Dr. Anuj Gupta, MD
2023 W. Vista Way Suite D Vista, CA
92083619-330-8771 (P) / 619-330-8772 (F)
Email: drgupta@sdpainmanagement.com
www.sdpainmangement.com

PATIENT REGISTRATION FORM

Date:_____ EMAIL ADDRESS:_____

Name:_____ _____ _____
Last First Middle Initial

Address:_____

City:_____ State:_____ Zip:_____

Home: ( )_____ Cell Phone: ( )_____

Birth Date: _____ Age:_____ Sex :☐Male ☐Female Ethnicity: _____

Marital Status: :☐ Single☐ Married ☐ Widowed☐ Separated Divorced Race: _____

Patient SS# _____-_____-_____ Occupation:_____

Employer _____ Work Phone: _____

Employer Address _____ City: _____ State:____ Zip:_____

INSURANCE INFORMATION
Primary Insurance Company: _____ Subscriber _____ DOB:_____

ID Number _____ Group Number _____

Secondary Insurance Company _____ Subscriber _____ DOB:_____

ID Number _____ Group Number _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact Information
Name:_____ Relationship:_____

Home Phone:_____ Work Phone: _____

I hereby assign and authorize payment directly to the physician named above of all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for services rendered by physician.

_____ _____ _____
Patient Signature Date Guardian Signature

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patients Name: _____

Patients Date of Birth: _____

I give _____ permission to provide

_____ Medical Records: Dates _____ and/or _____ MRI-XRAY. Dates: _____

to ADVANCED PAIN MANAGEMENT which is to be used for the preparation, review, investigation, evaluation, and handling of medical care. Further, I herby authorize Advanced Pain Management to discuss my medical records with any and all parties involved in my care and/or case, which includes but is not limited to: Insurance companies, ancillary care providers, attorneys, and investigators. This authorization will expire 12 months from the date of signature below.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this authorization. Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by the Federal Patient's Privacy Law, commonly referred to as HIPAA. However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. Client can obtain more information about HIPAA from the U.S Department of Health and Human Services at 200 Independence Avenue. S. W. Washington, D.C 20201. Toll Free: 1-877-696-6775

I have read, agree with, and received a copy of this document. I have the authority to execute this document. My facsimile signature shall have the same force and effect as if it were an original.

_____ _____

Patient/Responsible Party Signature Date

PATIENT NAME:
ATTORNEY NAME:
Do you feel any Radiation? Yes or No
Please describe)

_____

_____

_____

1. ☐ Pain Level __/10 (1 Mild pain 10 serve pain)

2. ☐ Numbness/Tingling

3. ☐ Tension/Spasm/Stiffness

4. ☐ Imbalance w/Walking

5. ☐ Daily routine difficulties on: Bending /Stooping

6. Past Medical History: High Blood Pressure/Diabetes/ Cholesterol Other:

7. Medications:
   ☐ Pain medications:
   ☐ Mediations:

8. Allergies:
   ☐ I do not have any allergic reaction to mediation.
   ☐ I am allergic to certain medication:

   lf taken causes:
   ☐ Vomit/Nausea/Dizziness
   ☐ Other:

9. Bowel or Bladder Dysfunction? No/Yes

10. Work Type:
    ☐Heavy Labor ☐Light Labor ☐ Desk Work ☐ Housewife
    ☐Retired ☐Disabled

11. Bowel or Bladder Dysfunction? No/Yes

12. Cigarette Smoker: No/Yes (if yes estimate daily)
    ☐ More than 1 pack a day
    ☐ 1 pack a day 0 few a day

13. Alcohol Use : No/Yes
If yes estimate daily/week intake:

_____

Onset of Pain:
☐Gradual Onset (gradually over a period of time)
☐Previous pain due to:

_____

_____

_____

☐No History

Pain Trend: Stable/Getting Better/Getting Worse

How Long Can You Comfortably:

Sit: ☐ No Restrictions ☐ < 15min ☐ 15-30min ☐30-60min ☐>60min
Stand: ☐ No Restrictions ☐ < 15min ☐ 15-30min ☐30-60min ☐>60min
Walk: ☐ No Restrictions ☐ < 15min ☐ 15-30min ☐30-60min ☐>60min

Bowel or Bladder Dysfunction? No/Yes

Previous Conservative Management:

☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture ☐ Epidural ☐ Medications

☐ Duration of Treatment: ____ Days/Weeks ☐ Improved/Unimproved/Somewhat

Previous Ortho/Spine Surgery: ☐None ☐Type:

History: (describe accident)

Location of Pain:

2023 W. Vista Way Suite D, Vista CA 92083
Tel:(619)330-8771
Fax:(619)330-8772

ATTORNEY:
ADDRESS:
PHONE:
FAX:

RE: MEDICAL REPORTS, ITEMIZED BILLING AND DOCTOR'S LIEN

FOR:
DATE OF INJURY:

I hereby authorize the above-named health care provider (hereinafter referred to as "the doctor"), to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident and/or incident in which I was involved and have sought medical attention.

I further authorize you, my attorney and /or any subsequent attorney, to pay directly to the doctor such sums as may be due and owing him for medical services rendered to me, both by reason of the accident and I or incident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the doctor, and I hereby give a lien and assignment on my case to the doctor against any and all proceeds of any settlement, judgment or verdict , which may be paid you, my attorney, or myself as result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the doctor for all medical bills submitted by him for services rendered to me and that this agreement is made solely for the doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

I agree that this lien is enforceable against any and/or all subsequent attorney representing me in regard to the accident and I or incident. I further agree that if I change my residence or my attorney, I will notify the doctor within 30 days of such changes including the new attorney 's name, address and telephone number. If I do not notify the doctor within the time prescribed, then all monies will be due and payable immediately . The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and costs incurred in that action or proceeding or in efforts to negotiate the matter.

Patient's Signature: DATE:

The undersigned being the attorney of record for the above patient hereby agrees to observe all terms of this lien and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect the doctor .

Attorney's Signature: DATE

PLEASE DATE, SIGN AND RETURN TO THE DOCTOR'S OFFICE.