HENRY SARDAR, DO
Physical Medicine, Rehabilitation and Pain Management
Phone: 718-919-1000

Date: _____
(Fecha)

Last Name: _____ **First Name**: _____
(Apellido) (Nombre)

Street Address: _____ **City:** _____ **Zip:** _____
(Direccion)

Date of Birth: _____ **Sex: M or F** **SSN:**_____
(Fecha de nacimiento) (sexo) No. seguro social

Home Phone: _____ **Cell phone:** _____ **Work:** _____
(Telefono de casa) (Celular) (Telefono de trabajo)

Employer:_____**Can we call you at work? Yes or No**
(Donde trabaja?) (Podemos llamarlo a su trabajo?)

Primary Physician:
_____**Phone:**_____
(Doctor primario) (Telefono)

Referring Physician:
_____**Phone:**_____
(Doctor referente) (Telefono)

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PLEASE CHECK ALL YOUR MEDICAL CONDITIONS: (Por favor marquee su condicion medica)

Heart surgery (cirugia del Corazon)
Heart stent (stent cardiac)
Pace maker (marcapaso)
Angina (angina)
Cholesterol (cholesterol)
Difficulty Breathing (dificultad para respirar)
Emphysema (enfisema)
Asthma (asma)
Smoker (fumador/a)
Diabetes(how many years) (diabetic/a por cuanto tiempo?)
Thyroid disease (enfermedad de la tiroide)
Weight loss (perdida de peso)
Weight gain (aumento de peso)
Fever or chills (fiebre o escalofrio)
Fatigue (fatiga)
Stroke (CVA) (derrame cerebral)
Seizure (convulsion)
Dizziness (mareos)
Visual problems (problemas visuals)
Changes in memory (cambios en la memoria)
Frequent cramping (calambres frequentes)
Immunity disorders (desordenes inmunologicos)
Indigestion (indigestion)
Heartburn (acidez)
GI bleed (sangrado gastrointestinal)
Nausea or vomiting (nausea o vomito)
Constipation (estrenimiento)
Hepatitis (hepatitis)what type [ ]
Urinary Incontinence (incontinencia urinaria)
Enlarge Prostate (agrandamiento de la prostata)
Sexual dysfunction (disfuncion sexual)
Cancer (specify) (especifique)
Osteoporosis
Arthritis (arthritis)
Other (otro)_____

Please list all surgeries you have had (Liste las cirugias que ha tenido) **Date** (fecha)

_____ _____

_____ _____

_____ _____

IMPORTANT MEDICAL INFORMATION (*INFORMACION MEDICA IMPORTANTE):*

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Age _____ (Edad) **Height:_____** (Estatura) **Weight: _____** (Peso)

Females: Are you pregnant? Yes / No Mujeres: esta embarazada? Si o no

Social history *(Historia social)*:

Do you smoke? (Usted fuma?) **Yes or NO** Si o No **How much a day? _____** Cuantos cigarillos al dia?

Do you drink alcohol? (Usted toma alcohol?) **Yes or NO** Si o No **How much a day? _____** (Cuanto tragos al dia?)

Do you use recreational drugs or have a problem with substance abuse? Yes or NO
(Usted usa drogas recreativas o tiene algun problema de abuso de sustancias? Si o No

What is your current working status? Employed Un-employed Retired Other _____
(Cual es su estado de trabajo actual? Empleado Desempleado Retirado Otro_____

List allergies to any medications:(Es alergico a algun medicamento?)_____

Are you currently taking Aspirin or any other blood thinners? _____
(Esta usted tomando aspirina o algun otro anticoagulante?)

Please list all your current medications: (Liste los medicamentos que esta tomando)

Name of Drugs **Nombre del medicamento**	**Dosage** **Dosis**	**Frequency(how many times a day)** **Frecuencia**

When did your pain start? _____**Is it related to a Car Accident or Work Injury:** _____

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(Cuando empezo su dolor?) (Esta su dolor relacionado a accidente de auto o trabajo?)

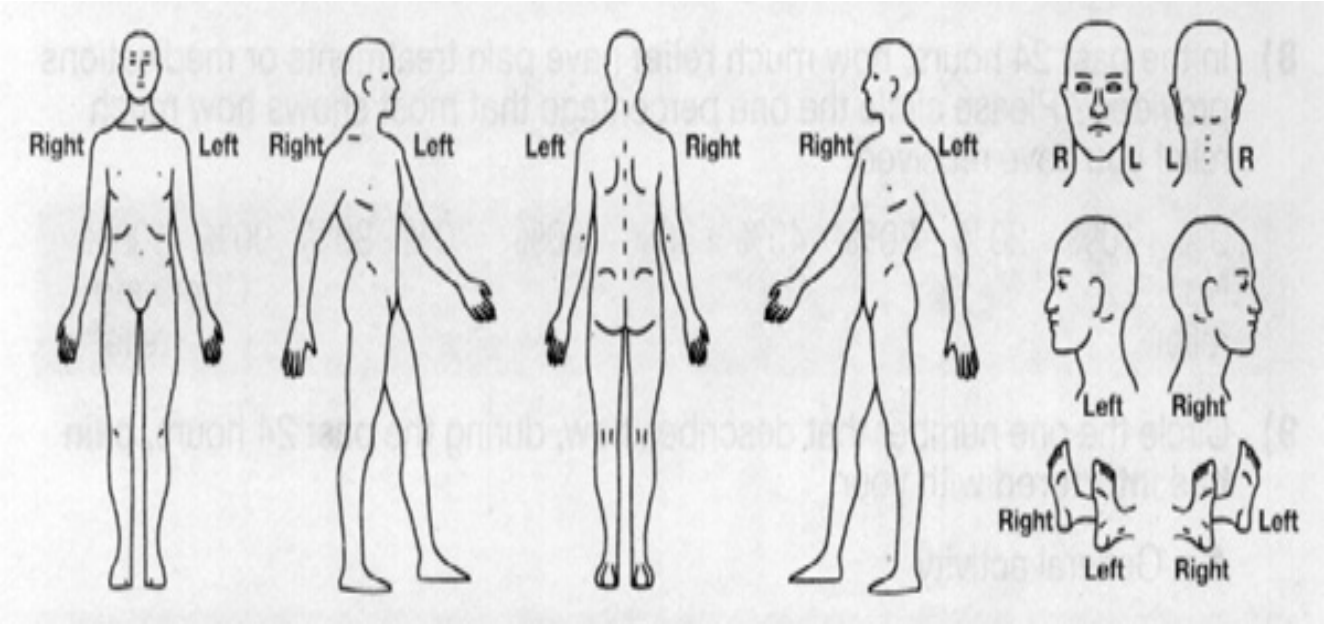
Which words describe the pain? (please circle):
(Describa su dolor)

Throbbing (palpitante) **Aching** (dolor) **Sharp** (punzante) **Dull** (sordo) **Shooting**

Tingling (hormigueo) **Burning** (ardiente) **Numbness** (entumecimiento) **Hot** (caliente)

Cold (frio) **Continuous** (continuo) **Intermittent** (intermitente) **Other** (otro)_____

Location: Please show where your pain is.
(Marque donde le duele).



your Pain on average is: (/out of 10) and when it is at its worst is (/out of 10)
(Cuanto es su dolor regular (/de 10) y cuanto es cuando es peor (/de 10)

What makes the pain worse? (con que empeora el dolor):
_____

What makes the pain better? (con que mejora el dolor):
_____

What pain medication are you taking? _____
Que medicamento para dolor esta tomando?

Does the pain cause you sleep disturbance? (El dolor le causa problemas para dormir?) _____

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Do you think you have depression? (El dolor le causa depression?) _____
Do you think you have anxiety? (El dolor le causa ansiedad?) _____

Does the pain cause you difficulty with: (El dolor le causa dificultad para):

Eating	**Dressing**	**Bathing**	**Getting up from bed/chair**	**Using the toilet**
Comer	Vestirse	Banarse	Levantarse de la cama o silla	Usar el bano.

What treatment have you had for your pain? (circle all that apply):
(Que tratamiento ha tenido para su dolor?)

Acupuncture	Chiropractic	Surgery	Physical Therapy
Acupuntura	Quiropractico	Cirugia	Terapia fisica
Orthopedic	Psychologist	Pain Clinic	Nerve Blocks
Ortopedico	Psicologico	Clinica del dolor	Bloqueo de nervios.

Family History:(Historia familiar):

Please circle or list any serious medical conditions suffered by your immediate family?
(Marque cualquier condicion medica sufrida por su familia?)

Father:Cancer Heart condition Diabetes High blood pressure Other_____
Padre: Cancer Problema del Corazon Diabetes Presion alta Otro_____

Mother: Cancer Heart condition Diabetes High blood pressure Other_____
Madre: Cancer Problema del Corazon Diabetes Presion alta Otro_____

Sibling:Cancer Heart condition Diabetes High blood pressure Other_____
Hnos: Cancer Problema del Corazon Diabetes Presion alta Otro_____

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Treatment Guidelines

This is an agreement **Henry Sardar, D.O. and I regarding the diagnosis of:**

chronic pain

for which the following medication(s) have been prescribed (narcotics):

all prescribed scheduled or controlled substances

I understand that there are alternative treatments, which have been explained to me.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks, which include, but are not limited to:

Addiction
Allergic reactions, overdose, and/or fatal complications
Breathing problems
drowsiness, dizziness, and/or confusion
Impaired judgment and inability to operate machines or drive motor vehicles
Nausea, vomiting and/or constipation
Development of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (See #2)
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will **NOT** be allowed to obtain early refills or receive replacement for lost or stolen medication. Refills will only be provided during regular office hours.
3. I will obtain **ALL** of my prescriptions through: ***Henry Sardar, D.O*** and his associates
4. will fill **ALL** my prescriptions at the same pharmacy
   In an acute emergency, another prescriber may prescribe medications for me, if this occurs, I will notify my primary care physician or nurse practitioner as soon as possible.
5. I will submit to random urine or blood tests if requested by my physician or nurse practitioner to to access my compliance.
6. I agree to see ***Henry Sardar, D.O*** and his associates
   And will keep regularly schedules appointments as long as I am taking this narcotic medication.
7. If I do not follow these guidelines, I understand that my treatment may be terminated.

I have discussed these risks, benefits, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Patient Signature: _____ .
Date: _____

ASSIGNMENT OF BENEFITS

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I hereby authorize Dr. Henry Sardar to submit claims, on my behalf, to the insurance company I provided to them. I hereby certify that the insurance information I have provided is true and accurate as of the date of service and that I am responsible for keeping it updated. I understand that I will be responsible for payment in full if the claim is rejected and no payment is made for any reason including but not limited to; denial for no referral, no preauthorization and no coverage. I understand that Dr. Henry Sardar does not participate with my insurance and there are no out of network benefits, I will be responsible for payment. I agree to pay all indebtedness in a timely manner.

I hereby authorize direct payment of medical and surgical benefits to Dr. Henry Sardar D.O. and Hyland Boulevard Physical Medicine and Rehabilitation for services performed by him or any person under his supervision. I understand that I am financially responsible for any balance not covered by insurance. Any unpaid balance is subject to a finance charge of up to 1.5% interest per month. I agree and understand that any funds I receive by my insurance company due for services rendered will be immediately signed over and sent to Henry Sardar, D.O. and Hyland Boulevar Physical Medicine and Rehabilitation.

Print patient name:_____
Patient's signature:_____ **Date** _____

HIPPA / AUTHORIZATION TO RELEASE INFORMATION

Your protected health information (PHI) will only be used with your consent to provide you treatment, to obtain payment from your health insurer, for case management and care coordination and health care operations. For any disclosure of PHI outside of this consent we will require written authorization from you. We may use or disclose your PHI if law or regulations requires the use or disclosure, such as but not limited to, legal proceedings, workman's compensation laws, and a threat to the health and safety of others.

Your PHI will not be shared with a family member, close friend or any other person without written consent by you. The only exception is for minor children (age 17 and under); the parent or legal guardian will have the right to the information.
You have the right to inspect and obtain a copy of your PHI. You may request an amendment of your PHI for as long as the PHI is maintained in the record. You have the right to request in writing, that we not use any part of your PHI for treatment, payment or health care operations. However, if we believe that the restriction is not in the best interest of either party or we cannot reasonably accommodate the request; we are not required to agree to your request. You have the right to receive confidential communication by alternative means and at alternative locations. For example, you can request your bills be sent to another address.

We cannot control or be held responsible for any third party misuse of your PHI. If you feel that your rights have been violated, please contact the office manager. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Please list all other persons we may speak to on your behalf and their relationship to you (for example parents and spouse):

_____

By signing below, you state that you have read and understand the above information and consent to the use of your PHI as outlined. A photocopy of this shall be considered as effective and valid as the original.

Print patient name:
Signature: . **Date:** _____

If minor, please state relationship to patient: _____