



BEVERLY HILLS SPINE SURGERY

Dr. Brian Perri

Dr. Khawar Siddique

Dr. Edward Nomoto

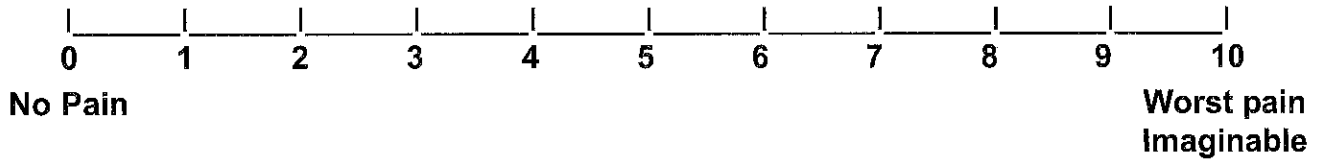
Dr. Albert Wong

| PATIENT INFORMATION | | | |
|------------------------------------|--|-------------|--|
| Last Name: | | First Name: | |
| Date of Birth: | Last 4 Digits of Social Security Number: XXX - XX - _____ | | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male |
| Address: | | | |
| City: | | State: | Zip: |
| Home Phone: | Cell: | Work Phone: | |
| PHYSICIAN INFORMATION | | | |
| REFERRING PHYSICIAN | | | |
| Last Name: | | First Name: | |
| Specialty: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Office Phone: | | Fax: | |
| INTERNIST / PRIMARY CARE PHYSICIAN | | | |
| Last Name: | | First Name: | |
| Address: | | | |
| City: | | State: | Zip: |
| Office Phone: | | Fax: | |
| | | | |



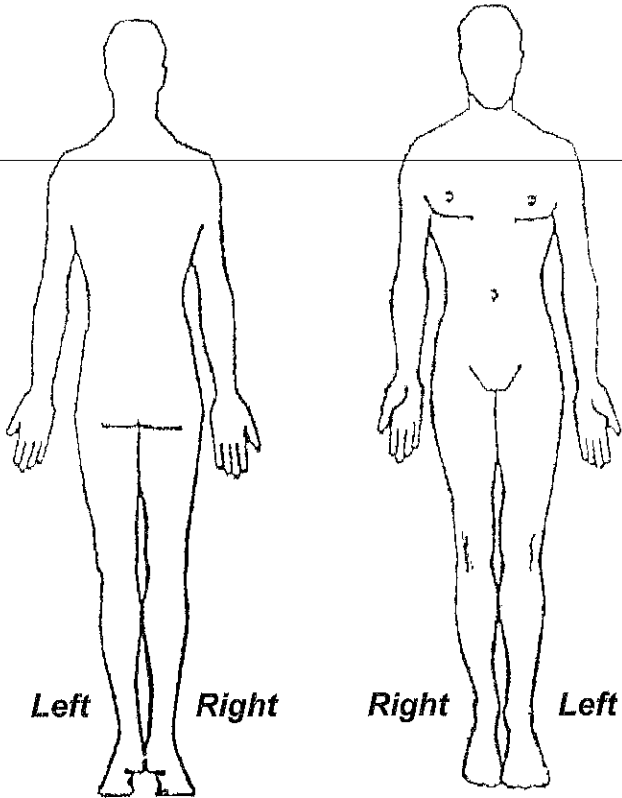
PATIENT I.D. _____

1. How much pain in general can you tolerate?



2. Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN SYMBOL

Ache <<<<<<
<<<<<<

Numbness ○○○○○○
○○○○○○

Pins & Needles ■■■■
■■■■

Burning XXXXXX
XXXXXX

Radiating Pain ///////////////
/////////////////

3. How bad is your pain?

Neck pain _____ %

Arm pain _____ %

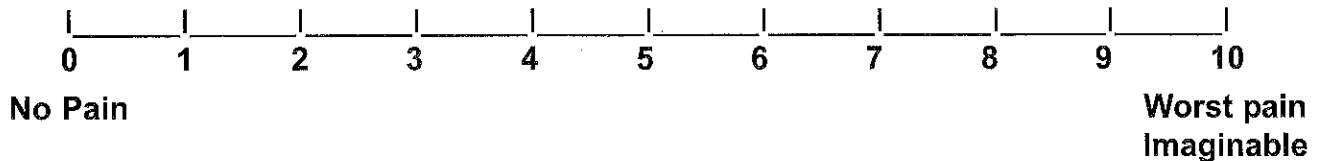
Total 100%

Back pain _____ %

Leg pain _____ %

Total 100%

4. How bad is your pain now?



5. The duration of pain:

- Continuous Positional Intermittent (On/Off) Unable to Rate

6. Have you taken pain medication in the past 24 hours?

- YES NO



BEVERLY HILLS SPINE SURGERY

PERSONAL INFORMATION

PATIENT I.D.

Last Name: _____ First Name: _____ MI: _____
 Age: _____ Occupation: _____ Right-handed Left-handed

Current Problem

| | |
|-----------|-----------|
| Symptoms: | Duration: |
| | |
| | |
| | |

Past Medical History

| | |
|----------------------|--------|
| Previous Operations: | Dates: |
| | |
| | |
| | |

Other Past and Current Medical Problems (e.g., hypertension, stroke, diabetes, cancer, etc.)

| |
|--|
| |
| |

Family Medical History (if deceased, list cause)

| |
|--|
| |
| |

Current Medications (including over-the-counter medicines)

| |
|--|
| |
| |

Allergies (medication and others)

| |
|--|
| |
| |

Allergies (medication and others)

Smoke _____ / Day Alcohol Usage: _____

Recent X-Rays, CTs, MRIs (including dates):

| |
|--|
| |
|--|

Regarding MRIs, are you claustrophobic? Yes No

Do you have metal implants? Yes No

| | | | |
|----------------------------------|-------------------------------|------|------|
| Patient / Guarantor Printed Name | Patient / Guarantor Signature | Date | Time |
| CSMC Representative Printed Name | CSMC Representative Signature | Date | Time |



BEVERLY HILLS SPINE SURGERY

GENERAL REVIEW OF THE SYSTEMS

PATIENT I.D.

Please mark any medical condition that applies to you

Allergies

- Asthma
- Hay fever
- Skin eruptions

Cardiocascular

- Chest pain
- Irregular heart beat
- High / low blood pressure
- Poor circulation
- Rapid heart rate
- Swelling of ankles
- Varicose veins
- Heart attack

Constitutional

- Chills / sweats / fever
- Fainting
- Forgetfulness
- Loss of sleep
- Nervousness
- Weight loss

Ears / Nose / Throat

- Bleeding gums
- Difficulty swallowing
- Earache
- Ear discharge
- Hearing loss
- Hoarseness
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems

Endocrine

- Rapid weight loss / gain
- Intolerance to warm room
- Multiple broken bones
- Cessation of menstrual periods
- Excessive hunger / thirst
- Loss of libido
- Spontaneous nipple discharge

Eyes

- Blurred vision
- Crossed eyes
- Double vision
- Vision flashes or halos

Genitourinary

- Blood in urine
- Lack of bladder control
- Painful urination
- Frequent urination

Gastrointestinal

- Bloating
- Bowel changes

- Constipation

- Diarrhea

- Gas

- Hemorrhoids

- Indigestion

- Nausea

- Poor appetite

- Rectal bleeding

- Stomach pain

- Ulcers

- Liver problems

Hematologic / Lymphatic

- Swollen lymph nodes

- Easy skin bruising

- Prolonged bleeding cuts tooth extractions

- Low blood count

- Frequent infections

Integumentary

- Skin rashes or eruptions

- Chronic skin itching

Men

- Breast lump

- Lump in testicle

- Penis discharge

- Sore on penis

Musculoskeletal

- Pain, weakness, numbness, or swelling in hands, wrist, hips, knees or joints

- Pain in arms or legs

Neurological

- Fainting

- Headaches

- Numbness of arm or leg

- Seizures

- Tingling in hands or feet

Psychiatric

- Anxiety

- Depression

- Panic attacks

- Restlessness

Respiratory

- Blood

- Cough

- Dizziness

- Shortness of breath

Women

- Abnormal pap smear

- Bleeding between periods

- Breast lump

- Extreme menstrual pain

- Hot flashes

- Nipple discharge

- Painful intercourse

Date of last period: _____

Date of last pap smear: _____

Date of mammogram: _____

Are you pregnant?

- Yes No

Number of children: _____

Patient / Guarantor Printed Name

Patient / Guarantor Signature

Date

Time

CSMC Representative Printed Name

CSMC Representative Signature

Date

Time



BEVERLY HILLS SPINE SURGERY

SPINE HEALTH ASSESSMENT

PATIENT I.D. _____

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

For each of the following questions, please mark an **X** in the one box that best describes your answer.

1. In general, would you say your health is:

| | | | | |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|----------------------------|
| Excellent | Very good | Good | Fair | Poor |
| ▼ | ▼ | ▼ | ▼ | ▼ |
| <input type="checkbox"/> 1..... | <input type="checkbox"/> 2..... | <input type="checkbox"/> 3..... | <input type="checkbox"/> 4..... | <input type="checkbox"/> 5 |

2. **The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

| | | | |
|--|---------------------------------|---------------------------------|------------------------------|
| | Yes, limited a lot | Yes, limited a little | No, Not limited at all |
| | ▼ | ▼ | ▼ |
| a <u>Moderate activities</u> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="checkbox"/> 1..... | <input type="checkbox"/> 2..... | <input type="checkbox"/> 3 |
| b Climbing <u>several</u> flights of stairs | <input type="checkbox"/> 1..... | <input type="checkbox"/> 2..... | <input type="checkbox"/> 3 |

3. **During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

| | | | | | |
|--|---------------------------------|---------------------------------|---------------------------------|---------------------------------|----------------------------|
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| | ▼ | ▼ | ▼ | ▼ | ▼ |
| a <u>Accomplished less</u> than you would like | <input type="checkbox"/> 1..... | <input type="checkbox"/> 2..... | <input type="checkbox"/> 3..... | <input type="checkbox"/> 4..... | <input type="checkbox"/> 5 |
| b Were limited in the <u>kind of</u> work or other activities | <input type="checkbox"/> 1..... | <input type="checkbox"/> 2..... | <input type="checkbox"/> 3..... | <input type="checkbox"/> 4..... | <input type="checkbox"/> 5 |

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| a <u>Accomplished less</u> than you would like | ▼ <input type="checkbox"/> 1 | ▼ <input type="checkbox"/> 2 | ▼ <input type="checkbox"/> 3 | ▼ <input type="checkbox"/> 4 | ▼ <input type="checkbox"/> 5 |
| b Did work or other activities <u>less carefully than usual</u> | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

| Not at all | A little bit | Moderately | Quite a bit | Extremely |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| ▼ | ▼ | ▼ | ▼ | ▼ |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|--|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| a Have you felt calm and peaceful? | ▼ <input type="checkbox"/> 1 | ▼ <input type="checkbox"/> 2 | ▼ <input type="checkbox"/> 3 | ▼ <input type="checkbox"/> 4 | ▼ <input type="checkbox"/> 5 |
| b Did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| c Have you felt downhearted and depressed? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| ▼ | ▼ | ▼ | ▼ | ▼ |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

Please answer by marking one box in each section for the statement which best applies to you.

| | |
|---|---|
| Pain Intensity | |
| I have no pain at the moment | <input type="checkbox"/> |
| The pain is very mild at the moment | <input type="checkbox"/> |
| The pain is moderate at the moment | <input type="checkbox"/> |
| The pain is fairly severe at the moment | <input type="checkbox"/> |
| The pain is very severe at the moment | <input type="checkbox"/> |
| The pain is the worst imaginable at the moment | <input type="checkbox"/> |
| Personal Care (Washing, Dressing, etc) | |
| I can look after myself normally without causing extra pain | <input type="checkbox"/> |
| I can look after myself normally but it causes extra pain | <input type="checkbox"/> |
| It is painful to look after myself and I am slow and careful | <input type="checkbox"/> |
| I need some help but can manage most of my personal care | <input type="checkbox"/> |
| I need help every day in most aspects of self-care | <input type="checkbox"/> |
| I do not get dressed, wash with difficulty and stay in bed | <input type="checkbox"/> |
| Lifting | |
| I can lift heavy weights without extra pain | <input type="checkbox"/> |
| I can lift heavy weights but it gives me extra pain | <input type="checkbox"/> |
| Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. on a table | <input type="checkbox"/> |
| Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned | <input type="checkbox"/> |
| I can only lift very light weights | <input type="checkbox"/> |
| I cannot lift or carry anything | <input type="checkbox"/> |
| Sleeping | |
| My sleep is never disturbed by pain | <input type="checkbox"/> |
| My sleep is occasionally disturbed by pain | <input type="checkbox"/> |
| Because of pain I have less than 6 hours sleep | <input type="checkbox"/> |
| Because of pain I have less than 4 hours sleep | <input type="checkbox"/> |
| Because of pain I have less than 2 hours sleep | <input type="checkbox"/> |
| Pain prevents me from sleeping at all | <input type="checkbox"/> |
| <p>The following section contains two columns of questions. Please complete the left column if your pain is primarily lumbar / lower back pain. Please complete the right column if your pain is primarily cervical / neck pain. Do not complete both columns.</p> | |
| LUMBAR / LOWER BACK PAIN | CERVICAL / NECK PAIN |
| Walking | Headache |
| Pain does not prevent me walking any distance <input type="checkbox"/> | I have no headaches at all <input type="checkbox"/> |
| Pain prevents me from walking more than 1 mile <input type="checkbox"/> | I have slight headaches that come infrequently <input type="checkbox"/> |
| Pain prevents me from walking more than 1 half mile <input type="checkbox"/> | I have moderate headaches that come infrequently <input type="checkbox"/> |
| Pain prevents me from walking more than 1 quarter mile <input type="checkbox"/> | I have moderate headaches that come frequently <input type="checkbox"/> |
| I can only walking using a stick or crutches <input type="checkbox"/> | I have severe headaches that come frequently <input type="checkbox"/> |
| I am in bed most of the time <input type="checkbox"/> | I have headaches almost all the time <input type="checkbox"/> |
| Sitting | Work |
| I can sit in any chair as long as I like <input type="checkbox"/> | I can do as much work as I want to <input type="checkbox"/> |
| I can only sit in my favorite chair as long as I like <input type="checkbox"/> | I can do my usual work, but no more <input type="checkbox"/> |
| Pain prevents me from sitting more than one hour <input type="checkbox"/> | I can do most of my usual work, but no more <input type="checkbox"/> |
| Pain prevents me from sitting more than 30 minutes <input type="checkbox"/> | I cannot do my usual work <input type="checkbox"/> |
| Pain prevents me from sitting more than 10 minutes <input type="checkbox"/> | I can hardly do any work at all <input type="checkbox"/> |
| Pain prevents me from sitting at all <input type="checkbox"/> | I can't do any work at all <input type="checkbox"/> |

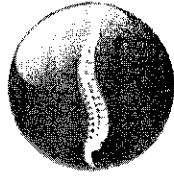
| LUMBAR / LOWER BACK PAIN | CERVICAL / NECK PAIN | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|---|-----------------------|---|---|---|---|----|---|----|---------|--|--|--|--|-----------------------|--|--|--|--|--|
| Standing | Concentration | | | | | | | | | | | | | | | | | | | | | | |
| I can stand as long as I want without extra pain <input type="checkbox"/> | I can concentrate fully when I want to, with no difficulty <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| I can stand as long as I want but it gives me extra pain <input type="checkbox"/> | I can concentrate fully when I want to, with slight difficulty <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents me from standing for more than 1 hour <input type="checkbox"/> | I have a fair degree of difficulty in concentrating when I want to <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents me from standing for more than 30 minutes <input type="checkbox"/> | I have a lot of difficulty in concentrating when I want to <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents me from standing for more than 10 minutes <input type="checkbox"/> | I have a great deal of difficulty of concentrating when I want to <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents me from standing at all <input type="checkbox"/> | I cannot concentrate at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| | Reading | | | | | | | | | | | | | | | | | | | | | | |
| Sex Life (if applicable) | I can read as much as I want to, with no pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My sex life is normal and causes no extra pain <input type="checkbox"/> | I can read as much as I want to, with slight pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My sex life is normal but causes some extra pain <input type="checkbox"/> | I can read as much as I want to, with moderate pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My sex life is nearly normal but is very painful <input type="checkbox"/> | I can't read as much as I want to, because of moderate pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My sex life is severely restricted by pain <input type="checkbox"/> | I can hardly read at all, because of severe pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My sex life is nearly absent because of pain <input type="checkbox"/> | I cannot read at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents any sex life at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| | Driving | | | | | | | | | | | | | | | | | | | | | | |
| Social Life | I can drive my car without neck pain <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My social life is normal and gives no extra pain <input type="checkbox"/> | I can drive my car as long as I want, with slight pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| My social life is normal but increases the degree of pain <input type="checkbox"/> | I can drive my car as long as I want, with moderate pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports <input type="checkbox"/> | I can't drive my car as long as I want, because of moderate pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain has restricted my social life and I do not go out as often <input type="checkbox"/> | I can hardly drive at all, because of severe pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain has restricted my social life to my home <input type="checkbox"/> | I can't drive my car at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| I have no social life because of pain <input type="checkbox"/> | Recreation | | | | | | | | | | | | | | | | | | | | | | |
| | I am able to engage in all my recreation activities, with no neck pain at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Traveling | I am able to engage in all my recreation activities, with some neck pain <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| I can travel anywhere without pain <input type="checkbox"/> | I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| I can travel anywhere but it gives me extra pain <input type="checkbox"/> | I am able to engage in few of my recreation activities, because of pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain is bad but I manage journeys over two hours <input type="checkbox"/> | I can hardly do any recreation activities, because of pain in my neck <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain restricts me to journeys of less than one hour <input type="checkbox"/> | I can't do any recreation activities at all <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| Pain restricts me to short journeys under 30 minutes <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| Pain prevents me from traveling except to receive treatment <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| On average, how bad is your LOWER BACK pain? | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="width:100%; border:none;"> <tr> <td style="text-align:center;">0</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td style="text-align:center;">4</td> <td style="text-align:center;">5</td> <td style="text-align:center;">6</td> <td style="text-align:center;">7</td> <td style="text-align:center;">8</td> <td style="text-align:center;">9</td> <td style="text-align:center;">10</td> </tr> <tr> <td colspan="5">No pain</td> <td colspan="6" style="text-align:right;">Worst Pain Imaginable</td> </tr> </table> | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | No pain | | | | | Worst Pain Imaginable | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | | | | | | | | | | | |
| No pain | | | | | Worst Pain Imaginable | | | | | | | | | | | | | | | | | | |
| On average, how bad is your NECK pain? | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="width:100%; border:none;"> <tr> <td style="text-align:center;">0</td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td style="text-align:center;">4</td> <td style="text-align:center;">5</td> <td style="text-align:center;">6</td> <td style="text-align:center;">7</td> <td style="text-align:center;">8</td> <td style="text-align:center;">9</td> <td style="text-align:center;">10</td> </tr> <tr> <td colspan="5">No pain</td> <td colspan="6" style="text-align:right;">Worst Pain Imaginable</td> </tr> </table> | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | No pain | | | | | Worst Pain Imaginable | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | | | | | | | | | | | |
| No pain | | | | | Worst Pain Imaginable | | | | | | | | | | | | | | | | | | |
| Thank you for completing these questions! | | | | | | | | | | | | | | | | | | | | | | | |

EQ-5D: Please indicate which statements best describe your own health state today by placing a check in one box in each group below.

| | | | |
|---|--------------------------|--|--|
| Mobility | | <ul style="list-style-type: none"> We would like to know how good or bad your health is TODAY. This scale is numbered from 0 to 100. 100 means the best health you can imagine. 0 means the worst health you can imagine. Please circle on the scale to indicate how your health is TODAY. | <p style="text-align: center;">Best Imaginable Health State</p> <p style="text-align: center;">100</p> <p style="text-align: center;">90</p> <p style="text-align: center;">80</p> <p style="text-align: center;">70</p> <p style="text-align: center;">60</p> <p style="text-align: center;">50</p> <p style="text-align: center;">40</p> <p style="text-align: center;">30</p> <p style="text-align: center;">20</p> <p style="text-align: center;">10</p> <p style="text-align: center;">0</p> <p style="text-align: center;">Worst Imaginable Health State</p> |
| I have no problems in walking | <input type="checkbox"/> | | |
| I have slight problems walking | <input type="checkbox"/> | | |
| I have moderate problems walking | <input type="checkbox"/> | | |
| I have severe problems walking | <input type="checkbox"/> | | |
| I am unable to walk | <input type="checkbox"/> | | |
| Self-Care | | | |
| I have no problems washing or dressing myself | <input type="checkbox"/> | | |
| I have slight problems washing or dressing myself | <input type="checkbox"/> | | |
| I have moderate problems washing or dressing myself | <input type="checkbox"/> | | |
| I have severe problems washing or dressing myself | <input type="checkbox"/> | | |
| I am unable to wash or dress myself | <input type="checkbox"/> | | |
| Usual Activities (e.g. work, study, housework, family or leisure activities) | | | |
| I have no problems doing my usual activities | <input type="checkbox"/> | | |
| I have slight problems doing my usual activities | <input type="checkbox"/> | | |
| I have moderate problems doing my usual activities | <input type="checkbox"/> | | |
| I have severe problems doing my usual activities | <input type="checkbox"/> | | |
| I am unable to do my usual activities | <input type="checkbox"/> | | |
| Pain/Discomfort | | | |
| I have no pain or discomfort | <input type="checkbox"/> | | |
| I have slight pain or discomfort | <input type="checkbox"/> | | |
| I have moderate pain or discomfort | <input type="checkbox"/> | | |
| I have severe pain or discomfort | <input type="checkbox"/> | | |
| I have extreme pain or discomfort | <input type="checkbox"/> | | |
| Anxiety/Depression | | | |
| I am not anxious or depressed | <input type="checkbox"/> | | |
| I am slightly anxious or depressed | <input type="checkbox"/> | | |
| I am moderately anxious or depressed | <input type="checkbox"/> | | |
| I am severely anxious or depressed | <input type="checkbox"/> | | |
| I am extremely anxious or depressed | <input type="checkbox"/> | | |

Your own health state today

| | | | |
|--|---|------|------|
| 1) Are you currently working (employed, self-employed)? <i>If yes, skip to question 3. If no, go to next question</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 2) If not, is it because of your spine condition? <i>If this question was applicable skip to question 5</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 3) What is your occupation? <i>If this question was applicable, answer next two questions</i> | | | |
| 4) How many days of work have you missed because of your spinal condition? | <input type="checkbox"/> N/A <input type="checkbox"/> 2 weeks <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years <input type="checkbox"/> >5 years | | |
| 5) How many days of work has your family missed because of your spinal condition? | <input type="checkbox"/> N/A <input type="checkbox"/> 2 weeks <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years <input type="checkbox"/> >5 years | | |
| PATIENT NAME (please print) | SIGNATURE OF PATIENT | DATE | TIME |
| STAFF NAME (please print) (for review of information) | SIGNATURE OF STAFF MEMBER | DATE | TIME |



BEVERLY HILLS SPINE SURGERY

EDWARD NOMOTO, MD
BRIAN PERRI, DO
ALEXANDRE RASOULI, MD
KHAWAR SIDDIQUE, MD
ALBERT WONG, MD

AUTHORIZATION TO COMMUNICATE VIA ELECTRONIC MEANS

Our office prefers the efficiency and convenience of electronic communication. We may send you office reminders, test results, and surgery instructions via the electronic method you prefer. If you agree to communicate with us electronically, please fill out your information below. We will never sell your information to any third party.

Per California law, certain test results such as HIV, cancer, pathology, and STD will not be sent via electronic means.

Fax number _____

EMAIL address _____

Phone number for messages _____

Name (Printed) _____

Signature _____

Date _____

Assignment of Benefits Form

Beverly Hills Spine Surgery Inc.
9663 Santa Monica Blvd Suite 115
Beverly Hills, Ca 90210
Ph#: 310-423-9780
Fax#: 310-423-9819

Patient _____

Employer _____

Claim Group # _____

SS#/ID# _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

**Beverly Hills Spine Surgery Inc.
9663 Santa Monica Blvd Suite 115
Beverly Hills, Ca 90210**

If my current policy prohibits direct payment to Dr. Nomoto, Dr. Perri, Dr. Rasouli, Dr. Siddique and/or Dr. Wong, I hereby also instruct and direct you to make out the check to me and mail it as follows:

**Patient name:
C/O: Beverly Hills Spine Surgery Inc.
9663 Santa Monica Blvd Suite 115
Beverly Hills, Ca 90210**

For the professional or medical expenses benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over an above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Dr. Nomoto, Dr. Perri, Dr. Rasouli, Dr. Siddique and/or Dr. Wong to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____ this _____ day of _____, 20____
(Time) (Month) (Day) (Year)

Signature of Policyholder

Witness

SIMPLE AGREEMENT FORM

Patient authorizes the Doctor to deposit checks received on Patient's account when made out to the patient.

Signature: _____

Date: _____