Mind Your Body Clinic

www.mindyourbodyclinic.com 206 957 7246

Office of Rajni K Jutla, MD Board Certified in Anesthesiology and Pain Management

Welcome to MYBC Patient Data Sheet

Name:_Mr/Ms _____

Address:_____

City _____ State _____ Zip _____

Phone: Home_____Cell_____

E mail _____

Soc Sec #_____Age_____Birthdate_____

Referring Physican: _____ Clinic:_____ Phone #:_____ Fax #:_____

Primary Care: _____ Clinic:_____ Phone #:_____ Fax #:_____

Pharmacy:_____ _____ Address:_____ Phone #:_____ Fax #:_____

Emergency Contact:_____ Home #_____ If marrred _____ Spouse's Name _____

Relationship:_____ Work #_____

Occupation:_____

Is this a Labor & Industry/ Auto Injury Case ? _____

Date of Injury _____ Cause _____ Claim # _____

Employer:

_____ Approved Diagnosis Codes _____

Employer address:_____ Case Manager Name _____ ph #_____

Insurance

Expected Copay Per Visit $

Who is responsible?		
Relationship to Patient		
Primary Insurance Company	**Subscriber's Name:**	
Group #	**Birthdate:**	**Soc Sec #:**
Secondary Insurance Co.	**Subscriber's Name:**	
Group #	**Birthdate:**	**Soc Sec #:**

Insurance Assignment and Release: I certify that I have insurance coverage with: _____

And assign directly to Mind Your Body Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr Rajni Jutla may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end when my current treatment plan is completed.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mind Your Body Clinic.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to Medicare and their agents any information needed to determine these benefits or benefits for related services.

Signature: _____ Date_____

ALLERGIES:		
Family History	**Diseases- Include alcoholism, substance abuse**	**Cause of Death**
Mother		
Father		
Sister		
Brother		
Children		

Health History

Write in all medical conditions from which you suffer Please put an X for active symptoms

General: Fever [ ] Night Sweats [ ] Chills [ ] Unintended weight loss [ ] Weight gain from inactivity [ ]

Psychiatric: Depression [ ] Anxiety [ ] Headache [ ] Loss of Sleep [ ] Bipolar Disease [ ] Substance abuse [ ]
Other:

Neurological: Bowel Incontinence [ ] Bladder Incontinence [ ] Decreased sensation [ ] Decreased strength [ ] Headache [ ]
Other:

Head and Neck: Blurry vision [ ] Nasal discharge [ ] Loss of Hearing [ ] Nosebleeds [ ] Bleeding after brushing teeth [ ]
Other:

Pulmonary: Shortness of Breath [ ] Wheeze [ ] Cough [ ] Asthma [ ] Emphysema [ ] Sleep Apnea [ ]
Other:

Heart and Circulation: Chest pain [ ] Irregular heart rhythm [ ] Heart Attack [ ] Poor Circulation [ ] High Blood Pressure [ ]
Other:

Gastrointestinal: Ulcer disease [ ] Nausea [ ] Vomiting [ ] Constipation [ ] Diarrhea [ ] Anorexis [ ] Abdominal Pain [ ] Ulcer [ ]
Other:

Genitourinary: Painful Urination [ ] Blood in urine [ ] Sexual dysfunction [ ] Groin pain [ ] Painful intercourse [ ] Herpes [ ]
Other:

Musculoskeletal: Neck pain [ ] Low back pain [ ] Arm pain [ ] Leg pain [ ] Shoulders [ ] Feet [ ] Arthritis [ ] where_____
Other:

Blood/Tumor: Blood infections such as hepatitis [ ] HIV [ ] Easy bruising [ ] Clotting problems [ ] Cancer[ ] where_____
Other:

Endocrine: Diabetes [ ] Thyroid problems [ ] High Cholesterol [ ]

Medications and Doses

Habits

Tobacco [ ] years___ ppd ___ Alcohol occasionally [ ] each day [ ] never [ ] prior heavy use [ ] Illicit Drugs [ ] which _____

Surgical History

List all surgeries in order of most oldest to most recent Include Surgeon's name and year

1st _____

2nd _____

3rd _____

4th and others: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my custodee, ever have a change in health. Sign below:

_____ Date _____ Relationship_____