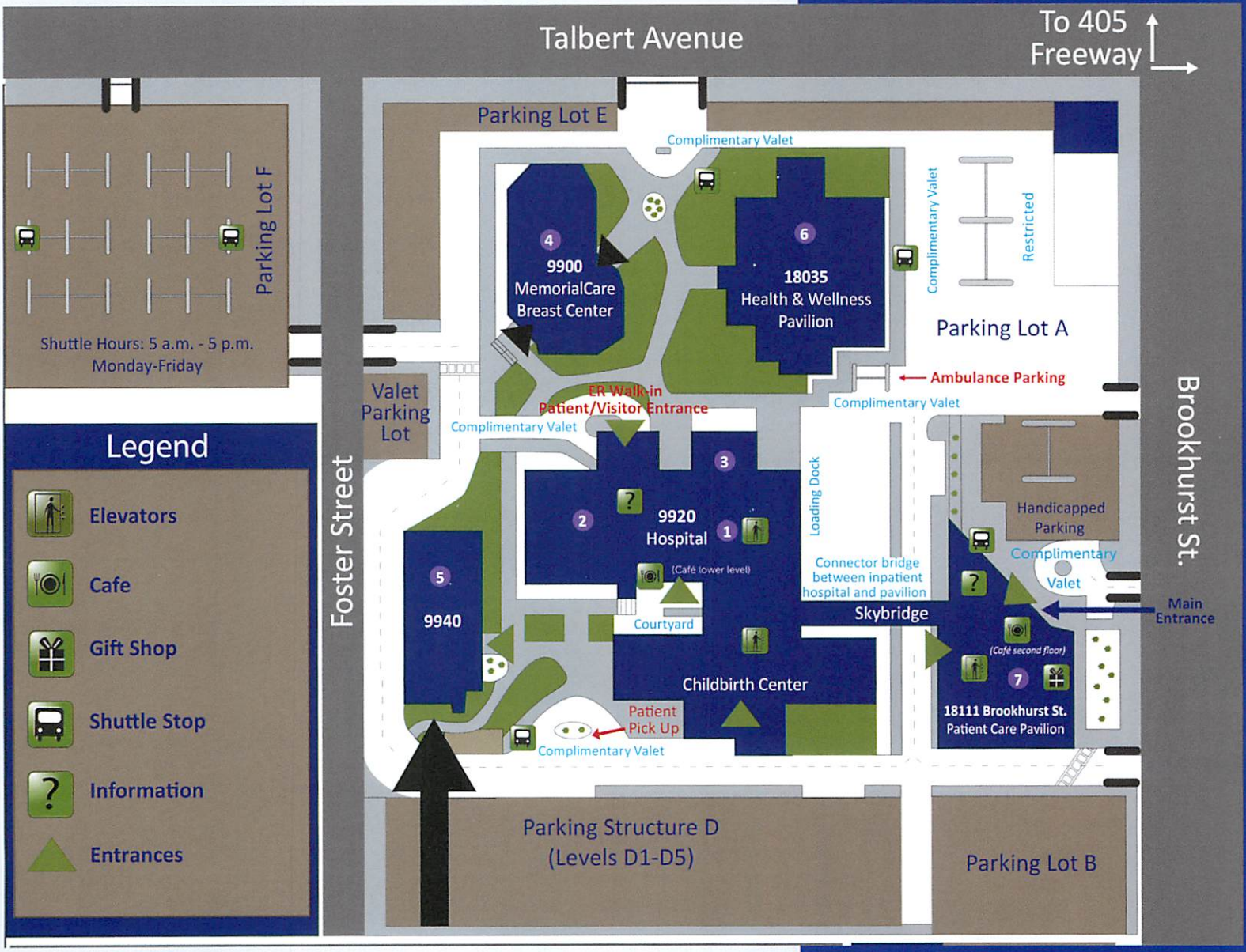
Brain & Elective Spine Treatment Center
Dr. Devin K. Binder
9940 Talbert Ave., Suite 201
Fountain Valley, CA 92708
Tel: 949-829-2378 Fax: 714-769-6121

MemorialCare™
Orange Coast Medical Center



Parking directions: You may park in Structure D or use complimentary valet parking.

Please bring your

- ☑ Insurance card
- ☑ Patient forms
- ☑ Imaging disc(s)
- ☑ Radiology reports
- ☑ Diagnostic test results

B.E.S.T. CENTER
BRAIN & ELECTIVE SPINE TREATMENT

Appointment Date/Time:

Initials: _____

PERSONAL INJURY PATIENT INFORMATION					
DATE	**LAST NAME**		**FIRST NAME**		**MIDDLE INITIAL**
ADDRESS		**CITY**		**STATE**	**ZIP CODE**
DATE OF BIRTH	**AGE**	**GENDER**	**HOME PHONE**	**CELL PHONE**	
EMAIL			**DATE OF INJURY**		

DESCRIBE THE DETAILS OF THE ACCIDENT AND YOUR INJURY (*e.g.* place, time, impact type, *etc.*):

WERE YOU THE DRIVER? ☐ **YES** ☐ **NO**	**WERE YOU THE ONLY ONE IN THE CAR?** ☐ **YES** ☐ **NO** **IF NOT, WHO WAS WITH YOU?**
DID THE AIRBAGS DEPLOY? ☐ **YES** ☐ **NO**	**DID YOU LOSE CONCIOUSNESS?** ☐ **YES** ☐ **NO**
WERE YOU TAKEN TO THE HOSPITAL? ☐ **YES** ☐ **NO**	**IF SO, HOW?**

DESCRIBE YOUR SYMPTOMS RIGHT AFTER THE ACCIDENT:

PLEASE RATE YOUR PAIN BY CIRCLING THE ONE NUMBER THAT BEST DESCRIBES YOUR PAIN IMMEDIATELY AFTER THE ACCIDENT.

NONE SEVERE

0 1 2 3 4 5 6 7 8 9 10

PREVIOUS INJURIES:

Initials: _____

DESCRIBE YOUR <u>CURRENT</u> SYMPTOMS AS OF TODAY:

PLEASE RATE YOUR PAIN BY CIRCLING THE ONE NUMBER THAT BEST DESCRIBES YOUR PAIN TODAY.
NONE SEVERE
0 1 2 3 4 5 6 7 8 9 10

CONSERVATIVE THERAPIES TRIED: PHYSICAL THERAPY X____MONTHS, STEROID INJECTIONS X_____, PAIN MEDICATIONS X____ MONTHS, CHIROPRACTIC X_____MONTHS, ACUPUNCTURE X____MONTHS

OTHER: PAIN MEDICATIONS X____MONTHS
PLEASE LIST THE PAIN MEDICATIONS THAT YOU HAVE TRIED:
_____

CURRENT MEDICATIONS	DOSE, ROUTE, AND FREQUENCY

ALLERGIES TO MEDICATION	TYPE OF REACTION

PREFERRED PHARMACY

NAME	ADDRESS	PHONE

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

BACK PAIN / LEG PAIN / NECK PAIN / ARM PAIN	TREMOR / STIFFNESS / FALLS
LOSS OF CONSCIOUSNESS / SEIZURES	DIZZINESS / HEADACHES
NUMBNESS / WEAKNESS / TINGLING	BLURRED VISION / DOUBLE VISION
EAR PAIN / NOSE BLEEDS / SORE THROAT	CHEST PAIN / PALPITATIONS
SHORTNESS OF BREATH / COUGHING / WHEEZING	NAUSEA / VOMITING / DIARRHEA
URINARY / BOWEL INCONTINENCE	DEPRESSION / MANIA
FEVER / NIGHT SWEATS / CHILLS	OTHER:

Initials: _____

PREVIOUS SURGERIES (PLEASE LIST DATES IF POSSIBLE)

CHRONIC MEDICAL CONDITIONS (*e.g.* DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL)

FAMILY MEDICAL HISTORY (*e.g.* CANCER, DIABETES, HEART ATTACK, STROKE)

SOCIAL HISTORY		
MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**	**OCCUPATION**	
EMPLOYED: ☐ **FULL TIME** ☐ **PART TIME** ☐ **HOMEMAKER** ☐ **UNEMPLOYED** ☐ **DISABLED**		
DO YOU SMOKE? ☐ **YES** ☐ **NO**	**HOW MANY PACKS PER DAY?**	**FOR HOW MANY YEARS?**
DO YOU CHEW TOBACCO? ☐ **YES** ☐ **NO**		
ALCOHOL CONSUMPTION? ☐ **YES** ☐ **NO**	**HOW MANY DRINKS PER DAY** _____ **PER WEEK** _____ **PER MONTH** _____	
ANY DRUG USE? (*e.g.* marijuana, cocaine)		

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Dr Devin Binder
BEST Center
9940 Talbert Ave Ste 201
Fountain Valley, CA 92708
Tel: 949-829-2378

PLEASE FAX to 714-769-6121

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____(initial)
HIV Diagnosis/Treatment _____(initial)
Psychiatric/Mental Health _____(initial)
Genetic Information _____(initial)
Tests for Antibodies to HIV _____(initial)

DURATION: This authorization shall be effective immediately and remain in effect for 1 year.

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative
Relationship *if other than patient*

_____ _____
Patient's Name (PRINT)
Date

_____
Patient's Date of Birth

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9940 TALBERT AVE SUITE 201
FOUNTAIN VALLEY, CA 92708
949-829-BEST
www.bestcenteroc.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Brain & Elective Spine Treatment Center.

Signature of Patient *(or Parent, if minor):* _____

Print Name: _____

Date: _____

If a personal representative signs this acknowledgement on behalf of the patient, please complete the following:

Name of Personal Representative:

_____

Relationship to Patient: _____