DR. ZESHAN HYDER

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

Patient Information

Today's Date

Last Name | First Name | Middle Inital

Date of Birth | SSN | Gender ☐ F ☐ M ☐ Other

Address | City | State | Zip

Phone ☐ Cell ☐ Home ☐ Work

Email Address

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered Partnership ☐ Other

Spouse's Name *(if applicable)* | Spouse's Phone

Emergency Contact | Emergency Contact Phone

Relationship

Name of Physician

Employer | Occupation

Is this visit related to a work comp or auto injury? ☐ Yes ☐ No

PRIMARY INSURANCE PROVIDER

Name of Subscriber on Policy *(if other than yourself)*

Relationship | Date of Birth

SECONDARY INSURANCE PROVIDER

Name of Subscriber on Policy *(if other than yourself)*

Relationship | Date of Birth

How were you referred to Dr. Hyder?

DR. ZESHAN HYDER

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

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

RELEASE OF INFORMATION/MEDICAL RECORDS: I hereby authorize the physician providing service and any other authorized person to release to its authorized billing agents, any physicians who treated me, my insurance carrier, employer, workman's compensation insurance, other third-party payor, the Social Security Administration under Title XVIII (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 services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if 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 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 and interest to medical reimbursement, not limited to the right to designate a beneficiary, to add dependent eligibility, 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 fees and court costs. I understand that it is this office's 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, the payment is due at the time of service.

NO-SHOW POLICY: Each time an appointment is missed without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurances. Due to high patient demand and limited availability of appointments, we have instituted a $35 no-show fee. You must give 24-hour notice to cancel appointments. Failure to do so will result in a $35 fee charged to your account.

PRECERTIFICATION: If my insurance requires a referral or precertification, it is my responsibility to ensure it is obtained. I will be financially responsible if a referral or precertification is required and not obtained.

H.H.S. Pursuant to Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of the privacy practices.

ADVANCED DIRECTIVES:

I have a power of attorney? ☐ Yes ☐ No

I have a living will? ☐ Yes ☐ No

I give consent for the office to release information regarding my medical care to:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____ Date _____

DR. ZESHAN HYDER

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

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 Care Physician

Pain Location

Mark the image where you experience:

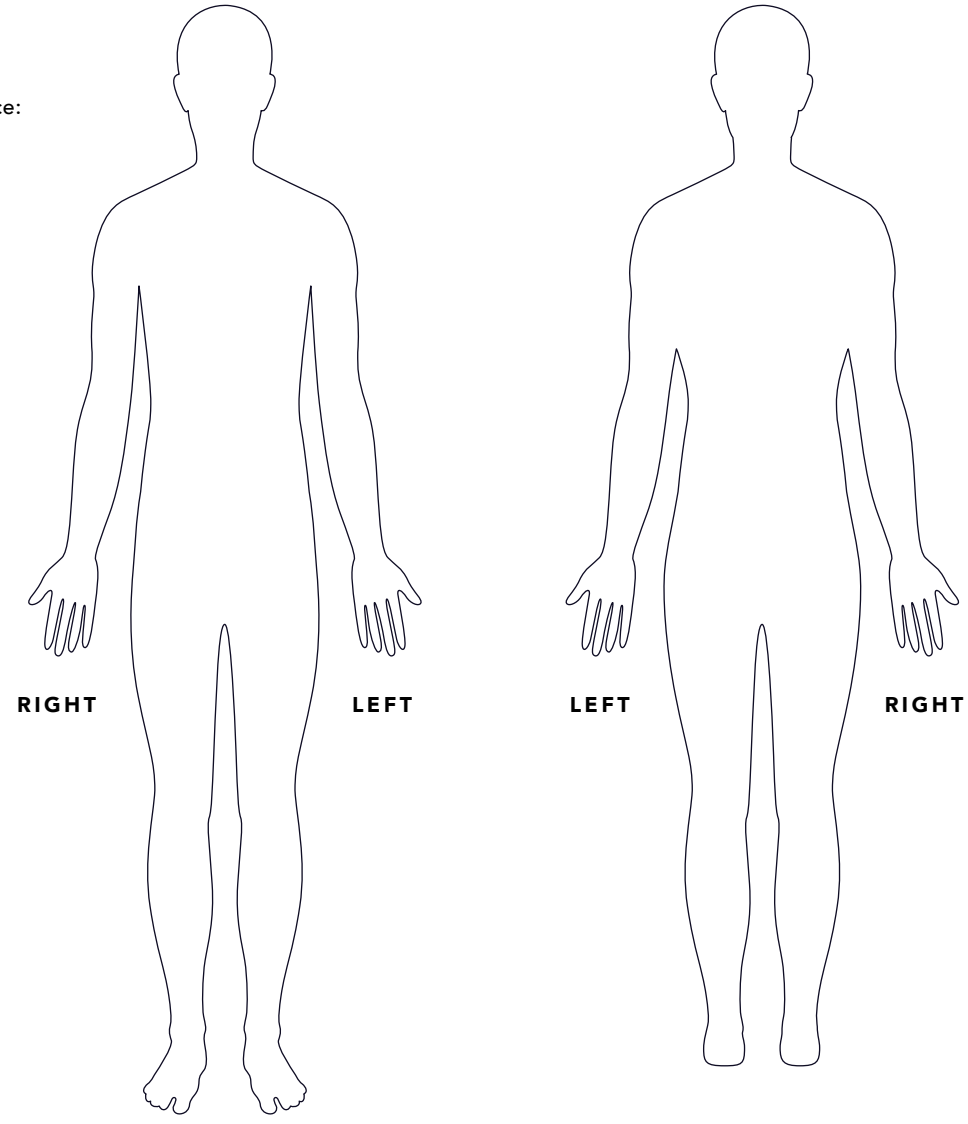
Numbness: 0

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.?

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

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? ☐ Yes ☐ No Cause

FATHER

Age Deceased? ☐ Yes ☐ No 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 withx 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