MOBIN
NEUROSURGERY

FARDAD MOBIN, MD, FAANS

Patient Health History Form Date of Visit _____

Patient Name: _____ Age:_____ DOB_____

Name of Physician requesting this consultation: _____

Complaint Description:_____

Past Medical History:

1. Major illness:_____
   _____
2. Injury:_____
   _____
3. Past Spine / Other Surgical History: ☐ No ☐Yes (If Yes, please provide Date, Type of Surgery & complications)

Surgeries/Hospitalizations	**Year**	**Complications**

Treatment Details: (provide dates, duration, and if the treatment helped)

Chiropractic: _____
Physical Therapy: _____
Acupuncture: _____
Pain injections: _____

ALLERGIES to Medications & Reactions:

Allergic to:	Reaction

Have you ever had Problems with Anesthesia? Yes_____ No _____
Latex Allergy _____Yes ____ No

Family History (circle one)
Do you have a family history of trouble with anesthesia? Yes No
Do you have a family history of easy bleeding? Yes No

Social History
Do you smoke? ___ Yes. ___ packs of cigarettes per day for ____ years. ____ No, I have never smoked.
____ No, I quit _____ ago. At the time I was smoking __ packs/day for ___ years.
Do you drink alcohol? ____ No, never (or rarely) ___ No, but I used to. ____
Yes, How often? _____ Daily, _____ 1 or more times a week, _____ 1 or more times a month

Current Medications: (including Aspirin and herbal supplements)
Include: Medication, Dose/strength, Number of pills per day.

_____
_____
_____

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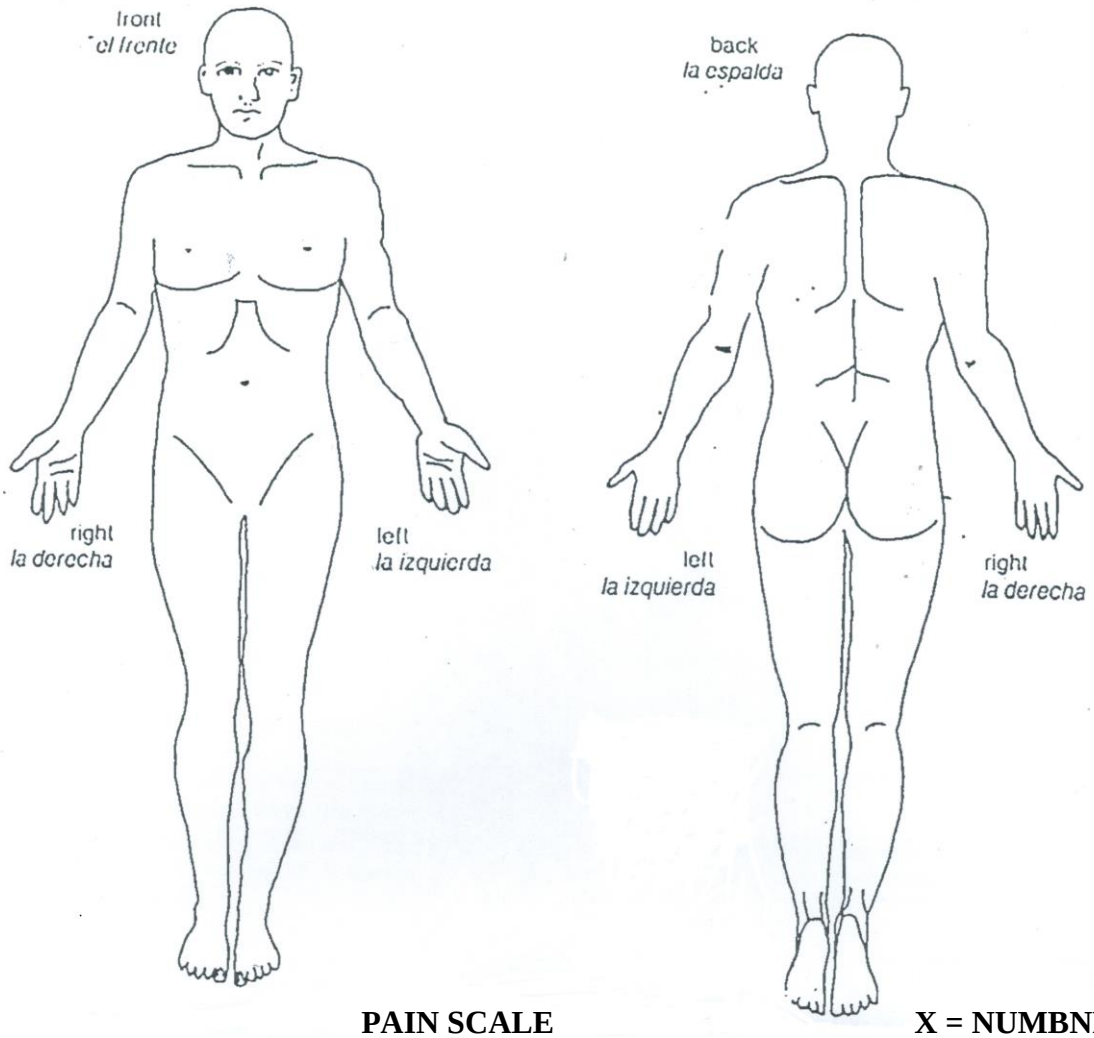
NAME: _____



PAIN SCALE **X = NUMBNESS O = PAIN**
TABLA DE DOLOR

Please circle on this pain scale 1 being no pain, 10 being the worst pain.
Por favor circule in la tabla de dolor 1 siendo no dolor 10 siendo el dolor maximo.

1	2	3	4	5	6	7	8	9	10

1 Please describe your symptoms:_____
_____
_____

2 What position and/or medications releive your pain? _____
_____

3 Are you presently working? Full: _____ Part time: _____ Retired: _____ Disability: _____

4 Please list any Test you have had in the past (MRI, Xray, EMG,etc.):
_____
_____

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REVIEW OF SYSTEMS:

Are you currently, or have you had, problems with:

CONSTITUTIONAL	**Circle One**	
Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO
EYES		
Double vision	YES	NO
Visual Loss	YES	NO
EAR, NOSE THROAT AND MOUTH		
Hearing Loss	YES	NO
Noise/Ringing in ears	YES	NO
Nasal Congestion	YES	NO
Nasal Drainage	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO
CARDIOVASCULAR		
Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO
NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO
PSYCHIATRIC		
Depression	YES	NO
ALLERGIC/IMMUNOLOGIC		
Sneezing	YES	NO
Itchy Throat/Eyes/Nose	YES	NO
Skin Rash	YES	NO
HIV	YES	NO

I have reviewed the above information with the Patient.

RESPIRSTORY	**Circle One**	
Asthma	YES	NO
Cough up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing At Night	YES	NO
Snoring	YES	NO
GASTROINTESTINAL		
Indigestion or Heartburn	YES	NO
Ulcer	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood In Stool	YES	NO
Black, Tarry Stools	YES	NO
GENITOURINARY		
Bladder Trouble	YES	NO
Prostate Disease	YES	NO
Kidney Disease	YES	NO
MUSCULOSKELETAL		
Arthritis	YES	NO
ENDOCRINE		
Diabetes	YES	NO
Thyroid Disease	YES	NO
HEMATOLOGIC		
Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature ***Date***

_____

Fardad Mobin, M.D.

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REGISTRATION

Date_____ Home Phone_____ Work Phone_____

Email_____

Patient Last Name_____First Name_____ Initial_____

Street
Address_____
City_____ State_____
Zip_____

Sex ☐ M ☐ F Age_____ Birth date_____☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #XXX-XX-_____ Driver's License #_____

Insured Name_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____☐ Full-time ☐ Part-time City _____ State _____ Zip_____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____Phone_____ Occupation_____ City_____ State _____ Zip_____☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____

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PATIENT FINANCIAL RESPONSIBILITY

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him for services rendered me 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. If this account is assigned for collection and/or suit, collection cost and/or interest, and/or attorneys, fees, and/or court costs will be added to the total amount due.

_____ _____

Signature of patient / Guardian Date

DISCLOSURE OF FINANCIAL INTEREST

I acknowledge and accept that Fardad Mobin, M.D. (neurosurgeon) has a financial interest in the following facility: Bay City Surgery Center in Torrance, CA. I hereby recognize my right to choose a different facility. I have been assured that I will receive the same care from Dr. Mobin, regardless of the facility. In case Dr. Mobin is unable to perform the procedure at the facility that I request, I have been informed and am aware that I may choose a different provider for my care.

Patient Last Name _____ First Name _____ Initial _____

_____ _____

Signature of Insured / Guardian Date

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FARDAD MOBIN, M.D., F.A.A.N.S
Diplomate of the American Board of Neurological Surgeons
Minimally Invasive Spine and General Neurosurgery
Fellowship Trained Neurological Surgeon

AUTHORIZATION FOR USE AND RELEASE OF MEDICAL RECORDS

This authorization allows the healthcare provider or healthcare facility to release all confidential medical information and records:

Mobin Neurosurgery
Fardad Mobin, M.D.
8929 Wilshire Boulevard
Suite 415
Beverly Hills, CA 90211
Tel #: (310) 829-5888
Fax #: (310) 943-2636

The person named below hereby authorizes _____ to request medical information from _____.

INFORMATION TO BE RELEASED FOR DATES: _____ FOR THE FOLLOWING INFORMATION:

- ☐ History & Physical
- ☐ Procedure/Operative Reports
- ☐ X-rays/Imaging Reports
- ☐ Consultation Reports

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. have been advised of my right to receive a copy of this information.

_____ _____
Signature of patient or legal/Personal Representative Patient's Date of Birth

_____ _____
Patient's Name (PRINT) Date

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****DO NOT MAKE ANY CHANGES TO THIS LIEN AS IT WILL BECOME INVALID*****

AUTHORIZATION AND MEDICAL LIEN

I, _____ intend to undergo potential surgical intervention and any necessary or desirable follow-up procedures for the treatment of injuries I sustained as a result of an incident/accident which occurred on (hereinafter the "Claim"). Having been counseled by the attorney of my choosing, I agree as follows:

1. PROVIDER'S LIEN. I hereby grant Dr. Fardad Mobin (hereinafter, "Provider") a lien on my Claim against any and all proceeds of any settlement, judgment, verdict, or award in the amount of Provider's standard billing costs for services provided to me or a family member for whom I am responsible. I understand that this lien is freely assignable.

2. ATTORNEY AUTHORIZATIONS. I hereby authorize and direct my attorney of record,_____ ,Esq., and any subsequent attorneys (hereinafter "Attorney"), to pay Provider all amounts owing under this lien from the proceeds of my Claim before any payments are made to me. I further authorize and direct said attorney to notify Provider of any subsequent change of representation regarding my Claim.

3. PROVIDER AUTHORIZATIONS. I hereby authorize Dr. Fardad Mobin to furnish Attorney with all medical records pertaining to my treatment, including reports on examination, diagnosis, treatment, prognosis, and other medical bills on record.

4. RESPONSIBILITY FOR PAYMENT. I acknowledge that I am directly and fully responsible to Provider for all medical bills submitted for services rendered to me and that this agreement is made solely for Provider's additional protection and in consideration of Provider awaiting payment. I further understand that such payment is ***not*** contingent upon any settlement, judgment, or verdict I may eventually receive on the Claim.

5. INTEREST. Dr. Fardad Mobin shall be entitled to receive, and I shall be required to pay, interest at the rate of ten percent (10%) per annum on all amounts owed by me for services rendered by Provider. Interest shall begin to accrue forty-five (45) days after settlement/judgment funds are received and shall continue until full payment of this Lien.

6. WAIVER OF HEALTH INSURANCE I declare that I have thoroughly discussed with my attorney all possible sources of funding for the treatment of my injuries including, but not limited to, commercial health insurance, health management organizations, and government programs such as Workers' Compensation and have decided that obtaining medical treatment on a lien is the best option. As such, bills for my treatment will not be submitted to any such health insurance program for payment.

7. REASONABLE RATES. I have been provided with a Surgical Estimate stating an approximate cost for the services which will be rendered by Provider. I have discussed such costs with my attorney, have compared the rates for such services through other providers, and have explored all possible funding sources. As such, I expressly agree that the fee rates and costs charged by Fardad Mobin, M.D. are reasonable.

8. INTEGRATED/ENTIRE AGREEMENT. This Agreement, and Provider's statement of fees and costs which will be generated after treatment, constitute the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of the parties. This agreement may only be modified by a written statement signed by Provider (or Assignee of Provider) and myself.

9. STATUTE OF LIMITATIONS. I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5.

10. ENFORCEMENT OF AGREEMENT. Should suit be filed, or any other action taken to enforce this agreement, outside of interpleader, the prevailing party shall be entitled to reasonable attorney's fees and costs. Jurisdiction and Venue is in North County San Diego, California where this agreement is entered into and to be carried out by the parties.

11. ACKNOWLEDGMENT. I acknowledge by my signature that I have read this entire agreement and that all provisions, rights, and obligations have been explained to me by my attorney. As such, we consent to the terms of this contract and agree to be bound by it.

Date:_____ PATIENT/ GUARDIAN SIGNATURE _____

Date: _____ ATTORNEY SIGNATURE _____

8929 Wilshire Blvd., Suite 415
Beverly Hills, CA 90211

www.SpineSurgeonLA.com
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F 310-943-2636