Date:______________ Name: ______________________________ DOB:____________________ Age:________

Handedness: ☐ R ☐ L Sex: ☐ M ☐ F Employer: ______________________ Type of work: ______________________

Did your injury has a gradual onset or a result of an accident? ☐ Gradual ☐ Accident.

Describe your accident: ____

Do you have pain: ☐ Neck **Shoulder:** ☐ R ☐ L **Arms:** ☐ R ☐ L **Elbows:** ☐ R ☐ L **Wrists:** ☐ R ☐ L **Hands:** ☐ R ☐ L

Do you have numbness: **Hands:** ☐ R ☐ L

Do you have weakness: : **Hands:** ☐ R ☐ L

Do you have pain: ☐ **Low back** **Hip:** ☐ R ☐ L **Thighs:** ☐ R ☐ L **Knees:** ☐ R ☐ L **Ankles:** ☐ R ☐ L **Feet:** ☐ R ☐ L

Do you have numbness: **Feet:** ☐ R ☐ L

Do you have weakness: **Feet:** ☐ R ☐ L

Do you have:
- Aggravation at night........... N☐ Y☐
- Pacemaker.............................N ☐ Y☐
- Diabetes.................................N☐ Y☐
- High blood pressure............N☐ Y☐
- Hypothyroid disease.......... N☐ Y☐

Are you taking **anticoagulant** or **blood thinner**? N☐ Y☐ If yes ______________________
Do you consume excessive **alcohol**? N☐ Y☐ If yes, how often?______________________
Have you had **MRI**? N☐ Y☐ If yes, neck , back ______________________
Have you had **surgery**? N☐ Y☐ If yes, neck , back , other area

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FOR OFFICE USE ONLY:

Inspection: Scar :

Atrophy :

Range of motion : ☐ Fx Painful ☐ CS ☐ LS ☐ Other:

Motor Exam : ☐ G ⟹N

Grip : Weaker ☐ R ☐ L

☐ Able : T / H / S

Diff : T / H / S R / L

DTR:

Bic: ☐ T ☐ R ☐ L ☐ 1 + ☐ R ☐ L ☐ 2+ ☐ R ☐ L

Tric: ☐ T ☐ R ☐ L ☐ 1+ ☐ R ☐ L ☐ 2+ ☐ R ☐ L

Kn: ☐ T ☐ R ☐ L ☐ 1 + ☐ R ☐ L ☐ 2+ ☐ R ☐ L

An: ☐ T ☐ R ☐ L ☐ 1+ ☐ R ☐ L ☐ 2+ ☐ R ☐ L

Tinel's Sign:
W − + R / L
E − + R / L

Phalen's Test
− + R / L

Sen: ☐ Int. ☐ Abnl.

SLR: Lying : / Sitting: /

Kamran Hakimian , M.D.

Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means, such as sending a correspondence to the individual's office instead of the individual's home.

I have read, understood and received the HIPAA Notice of Privacy Practices.

I wish to be contacted in the following manner (check all that apply)

____Home Telephone #____________
____Okay to leave detailed information
____Leave only call back name and number
____Okay to fax to home

____Written communication
____ Okay to mail to my home
____ Okay to mail to work/office
____ Okay to fax to office

____Work Telephone #____________
____Okay to leave detailed information
____Leave only call back name and number

____ Cell Phone # ____________
____ Okay to leave detailed information
____ Leave only call back name and number

Patient signature: X__________________________ Date ____________________

Print patient name: _______________________ Date of birth _____________

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Date	Disclosure to whom address or fax #	Description/ purpose of disclosure	By whom disclosed

KAMRAN HAKIMIAN, M.D., INC.
CALIFORNIA SPORT AND REHABILITATION CENTER
American Board of Electrodiagnostic Medicine
American Board of Physical & Rehabilitative Medicine
Fellow, Rheumatology
50 N. La Cienega Blvd. Suite 219, Beverly Hills, CA 90211
Tel. No.: (310) 652 6060; Fax No.: (310) 652 6607

AUTHORIZATION TO RELEASE RECORDS

TO: ______________________________

____

____

I hereby authorized and request that you release to:

Dr.: ______________________________

____

____

all Medical Records in your possession of my illness, examinations and/ or treatment during the period from

______________________________ to ______________________________

Please send M.R.I results of ______________________________

Patient: ______________________________
(Full Name-Previous Name if recently changed)

D.O.B: ____________________

Patient Signature: X ______________________________

Signature of Parent or Guardian if Patient is Minor: ______________________________

Date: ____________________ Witness: ______________________________

AUTHORIZATION TO PAY DOCTOR

I hereby authorize the____
(Insurance Company) to pay by check made out and mailed directly to

____

____

____

the expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

X______________________________
(Signature)

(Do not write in this space; for office use only.)
Policy No.______________________
Agent__________________________
Claims Office Address_____________
____

____
(Street Address)

____
(City) (State)

____
(Date)

PATIENT INFORMATION

PATIENT'S NAME:______________________________ SEX:_____ AGE:_____

ADDRESS: ______________________________ SSN: ________________ BIRTH DATE___/___/___

CITY: ____________ STATE_____ ZIP______ PHONE # HOME: __________ WORK: __________ CELL: __________

DRIVER'S LICENSE #:________________ ETHNICITY:________________ LANGUAGE:________________

SINGLE___ MARRIED___ DIVORCED___ SEPARATED___ EMAIL ADDRESS:________________

EMPLOYER______________________________ SPOUSE'S NAME______________________________

ADDRESS______________________________ SPOUSE'S TELEPHONE #______________________________

CITY____________________ ZIP__________ EMPLOYER TELEPHONE #______________________________

IN CASE OF EMERGENCY CONTACT______________ TEL #__________ RELATION______________

REFERRING PHYSICIAN______________________________ TEL #______________________________

INSURANCE INFORMATION

INSURED'S NAME______________________________ RELATIONSHIP TO PATIENT______________________________

PRIMARY: SECONDARY:

INS. CO.______________________________ INS. CO.______________________________

ADDRESS______________________________ ADDRESS______________________________

I.D. #________________ GROUP #__________ I.D. #________________ GROUP #__________

MEDI-CAL/MEDICARE #______________________ MEDICAL/MEDICARE #______________________

MEDICAL-LEGAL INFORMATION

INSURANCE COMPANY.______________________________ ATTORNEY______________________________

ADDRESS______________________________ ADDRESS______________________________

CITY____________________ ZIP__________ CITY____________________ ZIP__________

TEL #______________________________ TEL #______________________________

CLAIM #______________________________ FAX #______________________________

INS. ADJUSTOR________________ WCAB #________________ DATE OF INJURY________________

AUTHORIZATION

I hereby authorize the above medical Doctor to release any information acquired in the course of my examination and treatment. I also authorize you to send payment to the above physician for any of my medical benefits. I understand I am responsible for any charges not paid by the insurance company. I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise and that this non credit card challenge agreement is irrevocable. I understand that for any outstanding balance on my account, there will be a **$40** monthly late charge fee as well as a **$15** statement fee.

PATIENT'S SIGNATURE: *X*______________________________ **Date:** *X*______________________________