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SPINE PATIENT INFORMATION

Name:______________________________________ Date: ________________________

Address:____________________________________ Social Security : ________________

City:________________ State:_____ Zip:__________ Home Phone: __________________

Age: ________ Sex: [ ] M [ ] F Date of Birth: __________________

Patient's employer: __________________________ Work Phone : __________________

Employer address: ___________________________ Cell Phone: ___________________

Spouse's name: _____________________________ Employer:_____________________

Are you covered under another persons insurance? (example: spouse, parent, etc.)

Insured's name (if other than patient): ____________________ Insured's social security:__________

Insured's address:__________________________ Relationship to patient: ________________

Insured's date of birth ___________

In the event of a medical emergency, whom would you like us to notify?

Name:________________________ Relationship:___________ Phone:______________

Were you referred by your physician? [ ] Yes [ ] No Should we send him/her a report? [ ] Yes [ ] No

Your physician's name:____

Physician's address: ____

Symptoms

What brings you to see us today? ____

How long have you had this problem? ______________________________________

Was there an injury involved? [ ] Yes [ ] No Date: _________ [ ] At work [ ] Auto accident

Previous back or neck surgery? [ ]Yes [ ]No

Year__________ Type ____

Year__________ Type ____

Which pain is worse? [ ] Back [ ] Leg [ ] Back and leg equal ______

[ ] Neck [ ] Arm [ ] Neck and arm equal______

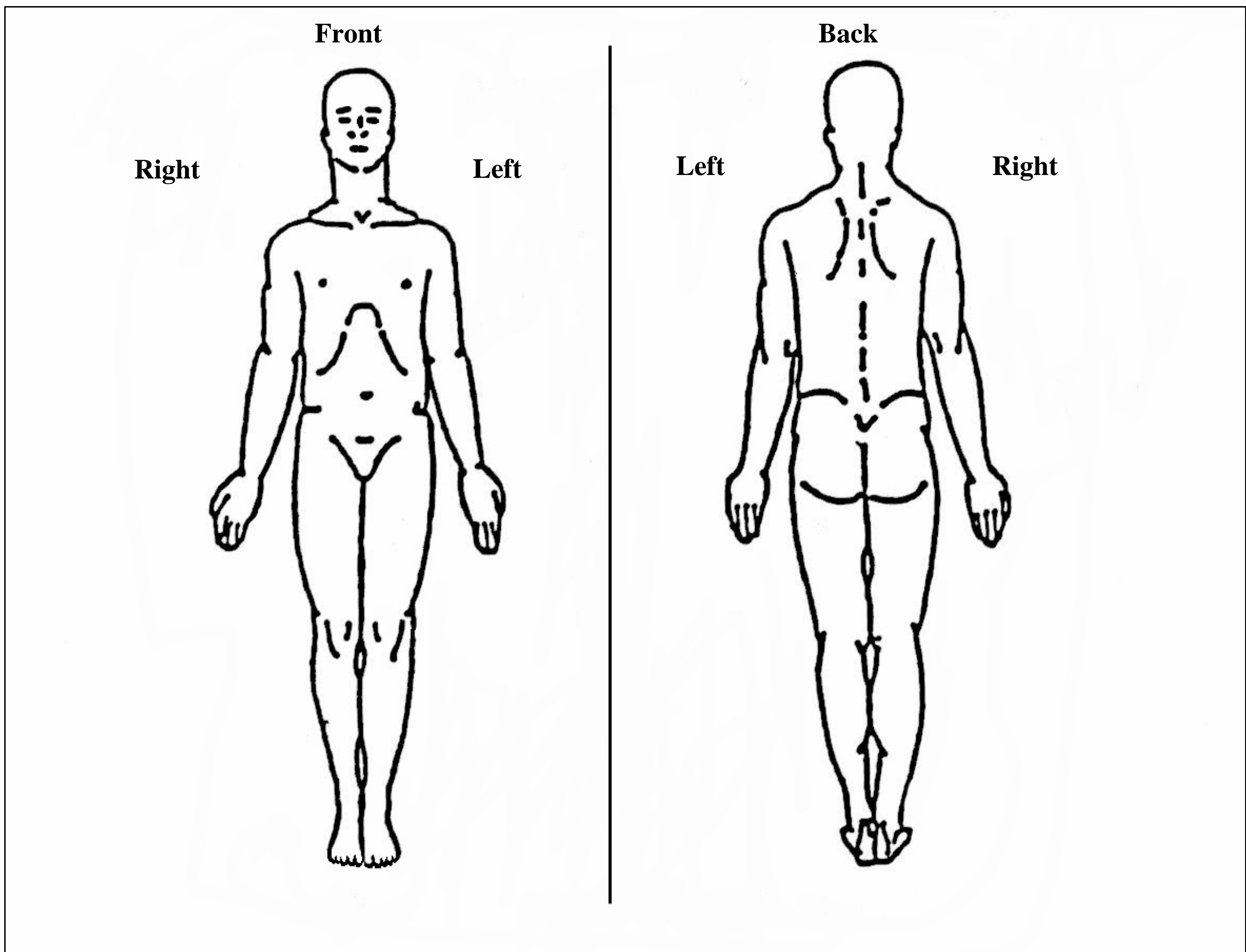
Circle your least and greatest **pain levels** over the last 2 weeks:

(None) 0----1----2----3----4----5----6----7----8----9----10 (Severe)

Mark in the areas of your body that you now feel your typical pain. Include all affected areas.

Use the appropriate symbols indicated below:

Pain = XXXXX   Numbness = OOOOO



Which of the following activities increase your leg or back pain? (*Check all that apply*)

[ ] Bending [ ] Lifting [ ] Walking [ ] Standing [ ] Sitting [ ] Lying [ ] Coughing

How far can you walk before you need to stop because of leg or back pain?

[ ] Less than 1 block [ ] 1 block [ ] 2 blocks [ ] 3 blocks [ ] 4+ blocks

Is your pain decreased by rest or sitting? [ ] Yes [ ] No

What else decreases your pain? ____

What Treatment have you had?	Having this treatment made things:		
	Better	Worse	No change
[ ] Physical therapy	_____	_____	_____
[ ] Injections	_____	_____	_____
[ ] Brace	_____	_____	_____
[ ] Pain medications	_____	_____	_____
[ ] Traction	_____	_____	_____

Are you currently receiving any type of financial compensation for your back problem? [ ]Yes [ ]No

Do you have an attorney for your back problem? [ ]Yes [ ]No

Medical History:

In general, your health is (mark one): [ ] Excellent [ ] Good [ ] Fair [ ] Poor [ ] Terrible

Have you ever had?

[ ] Asthma/ Breathing problems
[ ] Diabetes (years_____)
[ ] Cancer (Type______________)
[ ] AIDS or tested positive for HIV
[ ] Heart attack/ Heart Disease
[ ] Hepatitis
[ ] Fibromyalgia
[ ] Gall bladder disease

[ ] Phlebitis or blood clots
[ ] Stroke
[ ] Bleed or bruise easily
[ ] Ulcer
[ ] Rheumatoid arthritis
[ ] High blood pressure
[ ] Reaction to anesthetics
[ ] High cholesterol

[ ] Kidney stones
[ ] Tuberculosis
[ ] Seizures
[ ] Migraines
[ ] Alcoholism
[ ] Thyroid disease
[ ] Anemia
[ ] Pacemaker

Other:____

____

Please list all major **Surgeries**: (include month and year)

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________

Medicines: List all medications you are currently taking (prescription and non-prescription)

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________
6. ________________________________
7. ________________________________
8. ________________________________

Allergies or reactions to medications or other substances

Medicine/substance Reaction (example: penicillin-rash)

____

____

Family History

Explain:

Spinal Problems [ ] Yes [ ] No ________________________________

Bleeding Disorders [ ] Yes [ ] No ________________________________

Cardiac Disease [ ] Yes [ ] No ________________________________

Social History

Marital Status: [ ] Single [ ] Married [ ] Remarried [ ] Divorced [ ] Separated [ ]Widowed

How many years? _________

Work status: [ ] Working [ ] Not working [ ] Disabled [ ] Retired [ ] Student

Primary Occupation: ____

How long have you worked at your present job: _________ If not working, last date worked: _____________

Number of children:_______________ Ages: ____________________________

Spouse's occupation: ____

Do you smoke? [ ] Yes [ ]No Packs per day_________ Years_________ Quit [ ] Yes : Year ________

Do you Drink Alcohol? [ ] Yes [ ] No Number of drinks per week__________ Wine [ ] Beer [ ] Liquor [ ]

Have you used recreational drugs? [ ] Yes [ ] No

Review of systems:

During the past year have you had? Explain:

[ ] Night sweats ______________________________
[ ] Unplanned weight loss ______________________________
[ ] Loss of appetite ______________________________
[ ] Excessive fatigue ______________________________
[ ] Depression ______________________________
[ ] Difficulty sleeping ______________________________
[ ] Unusual stress in home life ______________________________
[ ] Unexplained fevers ______________________________
[ ] Unusual stress in work life ______________________________
[ ] Easy bruising ______________________________
[ ] Excessive bleeding ______________________________
[ ] Lumps in neck, groin, armpits ______________________________
[ ] Persistent or unusual cough ______________________________
[ ] Trouble breathing with exercise ______________________________
[ ] Trouble breathing lying flat ______________________________
[ ] Coughing up blood ______________________________
[ ] Swollen ankles ______________________________
[ ] Persistent diarrhea ______________________________
[ ] Excessive constipation ______________________________
[ ] Dark black stools ______________________________
[ ] Blood in stools ______________________________
[ ] Pain or burning with urinating ______________________________
[ ] Difficulty urinating (starting, stopping) ______________________________
[ ] Blood in urine ______________________________
[ ] Generalized morning stiffness ______________________________
[ ] Dry eyes or mouth ______________________________
[ ] Skin rashes ______________________________
[ ] Joint pain or swelling ______________________________

What do you hope to gain from your visit today?

____

____

____

Physician Use: Reviewed

Date: ______________________

Sig: ______________________

Office Financial Policy

Basic Policy: Payment for services are due in full at the time services are provided. We accept cash, check, or credit card.

Please present your insurance and/or Medicare cards to be photocopied when you check in. If the telephone number of the insurance company is not on the card, please provide the number to the receptionist.

Insurance/Medicare: As a courtesy, we will bill your insurance company or Medicare for you. All co-payments and deductibles are due at the time of service.

Referrals: If your insurance carrier or health plan requires a referral from your primary care physician, you will be responsible for making sure a valid referral has been obtained. Without this referral, your insurance carrier will not cover your office visit and you will be responsible for payment.

All medical records are the property of Orthopedic Associates of Abilene L.L.P. This includes x-rays. If x-rays need to be taken from this office for any reason, we will need 10 days notice in order to mail them to their destination. If x-rays are needed before that time, we can overnight them at the patient's expense. There are also times when x-rays need to be copied before they are taken out of the office. This will also be at the patient's expense.

The physicians at Orthopedic Associates of Abilene, L.L.P. do not accept cases where there is litigation and/or attorney involved. If your circumstances fall under this category, you will be responsible for your bill and must inform the receptionist immediately.

The patient is ultimately responsible for the payment of all professional fees. I understand that I may responsible for services rendered, including reasonable attorney's fees and cost incurred in the event of any default. The information provided on this form is complete and accurate to the best of my knowledge. I have read, understood, and agree to the above financial policy for payment of professional fees.

Signature:____ **Date:** ______________________________

Release of information

I hereby authorize my physician at Orthopedic Associates of Abilene L.L.P. to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the insurance, Medicare, or any other health plan or its agents, any information needed to determine these benefits or the benefits payable to related services. Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right to privacy may be compromised.

Signature:____ **Date:** ______________________________

Assignment of insurance benefits

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at Orthopedic Associates of Abilene L.L.P. This assignment of benefits allows our office to collect directly from your insurance company. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether of not paid by said insurance.

Signature:____ **Date:** ______________________________