RAVI RAMACHANDRAN, M.D.

Folsom Spine

New Patient Registration

If patient is a minor, each parent to fill out a copy of this form.

Patient Information

Last Name, First Name:		Date of Birth:	M / F
SSN:		Single / Married / Divorced / Widowed	
Email:			
Address:		City, State:	Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Emergency Contact Name:		Phone:	

Employment Information

Occupation:	Employer:	
Address:	City, State:	Zip:

Insurance Subscriber / Parent Information

Last Name, First Name:	Date of Birth:	M / F
Address:	City, State:	Zip:
Relation to Patient:		

Insurance Information`

Primary Insurance:	Secondary Insurance:
ID: #	ID: #
Group #:	Group #:
Plan:	Plan:
Primary Care Physician:	Primary Care Physician:
Phone:	Phone:

2330 East Bidwell Street, Suite 100, Folsom, CA 95630 Phone 916 245-3322 Fax 916 245-1150

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Spine History Form

Last Name, First Name: _____ Date of Birth: _____ M / F

Left Handed / Right Handed (circle one) Height: _____ Weight: _____

Referring Provider and Phone # (if different than PCP) : _____

How did you hear about our office? _____

What is the main reason for your visit today? _____

_____

Date start of symptoms or accident: _____

Please describe injury or accident: _____

_____

List other doctors seen for this issue: _____

_____

Are you getting ? (circle one) Better Worse No Change

How severe is your current pain on a scale of 1 to 10 *(ten being unbearable)* ?

1 2 3 4 5 6 7 8 9 10

What makes your pain worse ? _____

What makes your pain less ? _____

Is the pain every day ? Yes No

Does the pain wake you up at night ? Yes No

Does the pain interfere with activities of daily living ? Yes No

Does the pain stay in one spot ? Yes No

Have you had X-rays or other imaging studies ? Yes No

If Yes: What part of your body was imaged ? _____

When and Where were studies performed ? _____

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Pain Management Procedure Update

How much relief did you get on a scale of 1 to 10 *(ten being total relief)* ?

Injection Type	Dates	Last Date	Physician	Relief	Duration
Epidural					
Transforaminal					
Facet					
Medial Branch					
Trigger Point					
Acupuncture					
Radio Frequency					
Other					
Comments:					

How severe is your current pain on a scale of 1 to 10 *(ten being unbearable)* ?

1 2 3 4 5 6 7 8 9 10

Does the pain affect your sleep ? Yes No

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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Physical Therapy Update

How much relief did you get on a scale of 1 to 10 *(ten being total relief)* ?

Therapy Type	Dates	Last Date	Facility	Relief	Duration
Physical Therapy					
Aqua Therapy					
Massage					
Chiropractic					
Acupressure					
Inversion					
Other					
Comments:					

How severe is your current pain on a scale of 1 to 10 *(ten being unbearable)* ?

1 2 3 4 5 6 7 8 9 10

Does the pain affect your sleep ? Yes No

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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Medication List

In order to provide the safest patient care possible, please list all the medications / therapeutics you are taking whether prescription, non-prescription (over-the-counter), herbal, vitamin or Cannabis.

Please complete this form and sign below. If no Medications Check This Box. **None:** ☐

Medication	Strength / Dosage	Frequency (Times per day or Days)

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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Medical History

Allergy Information

Medication	Reaction	Medication	Reaction

Personal History

Type of Illness	Yes	No	Type of Illness	Yes	No	Type of Illness	Yes	No
Asthma / COPD			Addiction			Chest Pain with Activity		
Home oxygen			Cancer (_____)			High Blood Pressure		
Short of Breath			MRSA			High Cholesterol		
Diabetes			Bleeding / Anesthesia			Heart Attack		
Thyroid			Anxiety / Depression			Heart Valve		
Autoimmune Disease			Sleep Disorder			Arrhythmia / Palpitations		
Chronic Steroid Use			GERD / Reflux			CHF (Heart Failure)		
Seizure			Liver Disease			Cardiomyopathy		
Stroke / CVA / TIA			Kidney Disease			Pacemaker / AICD		
Muscle Disease			Other Medical Issues			Syncope / Fainting		

Details:

Surgical Information

Surgery	Date

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Personal Review of Symptoms

Pulmonary	Yes	No
Productive Cough		
Blood In Sputum		
Wheezing		
Loud Snoring		
Night Breathing Pauses		
Breathing Device		
Constitutional		
Fever / Chills		
Night Sweats		
Appetite Loss / Gain		
Weight Loss / Gain		
Daytime Fatigue		
Sleep Disturbance		
GI		
Nausea / Vomiting		
Indigestion / Reflux		
Constipation / Diarrhea		
Blood in Stool		
Loss of Bowel Control		
Abdominal Pain		
Gastric Bypass		
Psychiatric		
Anxiety / Depression		
Mood Swings		
Paranoia		
Thoughts of Self Harm		

Cardiac	Yes	No
Chest Pain		
Palpitations / Arrhythmia		
Heart Racing		
Irregular Heart Rate		
Shortness of Breath		
Heart Murmur		
Ankle / Leg Swelling		
Skeletal / Skin		
Joint Pain / Stiffness		
Swelling / Rash		
Skin Disease / Cysts		
Discolor / Pigmentation		
Wounds / Pressure Sore		
Assistance Device		
GU		
Urine Difficulty / Blood		
Urine Frequency / Pain		
Loss of Urine Control		
Impotence		
Kidney Stones		
Prostate Issues		
Genital Sores / Lesions		
Eyes		
Vision Double / Blurred		
Eye Pain / Itching		
Light Sensitivity		

Neuro	Yes	No
Epilepsy / Convulsions		
Paresthesias / Numbness		
Neuropathy		
Balance Issues		
Memory Loss		
Headaches		
Fainting / Light Headed		
Dizziness / Vertigo		
Weakness / Paralysis		
ENT		
Ear Pain / Discharge		
Hearing Loss		
Sore Throat / Cough		
Hoarseness		
Sinus Problems		
Heme / Other		
Infection		
Nose / Gum Bleeding		
Bruise Easily		
Bleeds Easily		
Abnormal Blood Clots		
Anesthesia Reaction		
Endocrine		
Heat / Cold Sensitivity		
Hair Loss		
Increased thirst		

Details:

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Social History

Family History

Type of Illness	Yes	No	Relative	Type of Illness	Yes	No	Relative
Diabetes				Addiction			
Stroke				Cancer(_____)			
Heart Disease				MRSA			
High Blood Pressure				Bleeding / Anesthesia			

Recreational History

Tobacco:	Yes	No	Cigarettes	Cigar	Chewing	Vape	Other	Frequency:
Alcohol:	Yes	No	Wine	Beer	Liquor	Mixed	Other	Frequency:
Substances:	Yes	No	Marijuana	Cocaine	Amphetamine	Other		Frequency:
Exercise:	Yes	No	Gym	Cycle	Jog/Run	Other	Type:	Frequency:

Disability Information

Are You Disabled?	Yes	No	Date of Disability:
Briefly Explain:			

Household Information

Marital Status: Married Single Widowed Divorced

Number of People in Household (including children):

List names of the people who live in your household along with the information listed.

Name	Age	Relation to You	Occupation

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RAVI RAMACHANDRAN, M.D.

Folsom Spine

Financial Consent

Financial Agreement

"I, the undersigned, have insurance coverage with_____ (name of insurance company), and assign directly to Folsom Spine all medical benefits, if any, otherwise payable to me for services rendered. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment for services. I authorize Ravi Ramachandran, M.D., to perform any medical treatment as deemed medically necessary and appropriate. I authorize the use of this signature on all my insurance submissions."

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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RAVI RAMACHANDRAN, M.D.

Folsom Spine

Privacy Consent

Use and Disclosure of Protected Health Information

With my consent, the office of Folsom Spine may use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**HOP**). Please refer to the office Notice of Privacy Practices for a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Folsom Spine reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Privacy Officer
Folsom Spine
2330 East Bidwell Street Suite 100
Folsom, CA 95630

With my consent the office of Folsom Spine may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **HOP**, such as appointment reminders, insurance items or any call pertaining to my clinical care, including laboratory results among others.

I authorize any holder of medical information about me to release information to any of the following: my insurance company; the Social Security Administration; Medicare program or its intermediaries / carriers; and professional review organizations. This includes information needed for processing and payment of insurance claims.

With my consent the office of Folsom Spine may mail to my home or other designated location any items that assist the practice in carrying out **HOP**, such as appointment reminders and patient statements. I have the right to request that the office of Folsom Spine restrict how it uses or discloses my **PHI** to carry out **HOP**. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Folsom Spine to the use and disclosure of my **PHI** to carry out treatment, payment and health operations. This is a life time authorization.

_____ (Patient / Guardian Initials)

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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RAVI RAMACHANDRAN, M.D.

Folsom Spine

Release of Medical Records Authorization

To Folsom Spine

Patient Information

Last Name, First Name:	Date of Birth:	M / F
Address:	City, State:	Zip:
Phone:		

Healthcare Provider Authorized to Disclose Information

Name:		
Address:	City, State:	Zip:
Phone:	Fax :	

Healthcare Provider Authorized to Receive Information

Name:	**Ravi Ramachandran, M.D. / Folsom Spine**			
Address:	**2330 East Bidwell Street Suite #100**	City, State:	**Folsom, CA**	Zip: **95630**
Phone:	**(916) 245-3322**	Fax :	**(916) 245-1150**	

Specific Information to be Disclosed

☐ Entire Medical Record, including patient histories, office notes. Test results, radiology studies, films, referrals, consults billing records, insurance records, and records received from other health care providers

☐ Other:

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Release of Medical Records Authorization

(continued)

Reason for Information Disclosure

(choose all that apply)

☐	Treatment / Continuing Medical Care
☐	Personal Use
☐	Billing of Claims
☐	Insurance
☐	Legal Purposes
☐	Disability Determination
☐	School
☐	Employment
☐	Other

Signature Authorization: I have read this form and voluntarily agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation, or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that I can revoke this Authorization at any time, and have the right to receive a copy of this form.

Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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RAVI RAMACHANDRAN, M.D.

Folsom Spine

Release of Medical Records Authorization

From Folsom Spine

Patient Information

Last Name, First Name:	Date of Birth:	M / F
Address:	City, State:	Zip:
Phone:		

Healthcare Provider Authorized to Disclose Information

Name:	**Ravi Ramachandran, M.D. / Folsom Spine**			
Address:	**2330 East Bidwell Street Suite #100**	City, State:	**Folsom, CA**	Zip: **95630**
Phone:	**(916) 245-3322**	Fax :	**(916) 245-1150**	

Healthcare Provider Authorized to Receive Information

Name:		
Address:	City, State:	Zip:
Phone:	Fax :	

Specific Information to be Disclosed

☐ Entire Medical Record, including patient histories, office notes. Test results, radiology studies, films, referrals, consults billing records, insurance records, and records received from other health care providers

☐ Other:

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Folsom Spine

Release of Medical Records Authorization

(continued)

Reason for Information Disclosure

(choose all that apply)

☐	Treatment / Continuing Medical Care
☐	Personal Use
☐	Billing of Claims
☐	Insurance
☐	Legal Purposes
☐	Disability Determination
☐	School
☐	Employment
☐	Other

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Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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Release of Medical Records Authorization

Patient Information

Last Name, First Name:	Date of Birth:	M / F
Address:	City, State:	Zip:
Phone:		

Healthcare Provider Authorized to Disclose Information

Name:		
Address:	City, State:	Zip:
Phone:	Fax :	

Healthcare Provider Authorized to Receive Information

Name:		
Address:	City, State:	Zip:
Phone:	Fax :	

Specific Information to be Disclosed

☐ Entire Medical Record, including patient histories, office notes. Test results, radiology studies, films, referrals, consults billing records, insurance records, and records received from other health care providers

☐ Other:

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Release of Medical Records Authorization

(continued)

Reason for Information Disclosure

(choose all that apply)

☐	Treatment / Continuing Medical Care
☐	Personal Use
☐	Billing of Claims
☐	Insurance
☐	Legal Purposes
☐	Disability Determination
☐	School
☐	Employment
☐	Other

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Date _____ Printed Name _____ Signature _____

Relationship if Other than Patient: _____

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