and authorization for the medical or billing staff of my physician's office to release information regarding my medical care to:

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

(SECTION 2) - AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent the action has already been taken in reliance on the consent.

Name	Relationship	Name	Relationship

I understand I may revoke this privilege listed in (SECTION 1) and (SECTION 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature _____ Date _____

Advance Directive

Have you appointed a Health Care Representative?	☐ Yes ☐ No	Is this related to an auto accident?	☐ Yes ☐ No
Have you given anyone your Power of Attorney?	☐ Yes ☐ No	Is this a work comp injury?	☐ Yes ☐ No
Do you have a living will?	☐ Yes ☐ No		

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New Patient Evaluation

Today's Date

Patient Name

Date of Birth

Age | Sex | Height | Weight

Chief Complaint

Date of Injury/Pain

Goals

Referral

Name of Primary Physician

Pain Location

Mark the image where you experience:

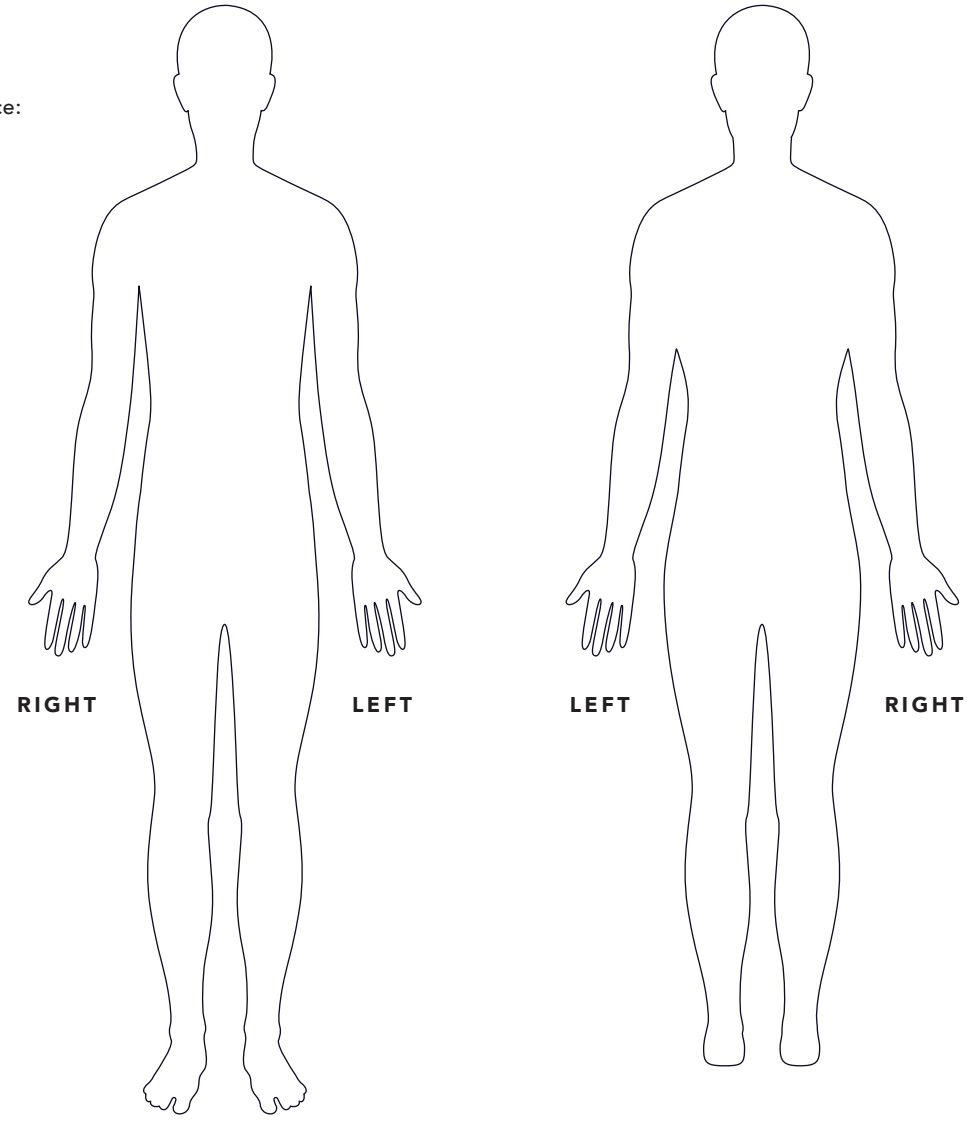
Numbness: 0

Burning: x

Ache: ^

Pins & Needles: *

Stabbing: /



How Bad is Your Pain? (Place an "X" on each line below to indicate pain level)

	0	1	2	3	4	5	6	7	8	9	10	
LOW BACK PAIN	No Pain											Worst Possible
LEG PAIN	No Pain											Worst Possible
MIDDLE BACK	No Pain											Worst Possible
NECK PAIN	No Pain											Worst Possible
ARM PAIN	No Pain											Worst Possible

Please check how each of the following affects your pain.

Is your pain worse at night? ☐ Yes ☐ No

Do your legs tire when you walk? ☐ Yes ☐ No

If yes: How far can you walk?

Is there relief when resting your legs? ☐ Yes ☐ No

Is there relief when bending forward? ☐ Yes ☐ No

Any tingling or numbness? ☐ Yes ☐ No

If yes: hands, arms, legs, feet, etc?

Any weakness or falling/dropping items? ☐ Yes ☐ No

If yes: hands, arms, legs, feet etc? ☐ Yes ☐ No

IMAGING: HAVE YOU HAD ANY XRAY, MRI, CT, ER TESTS IN THE PAST 6 MONTHS? ☐ Yes ☐ No

General History Please check all of the conditions that apply to you.

☐ Heart Attack	☐ Colon Problems	☐ Gout	☐ Menstrual Problems
☐ Heart Murmur	☐ Diabetes	☐ Anxiety	☐ Cancer:
☐ Angina	☐ Hepatitis	☐ Depression	
☐ High Blood Pressure	☐ Cirrhosis	☐ Emphysema	☐ Osteoporosis
☐ Stroke	☐ Kidney Stones	☐ Tuberculosis	☐ Stomach Ulcer
☐ Varicose Veins	☐ Kidney Infection	☐ Chronic Bronchitis	☐ Sexual Difficulty
☐ Duodenal Problems	☐ Degenerative Arthritis	☐ Frequent Pneumonia	☐ Bleeding Tendency
☐ Anemia	☐ Asthma	☐ Enlarged Prostate	

Please list any surgeries you have had.

Have you ever had any sugeries on your NECK or BACK before? If yes: date and surgeon

Date	Surgeon
Date	Surgeon
Date	Surgeon

Please check any TREATMENTS you have already had.

☐ Chiropractic ☐ Physical Therapy ☐ Injections ☐ Psychological Exam ☐ Other

If yes, did treatment make your condition better or worse?

How long ago were these treatments? Who performed each one?

Family History

MOTHER

Age Deceased Cause

FATHER

Age Deceased Cause

Check all that apply.

☐ Stroke ☐ Heart Problems ☐ Kyphosis ☐ Diabetes ☐ High Blood Pressure

☐ Lung Disease ☐ Cancer ☐ Back Problems ☐ Arthritis ☐ Other

Medication

Please list ALLERGIES you may have to medications.

PHARMACY NAME & LOCATION

Please list any MEDICATIONS you take, including herbal, over the counter, and prescription.

MEDICATION	REASON	HOW OFTEN	DOCTOR

Social History

MARITAL STATUS

☐ Married
☐ Separated
☐ Divorced
☐ Single
☐ Widow/Widower

CURRENT WORK SITUATION

☐ Full-Time
☐ Part-Time
☐ Retired
☐ Other

ALCOHOL USE FREQUENCY

☐ Never
☐ Rarely
☐ Socially
☐ Daily

TOBACCO USE: ☐ Yes ☐ No

CURRENT SMOKER: ☐ Yes ☐ No

____ Packs/Day for ____ Years

FORMER SMOKER: ☐ Yes ☐ No

____ Packs/Day for ____ Years

Review of Systems for the Patient

Please check all that apply.

- ☐ Recent weight loss of more than 10 pounds
- ☐ Recent weight gain of more than 10 pounds
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

Have you seen your Primary Care Physician in the past year? ☐ Yes ☐ No

CARDIAC

- ☐ Chest Pain
- ☐ Shortness of Breath

SKIN

- ☐ Open Sores
- ☐ New Moles
- ☐ Poor Healing
- ☐ Skin Infection

RESPIRATORY

- ☐ Wheezing
- ☐ Pneumonia
- ☐ Chronic Cough

GENITOURINARY

- ☐ Abnormal Kidney Function
- ☐ Pain With Urination
- ☐ Frequent Urinary Infections

GASTROINTESTINAL

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Liver Problems

BONES & JOINTS

- ☐ Shoulder Pain
- ☐ Wrist/Hand Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Lupus
- ☐ Muscle Weakness
- ☐ Fibromyalgia

HEMATOLOGY/ONCOLOGY

- ☐ Easy Bruising
- ☐ Blood Thinning Meds
- ☐ Blood Transfusions
- ☐ Organ Transplant

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Tremors
- ☐ Speech Problems
- ☐ Changes in Vision

MENTAL HEALTH

- ☐ Sleep Disturbances
- ☐ Feeling of Hopelessness

ENDOCRINE

- ☐ Thyroid Problems