

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

Name: Mr/Ms _____
 Address: _____
 City _____ State _____ Zip _____
 Phone: Home _____ Cell _____
 E mail _____
 Soc Sec # _____ Age _____ Birthdate _____

Welcome to MYBC Patient Data Sheet

Referring Physician: _____ Clinic: _____ Phone #: _____ Fax #: _____
 Primary Care: _____ Clinic: _____ Phone #: _____ Fax #: _____
 Pharmacy: _____ Address: _____ Phone #: _____ Fax #: _____
 Emergency Contact: _____ Home # _____ If married _____ Spouse's Name _____
 Relationship: _____ Work # _____ Is this a Labor & Industry/ Auto Injury Case ? _____
 Occupation: _____ 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 <input type="checkbox"/>	Night Sweats <input type="checkbox"/> Chills <input type="checkbox"/> Unintended weight loss <input type="checkbox"/> Weight gain from inactivity <input type="checkbox"/>
Psychiatric:	Depression <input type="checkbox"/>	Anxiety <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Bipolar Disease <input type="checkbox"/> Substance abuse <input type="checkbox"/>
Other:		
Neurological:	Bowel Incontinence <input type="checkbox"/>	Bladder Incontinence <input type="checkbox"/> Decreased sensation <input type="checkbox"/> Decreased strength <input type="checkbox"/> Headache <input type="checkbox"/>
Other:		
Head and Neck:	Blurry vision <input type="checkbox"/>	Nasal discharge <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Bleeding after brushing teeth <input type="checkbox"/>
Other:		
Pulmonary:	Shortness of Breath <input type="checkbox"/>	Wheeze <input type="checkbox"/> Cough <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Sleep Apnea <input type="checkbox"/>
Other:		
Heart and Circulation:	Chest pain <input type="checkbox"/>	Irregular heart rhythm <input type="checkbox"/> Heart Attack <input type="checkbox"/> Poor Circulation <input type="checkbox"/> High Blood Pressure <input type="checkbox"/>
Other:		
Gastrointestinal:	Ulcer disease <input type="checkbox"/>	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Anorexia <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Ulcer <input type="checkbox"/>
Other:		
Genitourinary:	Painful Urination <input type="checkbox"/>	Blood in urine <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Groin pain <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Herpes <input type="checkbox"/>
Other:		
Musculoskeletal:	Neck pain <input type="checkbox"/>	Low back pain <input type="checkbox"/> Arm pain <input type="checkbox"/> Leg pain <input type="checkbox"/> Shoulders <input type="checkbox"/> Feet <input type="checkbox"/> Arthritis <input type="checkbox"/> where _____
Other:		
Blood/Tumor:	Blood infections such as hepatitis <input type="checkbox"/>	HIV <input type="checkbox"/> Easy bruising <input type="checkbox"/> Clotting problems <input type="checkbox"/> Cancer <input type="checkbox"/> where _____
Other:		
Endocrine:	Diabetes <input type="checkbox"/>	Thyroid problems <input type="checkbox"/> High Cholesterol <input type="checkbox"/>

Medications and Doses

Habits
Tobacco <input type="checkbox"/> years ___ ppd ___ Alcohol occasionally <input type="checkbox"/> each day <input type="checkbox"/> never <input type="checkbox"/> prior heavy use <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> which _____

Surgical History	List all surgeries in order of most oldest to most recent	Include Surgeon's name and year
1 st		
2 nd		
3 rd		
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 _____

