CEDARS-SINAI®

SPINE CENTER

PATIENT INFORMATION SHEET

❑ 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: ❑ Female ❑ 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:	

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PAIN DRAWING

PATIENT I.D.

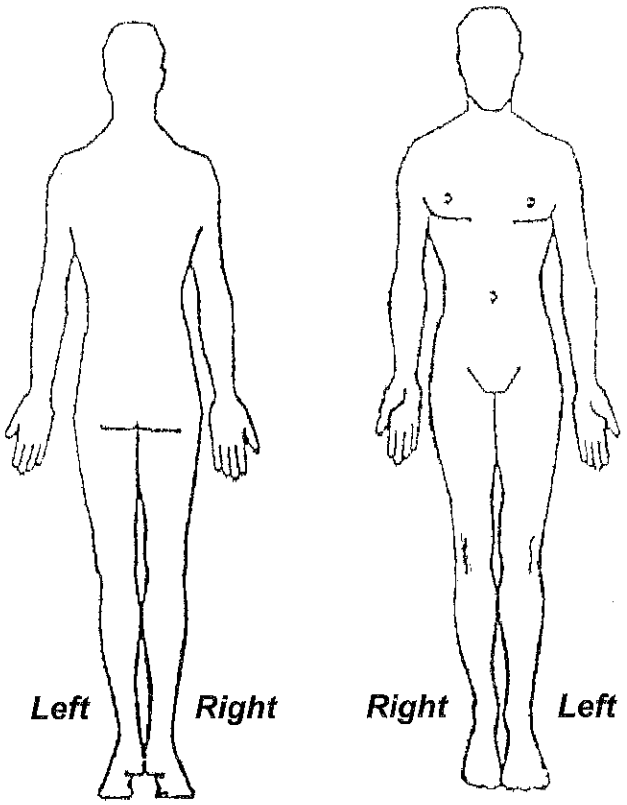
1. **How much pain in general can you tolerate?**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain Imaginable

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?**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain Imaginable

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

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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

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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
- ❑ Hemorroids
- ❑ Indigestion
- ❑ Nausea
- ❑ Poor appetite
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Ulcers
- ❑ Liver problems

Hemotologic / Lympathic
- ❑ 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

Form No. 9734 (Rev. 8/28/14)

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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
☐ 1	☐ 2	☐ 3	☐ 4	☐ 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 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐ 1	☐ 2	☐ 3
b Climbing several flights of stairs	☐ 1	☐ 2	☐ 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 Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Were limited in the kind of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 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 Accomplished less than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Did work or other activities less carefully than usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 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
☐ 1	☐ 2	☐ 3	☐ 4	☐ 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?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c Have you felt downhearted and depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 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
☐ 1	☐ 2	☐ 3	☐ 4	☐ 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	☐
The pain is very mild at the moment	☐
The pain is moderate at the moment	☐
The pain is fairly severe at the moment	☐
The pain is very severe at the moment	☐
The pain is the worst imaginable at the moment	☐
Personal Care (Washing, Dressing, etc)	
I can look after myself normally without causing extra pain	☐
I can look after myself normally but it causes extra pain	☐
It is painful to look after myself and I am slow and careful	☐
I need some help but can manage most of my personal care	☐
I need help every day in most aspects of self□care	☐
I do not get dressed, wash with difficulty and stay in bed	☐
Lifting	
I can lift heavy weights without extra pain	☐
I can lift heavy weights but it gives me extra pain	☐
Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. on a table	☐
Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	☐
I can only lift very light weights	☐
I cannot lift or carry anything	☐
Sleeping	
My sleep is never disturbed by pain	☐
My sleep is occasionally disturbed by pain	☐
Because of pain I have less than 6 hours sleep	☐
Because of pain I have less than 4 hours sleep	☐
Because of pain I have less than 2 hours sleep	☐
Pain prevents me from sleeping at all	☐

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.

LUMBAR / LOWER BACK PAIN		**CERVICAL / NECK PAIN**	
Walking		**Headache**	
Pain does not prevent me walking any distance	☐	I have no headaches at all	☐
Pain prevents me from walking more than 1 mile	☐	I have slight headaches that come infrequently	☐
Pain prevents me from walking more than 1 half mile	☐	I have moderate headaches that come infrequently	☐
Pain prevents me from walking more than 1 quarter mile	☐	I have moderate headaches that come frequently	☐
I can only walking using a stick or crutches	☐	I have severe headaches that come frequently	☐
I am in bed most of the time	☐	I have headaches almost all the time	☐
Sitting		**Work**	
I can sit in any chair as long as I like	☐	I can do as much work as I want to	☐
I can only sit in my favorite chair as long as I like	☐	I can do my usual work, but no more	☐
Pain prevents me from sitting more than one hour	☐	I can do most of my usual work, but no more	☐
Pain prevents me from sitting more than 30 minutes	☐	I cannot do my usual work	☐
Pain prevents me from sitting more than 10 minutes	☐	I can hardly do any work at all	☐
Pain prevents me from sitting at all	☐	I can't do any work at all	☐

LUMBAR / LOWER BACK PAIN

Standing

- I can stand as long as I want without extra pain ☐
- I can stand as long as I want but it gives me extra pain ☐
- Pain prevents me from standing for more than 1 hour ☐
- Pain prevents me from standing for more than 30 minutes ☐
- Pain prevents me from standing for more than 10 minutes ☐
- Pain prevents me from standing at all ☐

Sex Life (if applicable)

- My sex life is normal and causes no extra pain ☐
- My sex life is normal but causes some extra pain ☐
- My sex life is nearly normal but is very painful ☐
- My sex life is severely restricted by pain ☐
- My sex life is nearly absent because of pain ☐
- Pain prevents any sex life at all ☐

Social Life

- My social life is normal and gives no extra pain ☐
- My social life is normal but increases the degree of pain ☐
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sports ☐
- Pain has restricted my social life and I do not go out as often ☐
- Pain has restricted my social life to my home ☐
- I have no social life because of pain ☐

Traveling

- I can travel anywhere without pain ☐
- I can travel anywhere but it gives me extra pain ☐
- Pain is bad but I manage journeys over two hours ☐
- Pain restricts me to journeys of less than one hour ☐
- Pain restricts me to short journeys under 30 minutes ☐
- Pain prevents me from traveling except to receive treatment ☐

CERVICAL / NECK PAIN

Concentration

- I can concentrate fully when I want to, with no difficulty ☐
- I can concentrate fully when I want to, with slight difficulty ☐
- I have a fair degree of difficulty in concentrating when I want to ☐
- I have a lot of difficulty in concentrating when I want to ☐
- I have a great deal of difficulty of concentrating when I want to ☐
- I cannot concentrate at all ☐

Reading

- I can read as much as I want to, with no pain in my neck ☐
- I can read as much as I want to, with slight pain in my neck ☐
- I can read as much as I want to, with moderate pain in my neck ☐
- I can't read as much as I want to, because of moderate pain in my neck ☐
- I can hardly read at all, because of severe pain in my neck ☐
- I cannot read at all ☐

Driving

- I can drive my car without neck pain ☐
- I can drive my car as long as I want, with slight pain in my neck ☐
- I can drive my car as long as I want, with moderate pain in my neck ☐
- I can't drive my car as long as I want, because of moderate pain in my neck ☐
- I can hardly drive at all, because of severe pain in my neck ☐
- I can't drive my car at all ☐

Recreation

- I am able to engage in all my recreation activities, with no neck pain at all ☐
- I am able to engage in all my recreation activities, with some neck pain ☐
- I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck ☐
- I am able to engage in few of my recreation activities, because of pain in my neck ☐
- I can hardly do any recreation activities, because of pain in my neck ☐
- I can't do any recreation activities at all ☐

On average, how bad is your LOWER BACK pain?

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst Pain Imaginable

On average, how bad is your NECK pain?

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst Pain Imaginable

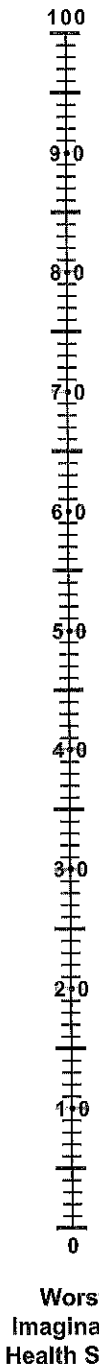
Thank you for completing these questions!

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	
I have no problems in walking	☐
I have slight problems walking	☐
I have moderate problems walking	☐
I have severe problems walking	☐
I am unable to walk	☐
Self-Care	
I have no problems washing or dressing myself	☐
I have slight problems washing or dressing myself	☐
I have moderate problems washing or dressing myself	☐
I have severe problems washing or dressing myself	☐
I am unable to wash or dress myself	☐
Usual Activities (e.g. work, study, housework, family or leisure activities)	
I have no problems doing my usual activities	☐
I have slight problems doing my usual activities	☐
I have moderate problems doing my usual activities	☐
I have severe problems doing my usual activities	☐
I am unable to do my usual activities	☐
Pain/Discomfort	
I have no pain or discomfort	☐
I have slight pain or discomfort	☐
I have moderate pain or discomfort	☐
I have severe pain or discomfort	☐
I have extreme pain or discomfort	☐
Anxiety/Depression	
I am not anxious or depressed	☐
I am slightly anxious or depressed	☐
I am moderately anxious or depressed	☐
I am severely anxious or depressed	☐
I am extremely anxious or depressed	☐

- 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.

Your own health state today



1) Are you currently working (employed, self-employed)?
If yes, skip to question 3. If no, go to next question

- ☐ Yes
- ☐ No

2) If not, is it because of your spine condition?
If this question was applicable skip to question 5

- ☐ Yes
- ☐ No

3) What is your occupation?
If this question was applicable, answer next two questions

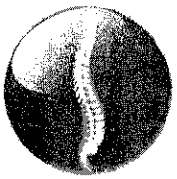
4) How many days of work have you missed because of your spinal condition?

- ☐ N/A
- ☐ 2 weeks
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 6 months
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ 4 years
- ☐ 5 years
- ☐ >5 years

5) How many days of work has your family missed because of your spinal condition?

- ☐ N/A
- ☐ 2 weeks
- ☐ 1 month
- ☐ 2 months
- ☐ 3 months
- ☐ 6 months
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years
- ☐ 4 years
- ☐ 5 years
- ☐ >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: _____