

**Dr. M. Ali Khan, M.D.**

7215 Wyoming Springs, Suite 300A

Round Rock, Texas 78681

Ph. (512) 388-1190 Fax (512) 388-1174

**New Patient History & Intake Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right/Left handed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy (Name & Address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_ Preferred language: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History: (please circle all that apply)**

Anemia, Chronic Diabetes- Non-Insulin Obesity

Anxiety End Stage Renal Disease PBPH

Asthma GERD Prostate Cancer

Irregular Heartbeat Hepatitis Pulmonary Embolism

Bipolar Disorder HIV/AIDS Radiation Therapy

Breast Cancer High Cholesterol Fibromyalgia

Hyperlipidemia Hyperparathyroidism Rheumatoid Arthritis

Ischemic Heart Disease Hypertension Sleep Apnea

Chronic Pain Hyperthyroidism Seizures

Colon Cancer Hypothyroidism Stroke

COPD Leukemia Other: \_\_\_\_\_\_\_\_\_\_\_\_

Coronary Artery Disease Lung Cancer NONE

Deep Vein Thrombosis Lymphoma

Depression Multiple Myeloma

Diabetes- Insulin Dependent Obesity- Morbid

**Past Surgical History: (please circle all that apply)**

Appendix (Appendectomy) Kidney Stone Removal

Breast: Mastectomy Kidney Transplant

**RIGTH – LEFT – BOTH** Liver: Hepatectomy

Breast: Lumpectomy Liver: Liver Transplant

**RIGHT – LEFT - BOTH** Liver: Shunt

Colectomy: Colon Cancer Resection Ovaries Removed: Ovarian Cancer

Colectomy: Diverticulitis Ovaries: Tubal Ligation

Colectomy: IBD Pancreas: Pancreatectomy

Colon: Colostomy Prostate Removed: Prostate Cancer

Gallbladder Removal Prostate Removed: TURP

Gastric Bypass Rectum: ARP

Heart: Biological Valve Replacement Rectum: Low Anterior Resection

Heart: Coronary Artery Skin: Basial Cell Carcinoma

Heat: Transplant Skin: Melanoma

Heart: Mechanical Valve Replacement Skin: Skin Biopsy

Heart: PTCA Skin: Squamous Cell Carcinoma

Hysterectomy Tonsillectomy

Hysterectomy: Caesarean Section Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy: Uterine Cancer NONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy: Cervical Cancer

**Past Orthopedic History: (please circle all that apply)**

Ankle Fracture Polio

Ankylosing Adhesive Spondylitis Primary Bone Sarcoma

Bursitis Psoriatic Arthritis

Capsulitis Rheumatoid Arthritis

Carpal Tunnel Syndrome Ricketts

DISH RSD

Distal Radius Fracture Sciatica

Epidural Injections-Spine Scoliosis

Fracture Spine Fracture

Gout Soft Tissue Sarcoma

Hip Fracture Spinal Stenosis- Cervical

Herniated Nucleus Pulposus- Cervical Spina Stenosis- Lumbar

Herniated Nucleus Pulposus- Lumbar Vertebral Body Compression Fracture

Metastatic Bone Disease Vitamin D Deficiency

Osteoarthritis Wrist Fracture

Osteopenia Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osteoporosis NONE

**Past Orthopedic Surgery: (please circle all that apply)**

Achilles Tendon Repair Knee Arthroscopy

**RIGHT- LEFT- BOTH RIGHT- LEFT - BOTH**

ACL Reconstruction Kyphoplasty/Vertebroplasty

**RIGHT – LEFT- BOTH** Lumbar Fusion

Ankle Fracture ORIF Lumbar Laminectomy

**RIGHT – LEFT – BOTH** Lumbar Spine Surgery: Decompression

Bunion Correction Lumbar Spine Surgery: Decomp. & Fusion

**RIGHT – LEFT – BOTH** Lumbar Spine Surgery: Disc Replacement

Carpal Tunnel Decompression Meniscus Repair

**RIGHT – LEFT – BOTH RIGHT -LEFT - BOTH**

Cervical Spine Surgery: ACDF Reverse Total Shoulder Replacement

Cervical Spine Surgery: Disc Replacement **RIGHT- LEFT - BOTH**

CMC Arthroplasty Reverse Total Knee Arthroplasty

Distal Radius ORIF **RIGHT – LEFT - BOTH**

**RIGHT – LEFT – BOTH** Reverse Total Shoulder Arthroplasty

Ganglion Cyst Excision **RIGHT – LEFT - BOTH**

Intermedullary Nailing Femur Revision Total Hip Arthroplasty

**RIGHT – LEFT – BOTH RIGHT – LEFT - BOTH**

Intermedullary Nailing Tibia Rotator Cuff Repair

**RIGHT – LEFT – BOTH RIGHT – LEFT - BOTH**

Joint Replacement: Hip Shoulder Arthroscopy

**RIGHT – LEFT – BOTH RIGHT – LEFT - BOTH**

Joint Replacement: Knee Trigger Finder Release:

**RIGHT – LEFT – BOTH** Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Joint Replacement: Shoulder Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RIGHT – LEFT – BOTH** NONE

**Social History: (please circle all that apply)**

**Cigarette Smoking:** **Alcohol Use:** **Exercise Level:**

Never Smoked DOES NOT DRINK Several times a day

Quit- Former Smoker Less than 1 drink a day Once a day

Current every day smoker 1-2 drinks a day Few times week

# packs per day: \_\_\_\_\_\_\_ 3 or more drinks a day Few times a month

NEVER

**MEDICATION: (please list all current or check options that applies below)**

* I have a copy of my medication list (please provide copy to front desk receptionist)
* Not currently taking any medications.

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **# times dosage/ per day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies: (please list all known allergies or check option that applies below)**

* I have a copy of my allergies list (please provide copy to front desk receptionist)
* No known Allergies

|  |  |
| --- | --- |
| **Allergy Type** | **Please describe reaction and severity & symptoms** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Family History: (please inform us of family members medical history by checking appropriate box)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | Mother | Father | Brother | Sister | Son | Daughter | Other |
| Hypertension |  |  |  |  |  |  |  |
| Osteoarthritis |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Scoliosis |  |  |  |  |  |  |  |
| Diabetes  Type 1 or 2 |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |



**PATIENT DEMOGRAPHICS**

**Dr. M. Ali Khan, M.D**

**7215 Wyoming Springs**

**Round Rock, TX 78681**

**P: (512)388-1190 F:(512)388-1174**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: F M

Marital Status: Single Married Divorced Separated Widow

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt #: \_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Employers Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PCP or Specialist

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP or Specialist

Other Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PCP or Specialist

**MEDICAL RELEASE OF CONTINUED CARE**

I hereby authorize the release of any medical information necessary to any/all physicians listed above, in regards to my continued care. I permit a copy of this authorization to be used in the place of the original.

**Initial:** \_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

I do hereby consent to necessary examination procedures and/ or treatment by my physician, his/her assistants, and designees as is necessary in his/her judgement.

**Initial:** \_\_\_\_\_\_\_\_



**INSURANCE INFORMATION**

**Dr. M. Ali Khan, M.D**

**7215 Wyoming Springs**

**Round Rock, TX 78681**

**P: (512)388-1190 F:(512)388-1174**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

|  |
| --- |
| Name: Relation: Sex: |
| Address: |
| City, State, Zip Code: |
| Home Phone: Alternate Phone: |
| Soc. Security No: Employer: |

**PRIMARY INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Insurance Carrier: | ID Number: |
| Phone Number: | Group/Policy Number: |
| Address: | City, State, Zip Code: |
| Subscriber’s Name: | Subscriber’s DOB: |
| Relationship to Patient: | Subscriber’s Employer: |

**SECONDARY INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Insurance Carrier: | ID Number: |
| Phone Number: | Group/Policy Number: |
| Address: | City, State, Zip Code: |
| Subscriber’s Name: | Subscriber’s DOB: |
| Relationship to Patient: | Subscriber’s Employer: |

**RELEASE OF MEDICAL INFORMAIOTN**

I hereby authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. **Initial:** \_\_\_\_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefit to signed physician or supplier for services described on health insurance claim forms. I also understand that this assignment of benefits is irrevocable and a photo static copy shall be considered as legal and binding as the original **Initial:** \_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

I have received a copy, read understand Texas Pain and Spine Physician’s Privacy Practices. **Initial:** \_\_\_\_\_\_\_\_

Guarantor Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PRESCRIPTION PICK- UP AUTHORIZATION**

**Dr. M. Ali Khan, M.D**

**7215 Wyoming Springs**

**Round Rock, TX 78681**

**P: (512)388-1190 F:(512)388-1174**

If you would like to give consent to another individual to pick up your prescriptions, please provide that person’s name below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION RELEASE OF MEDICAL INFORMATION**

I give consent for my provider, his/her assistants, to discuss my medical care with the person(s) listed below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please note that the authorized representative(s), listed above must present a valid photo ID upon pick up.**



**PATIENTS RESPONSIBILITIES**

**Dr. M. Ali Khan, M.D**

**7215 Wyoming Springs**

**Round Rock, TX 78681**

**P: (512)388-1190 F:(512)388-1174**

To better serve you and maintain a professional environment, Texas Pain and Spine Physicians has established guidelines to outline patient responsibilities. The guidelines have been established to that our patients can fully benefit from treatment received in our clinic.

Your responsibilities as a patient of our clinic are as follow:

1. Please arrive at least 15 minutes (30 minutes on your first visit) prior to your appointment time for clinic appointments to take care of any insurance issues or required paperwork. If you are 15 minutes or later for your scheduled appointment time and/or your initial paperwork is not completed by your appointment time, your appointment may be rescheduled.
2. We require at least 24 hours’ notice for cancellations and rescheduling of appointments. A missed clinic appointment or appointment for a scheduled procedure without calling to reschedule will be considered a “no call, no show” for the appointment. “No call, no shows” will be charged $25.00 for missed clinic appointments or $100.00 for a missed scheduled procedure. Patients who consistently fail to show up for their scheduled appointments without providing 24-hour advanced notice can be terminated from the program.
3. Prescriptions will only be filled during office hours by appointment only. No prescription will be filled after hours, on weekends, or holidays.
4. State law requires compliance and close monitoring for narcotic medications, if these are prescribed to you, you will be asked to sign a Patient Responsibility Agreement for Controlled Substance Prescriptions.
5. Payment is due at the time services are rendered to the patient. Failure to settle past due balances, pay at the time of service, est., can result in the patient’s termination from the treatment program.

Noncompliance with these guidelines will result in discharge from treatment at Texas Pain and Spine Physicians.

Your signature below constitutes acknowledgement and acceptance of the term of these guidelines.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient/ Legal Guardian Signature of Witness