Steward
MEDICAL GROUP
EMPLOYED PHYSICIAN GROUPS

Date: _____

Physician/Provider being seen today: _____

PATIENT INFORMATION

Patient Last Name	First Name	Middle Name		
Gender M F / DOB / /	Social Sec. #	Cell Phone	Home Phone	
Address	City	State	Zip	
Occupation	Employer	Business Phone		
Employer Address	City	State	Zip	
Driver License #	Email Address : *I would prefer not to receive periodic health information.* ☐	Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated		

Race and ethnicity questions are asked in order to identify additional care needs of our diverse patient population and is not used to discriminate in any manner.

☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Multiracial ☐ Other ☐ American Indian/Alaska Native

Preferred Language	Name and Address of Referring Physician

Emergency Contact Information (Full Name/Relationship to Patient):	Date of Birth / /	Relationship To Patient ☐ Spouse ☐ Child ☐ Other: _____	Phone (REQUIRED)

Authorization for telephone, cell phone and/or electronic communications:
I authorize the Physician Group of Utah and all third-party providers and practitioners who provide health care services to me, along with their billing and collection agents to contact me on my cell phone and/or home phone, including through the use of pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other computer assisted technology, or by electronic mail, text messaging or any other form of electronic communication for the purposes of payment for services or for health care related notice. ☐ Agree ☐ Decline

RESPONSIBLE PARTY INFORMATION

Relationship To Patient ☐ Self ☐ Spouse ☐ Child ☐ Other: _____	Last Name	First Name	Home Phone	
Billing Address	City	State	Zip	
Social Sec. #	Date of Birth	Employer	Business Phone	
Employer Address	City	State	Zip	
Spouse First Name (and last if different)	Employer	Phone		

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES)

Primary Insurance Company	Co-pay Amount	Policyholder Name	DOB / /	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Insurance Company Address			Effective Date:	Phone
Policy #	Group #	Group Name		
2nd Insurance Company	Co-pay Amount	Policyholder Name	DOB / /	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Insurance Company Address			Effective Date:	Phone
Group #	Policy #			

IS THIS A SCHOOL, WORK, OR AUTO RELATED INJURY? (IF SO, PLEASE FILL OUT COMPLETELY)

Reason for Visit?	What type of injury are we seeing you for? (indicate right or left if appropriate)		
Was this an: ☐ Accident ☐ Injury	Date of accident or injury / /	Place of Accident: ☐ Work ☐ Auto ☐ Home ☐ School ☐ Other: _____	
Name of School	Sport/Activity	How was injury sustained?	
Is this employment related? Yes ☐ No ☐ If so, who is your company's industrial carrier?		Claim Number	
Name of Address of Place of Injury:		Adjuster Name and Phone Number	

Patient name: Last, First, MI	Date of birth mm/dd/yyyy	Medical Record #

As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this Physician Group of Utah (PGU) Facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient. In partial consideration of health care services to be provided to the Patient in the PGU Facility, including IASIS Healthcare and its affiliates.

CONSENT FOR SERVICES: I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for services they perform.

INDEPENDENT CONTRACTORS: I understand that some physicians and other health care providers furnishing service to the Patient, including residents, interns and other persons in training may be independent contractors and not employees of PGU; and such employees are subject to provisions of the Utah Governmental Immunity Act, UCA 63-30-1, et seq., U.C.A. 1953 as amended, which controls all procedures and provisions with respect to any claim of liability or malpractice involving such individuals.

ASSIGNMENT OF BENEFITS: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understand and intend that all insurance companies and other third party payers will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

FINANCIAL RESPONSIBILITY: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all copayments, deductibles, co-insurance, and/ or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree than any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay a 20% collection fee, all costs and reasonable attorney's fees in connection with the collection process. As a courtesy to our personal pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available.

MEDICARE/MEDICAID/TRICARE PATIENT'S CERTIFICATION: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

RELEASE OF INFORMATION: The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice Of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

The undersigned signs this document either as the Patient or the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

The purpose of this Authorization and Release form is for your protection. The H.I.P.A.A. (Health Insurance Portability Accountability Act) of 1996 was created with the sole purpose and goal of protecting patients' medical records and financial information. We urge you to complete this form to allow us to better serve and protect your private information. We appreciate your attention to this sensitive matter. Please be specific when designating your choices.

I authorize the staff of Physician Group of Utah, Inc. to release any FINANCIAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Physician Group of Utah, Inc. to release any MEDICAL INFORMATION to the following people:

_____

_____

_____

I authorize the staff of Physician Group of Utah Inc. to leave laboratory or radiology tests results on my voice mail at the following telephone numbers:

HOME: _____

CELL: _____

NOTIFICATION OF PHYSICIAN OWNERSHIP

You may be referred for an ancillary service at one of our IASIS Utah hospitals or facilities. A number of our physicians have ownership in one of our IASIS hospitals. We want you to know you are free to choose where you go for your healthcare services that are delivered outside our clinic.

You were previously given a document explaining our physician ownership and listing those physicians who are owners. That document is saved in your personal health record. If you would like to review this document or receive more information, please ask a reception staff member.

Patient initial here: _____

DATE: _____ SIGNATURE: _____

WITNESS TO SIGNATURE: _____ RELATIONSHIP IF OTHER THAN PATIENT: _____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF PGU'S NOTICE OF PRIVACY PRACTICE.
DATE: _____ INITIALS: _____

Armen Khachatryan, MD
Dr. "K"

General Health Information

Name: _____ **Date of Appt:**_____
Date of Birth:____/____/____**Age:**_____F___M___ **Phone#**_____

Address:_____
Referring Doctor:_____**Primary Care Doctor:**_____
Names of Doctors who have treated your pain so far: _____
Chief Complaints (Medical Problems that brought you here)
1. _____
2. _____
Allergies: _____
Medicines:(Name and Dosage)_____
Surgeries: What and When? Any Complications? _____
_____
Other Medical Problems? _____
_____
Family History (Cancer, Diabetes, Hypertension, Stroke, etc.)
Father: _____ Mother: _____
Siblings: _____ Children: _____
Social History
Married ___ Single ___ Widowed ___ Divorced ____ Occupation _____
Smoke: No ___ Yes ___ Packs/ Day ___ Alcohol: Yes ___ No ___ How much _____

System Review

Height:_____ **Weight:**_____ **L R Handed**

Circle All That Apply:

General
Weight Loss
Weight Gain
Fever
Chills
Night Sweats

Skin
Rashes
Skin Cancer
Other Lesions

Head
Headache
Dizziness
Syncope

Eyes
Cataracts
Glaucoma
Double Vision

Ears
Pain
Infections
Hearing Loss

Respiratory
Chest Pain
Cough
Difficulty
Breathing
Pneumonia

Cardiovascular
Angina
Irregular Heart
Beat
Palpitation
Leg Cramps

Gastrointestinal
Indigestion
Stomach Ulcer
Diarrhea
Constipation
Dark
(or Black) Stool

Genitourinary
Frequent
Urination
Painful Urination
Loss of
Bladder Control

Musculoskeletal
Back Pain
Arthritis
Joint Pain
Broken Bones
Muscle Wasting

Vascular
Varicose Veins
Blood Clot
Easily Bruised

Neuropsychiatric
Syncope
Seizure
Memory
Problems
Depression

Armen Khachatryan, MD
Dr. "K"

NEW PATIENT QUESTIONAIRE

CURRENT SYMPTOMS

Briefly describe your current complaints: _____

_____

How and when did the problem begin? (gradually or suddenly?): _____

_____

TREATMENTS

Have you been seen by another doctor for this spinal condition? **YES** **NO**

SURGERY – Describe any surgeries you may have had for this problem.

Type _____ Type _____

Surgeon _____ Surgeon _____

Date _____ Date _____

MEDICINES FOR CURRENT PROBLEM			*Type?*	*Amt/day?*	*How long?*
Narcotics	**YES**	**NO**			
Muscle Relaxants	**YES**	**NO**			
Anti-inflammatory	**YES**	**NO**			

HAVE YOU WORN BRACES OR CORSETS? **YES** **NO**

PHYSICAL THERAPY? **YES** **NO** *Improvement from Therapy?* **YES** **NO**

Prescribed by whom? _____

Visits per week_____ how many weeks _____date of last visit _____

Types of therapy?

1 Active exercise **1** Home Exercise **1** Pool Therapy

1 Stretching **1** TENS Unit **1** Traction

HAVE YOU BEEN SEEN BY SPECIALIST FOR PAIN? **YES** **NO**

Name of facility: _____

Name of Specialist: _____

Did your ability to cope with pain improve? **YES** **NO**

INJECTIONS

1 Epidural steroids **1** Facet blocks **1** Other type of injections _____

How many times? _____ Did they provide relief? **YES** **NO**

For how long? _____ Date of last injection? _____

CHIROPRACTIC TREATMENTS

How many visits? _____ Did they Provide Relief? **YES** **NO**

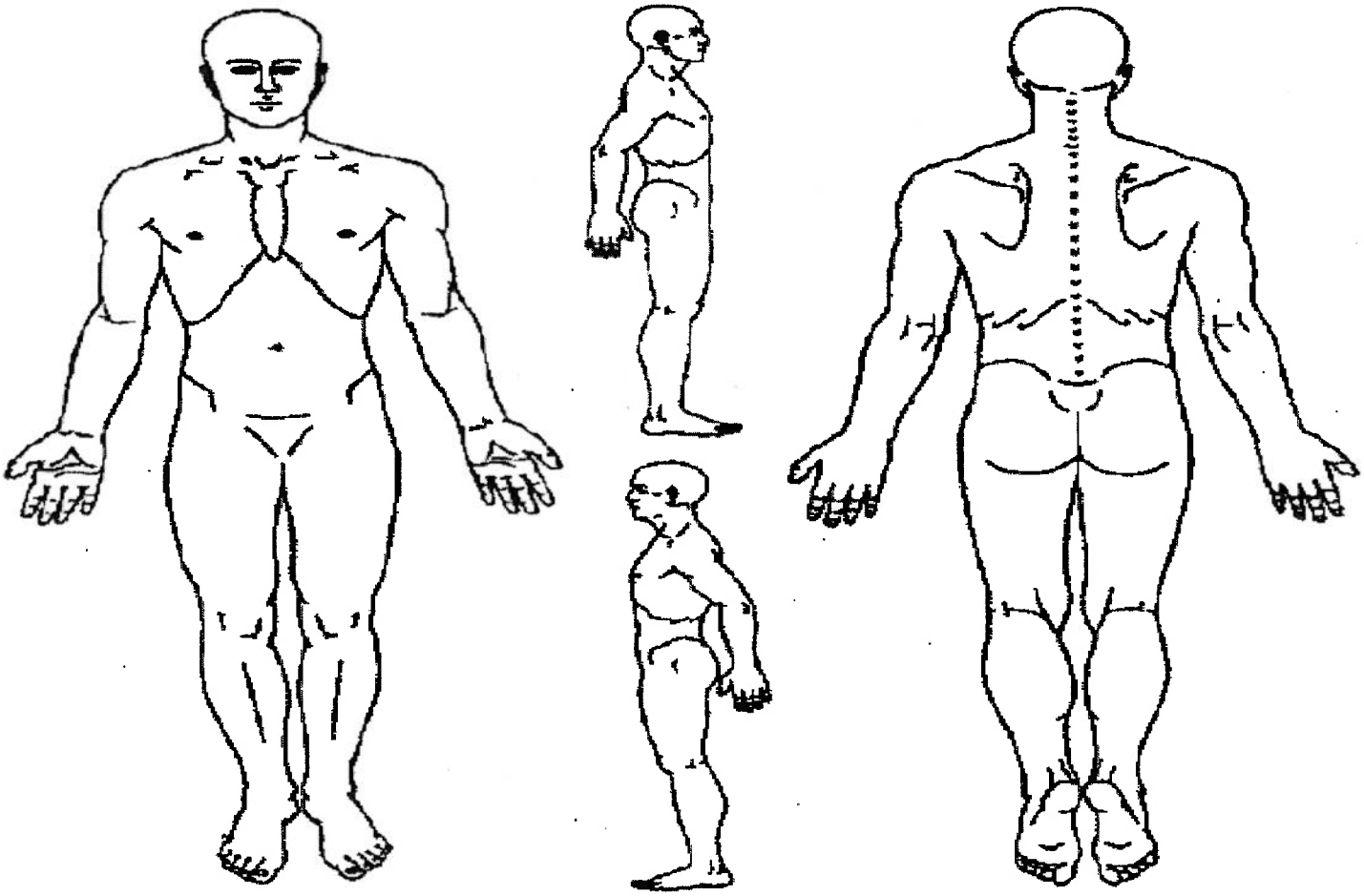
Steward

Armen Khachatryan, MD
Dr. "K"

Which is more troublesome to you? (Circle) *Neck/Back* *or* *Arm/Leg* *or* *Equal*

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols shown below. Mark the areas of radiation. Include all affected areas.

Ache ^ ^ ^ ^ ^ ^ ^ ^ ^ Numbness o o o o o o o o o Pins & Needles = = = = = = = = = Stabbing / / / / / / / / /



Distribution of pain (Total should equal 100%)

Neck/Back Pain _____% Right Arm/Leg _____% Left Arm/Leg _____%

How bad is your neck/back pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad is your Right Arm/Leg pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

How bad is your Left Arm/Leg pain now? (Circle one)
No Pain 1 2 3 4 5 6 7 8 9 10 Worst Possible

Since your pain first began, is your pain now ____Better ____ Same ____Worse