Please Fax or Email Completed Forms to:
Fax: (760) 416 – 4512
Email: ICON@tenethealth.com

DESERT REGIONAL MEDICAL CENTER
Institute of Clinical Orthopedics & Neurosciences

The Institute of Clinical Orthopedics & Neurosciences
1180 North Indian Canyon Drive, Suite 200, 201, 214
Palm Springs, CA 92262
Phone: (760) 416 – 4511

Patient's Information

Name (Last, First, Middle):		**Previous Last Name:**	**Preferred Name:**
Birthdate:	**Gender:** ☐ Man ☐ Woman ☐ Transgender	**E-mail Address:**	
Driver's License Number:		**Social Security Number:**	

Patient's Billing/Mailing Address

Street or PO Box:		
City:	**State:**	**Zip:**

Patient's Physical Address

Street Address: ☐ Check if same as billing/mailing address		
City:	**State:**	**Zip:**

Patient's Emergency Contact Information

Name:	**Address:**	**Relationship:**	**Contact Phone Number:**

Patient's Additional Information

Race: ☐ African American (Black) ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Caucasian (White) ☐ Other ☐ Hispanic ☐ Unknown	**Preferred Language:** ☐ English ☐ Spanish ☐ Other_____	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Declined to Specify	**Marital Status:** ☐ Divorced ☐ Single ☐ Life Partner ☐ Unknown ☐ Married
	Smoker: ☐ Yes ☐ No ☐ Former	**Home Phone Number:**	**Cell Phone Number:**

Primary Care Provider / Physician

Name:		**Name of Employer:**	
Street Address:		**Employer's Address:**	**Work Phone Number:**
City, State, Zip:		**City, State, Zip:**	**Fax Number:**
Office Phone Number:	**Fax Number:**	**Type of Business:**	**Occupation:**

Patient's Employer:

Responsible Party's Information (if different than above)

Name (Last, First, Middle):		**Relationship to Patient:**	
Birthdate:	**Gender:** ☐ Man ☐ Woman ☐ Transgender	**Home Phone Number:**	**Cell Phone Number:**
Street Address or PO box:		**E-mail Address:**	
City:	**State:**	**Zip:**	

Primary Insurance

Name of Subscriber (Last, First, Middle):		**Relationship to Patient:**	
Subscriber's Address (Street, City, State and Zip): ☐ Check if same as billing/mailing address		**Policy Number:**	
Subscriber's Date of Birth:	**Name of Insurance Company:**	**Group Number:**	
Address of Insurance Company (Street, City, State, and Zip):		**Effective Date:**	**Expiration Date:**

Secondary Insurance (if applicable)

Name of Subscriber (Last, First, Middle):		**Relationship to Patient:**	
Subscriber's Address (Street, City, State and Zip): ☐ Check if same as billing/mailing address		**Policy Number:**	
Subscriber's Date of Birth:	**Name of Insurance Company:**	**Group Number:**	
Address of Insurance Company (Street, City, State, and Zip):		**Effective Date:**	**Expiration Date:**

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Pharmacy Information

Preferred Pharmacy (Name, Address, Phone Number):

Back-up Pharmacy (Name, Address, Phone Number):

Reason For Visit

Reason(s) for Visit: _____

Onset Date: _____
Severity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

☐ Right ☐ Left ☐ Bilateral

☐ Fracture ☐ Pain ☐ Swelling

Allergies (Medication(s), Environmental Issue(s), and Food(s))

Item(s) that you are ***allergic*** to:	Reaction(s) you have had from the ***Allergen,*** you are allergic to:

Medications and Supplements You Take on a Regular Basis

Drug or Supplement Name (Brand name, or generic name)	Dosage	Times taken within 24 Hours	Reason for taking Medication

Review of Systems *(please check the box if you have had or are currently having any of the following symptoms)*

Constitutional (General):
☐ Chills ☐ Night Sweats
☐ Fatigue ☐ Weight Gain
☐ Fever ☐ Weight Loss
☐ Malaise

Cardiovascular:
☐ Chest Pain
☐ Claudication
☐ Edema
☐ Palpitations

Reproductive:
☐ Erectile Dysfunction
☐ Penile Discharge
☐ Sexual Dysfunction

Neurological:
☐ Aphasia ☐ Memory Impairment
☐ Dizziness ☐ Near Syncope
☐ Dysarthria ☐ Paresthesias
☐ Focal Weakness ☐ Seizures
☐ Gait Disturbance ☐ Speech Changes
☐ Headache ☐ Tremors
☐ Incontinence ☐ Vertigo
☐ Incoordination ☐ Visual Changes
☐ Light-Headedness
☐ Loss of Consciousness

Integumentary: ☐ Hives
☐ Brittle Hair ☐ Pruritis
☐ Brittle Nails ☐ Mole Changes
☐ Hair Loss ☐ Rash
☐ Hirsutism ☐ Skin Lesion

Head, Eyes, Ears, Nose Throat:
☐ Ear Drainage
☐ Ear Pain
☐ Eye Discharge
☐ Eye Pain
☐ Hearing Loss
☐ Nasal Drainage
☐ Sinus Pressure
☐ Sore Throat
☐ Visual Changes

Gastrointestinal:
☐ Abdominal Pain
☐ Blood in Stools
☐ Change in Stools
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Loss of Appetite
☐ Nausea
☐ Vomiting

Metabolic/ Endocrine:
☐ Cold Intolerance
☐ Heat Intolerance
☐ Polydipsia
☐ Polyphagia

Psychiatric:
☐ Anxiety
☐ Depression
☐ Insomnia

Musculoskeletal: ☐ Muscle Weakness
☐ Back Pain ☐ Neck Pain
☐ Joint Pain
☐ Joint Swelling

Hematologic:
☐ Easy Bleeding
☐ Easy Bruising
☐ Lymphadenopathy

Respiratory: ☐ Shortness of Breath
☐ Chronic Cough ☐ Wheezing
☐ Cough
☐ Known TB Exposure

Genitourinary (Urinary):
☐ Dribbling ☐ Slow Stream
☐ Dysuria ☐ Urinary Frequency
☐ Hematuria ☐ Urinary Incontinence
☐ Polyuria ☐ Urinary Retention

Immunological:
☐ Contact Allergy
☐ Environmental Allergies
☐ Food Allergies
☐ Seasonal Allergies

Other Conditions Not Noted:
_____
_____

Chronic Problem List

Chronic Problem(s):	Onset Date:

Past Surgical History

Procedure(s):	Year:

Family History (Please list only Mother, Father, Brother, and Sister)

☐ Patient Adopted ☐ No Relevant Family History

Diagnosis:	Family Member Relation and Name:	Age Onset / Age Death:

Social History

Tobacco Use: ☐ Currently ☐ Formerly ☐ Never ☐ Unknown
Type: ☐ Chewing ☐ Cigar ☐ Cigarettes ☐ Pipe ☐ Snuff ☐ Smokeless
Units/Day:_____ ***Years Used:***_____

Alcohol Use: ☐ Yes ☐ No ☐ Formerly
If "Yes", Year Quit:_____
Type of Alcohol:_____
Amount:_____ **Frequency:**_____
When was Last Drink:_____

Caffeine Use: ☐ Yes ☐ No
Type:_____ **Amount Daily:**_____

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Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to Dr. _____ all medical benefits. **I understand that I am financially responsible for all charges incurred. A copy of the back and front of my insurance card is required for billing purposes.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured _____ **Date** _____

Medical Research Authorization

Sometimes healthcare information may be used for medical research purposes. All such information is anonymous and patient confidentiality is maintained. If you do not want any information to be used for research please check here _____.

Consent for Treatment

I, the undersigned, hereby authorize and give consent to Dr. _____ for any x-rays examinations, laboratory tests, and treatment rendered to the patient named above.

Signature _____ **Date** _____

Medicare Authorization

I request the payment of authorized Medicare benefits be made directly to me or the physician rendering services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature _____ **Date** _____

Acknowledgement of Care by Mid-Level Professionals

I, the undersigned, hereby authorize and give consent that my care may be provided by a mid-level professional (Nurse Practitioner or Physician Assistant) during my treatment at The Institute of Clinical Orthopedics & Neurosciences.

Signature _____ **Date** _____

Billing Process Notification

The Institute of Clinical Orthopedics and Neurosciences (ICON) at Desert Regional Medical Center thanks you for choosing our facility for your medical needs. We would like to give you some helpful information regarding our billing process. ICON is an outpatient department of Desert Regional Medical Center. You will receive a billing statement from your ICON provider (Physician, Physician Assistant, Nurse Practitioner, or Resident) for professional services provided during your office visit. You will also receive a second billing statement for other services rendered by ICON on behalf of Desert Regional Medical Center. The Physician and their Associates (Physician Assistant, Nurse Practitioner, or Resident) bill independently for their services. If you have any questions about this portion of your bill please call your Provider's billing company as noted below:

PROVIDER	BILLING COMPANY	TELEPHONE NUMBER
Fnu Alfandy, N.P.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Thomas P. Barry, M.D.	Dependable Medical Billing	(760) 619-2309
Blake W. Berman, D.O.	RevMD	(480) 991-8100
Vladimir Cortez, D.O.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Reginald Fayssoux, M.D.	Desert Orthopedic Center	(760) 766-1239
Celia Gomes-McGillivray, N.P.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
David Hill, P.A.	Compliance Billing Specialists	(866) 336-3267
Silvio F. Hoshek, M.D.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
P. Mona Khanna, M.D.	Professional Billing Management Services	(209) 579-5628
Rosalinda M. Menoni, M.D.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Pedram Navab, D.O.	Corey Financial Billing	(760) 242-1354
Colleen Rose, N.P.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Natalie Rue, N.P.	RevMD	(480) 991-8100
Javed Siddiqi, M.D.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Raed Sweiss, D.O.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Sydney Pardino, M.D.	BWI Consulting	(760) 864-0010
D. Scott Peery, P.A.	Corey Financial Billing	(760) 242-6561
Ramin Pooyan, D.O.	Desert Oasis Healthcare Billing	(760) 416-1376
Vivek Ramakrishnan, D.O.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Douglas J. Roger, M.D.	Compliance Billing Specialists	(866) 336-3267
Ajeet Sodhi, M.D.	Arrowhead Neurosurgery – Madeline	(951) 486-4460
Louis Stabile, M.D.	Desert Oasis Healthcare Billing	(760) 416-1376
Todd A. Swenning, M.D.	Corey Financial Billing	(760) 242-6561
Benjamin Wehrli, D.P.M.	CA Services	(208) 520-4682
Efren F. Wu, M.D.	Arcie Lopez Billing	(760) 863-1592

You will receive a billing statement from Desert Regional Medical Center which includes a facility fee and may or may not include any other charges for services rendered such as injectable medications and supplies (i.e. crutches, braces, etc.). If you have any questions regarding this billing statement, please call Desert Regional Medical Center's Customer Care Center at (866) 904-6871. Please contact the appropriate billing company/facility as stated above to assist you further with any questions regarding your accounts.

Patient Name (print)_____**Signature**_____ **Date** _____

Please be advised, it is the patient's responsibility to ensure that the physician they see is contracted with their insurance plan.