CONFIDENTIAL PATIENT INFORMATION SHEET

DATE: _____

FIRST NAME: _____ MI: ____ LAST NAME: _____
RESPONSIBLE PARTY (IF A MINOR): _____
DATE OF BIRTH: _____ SEX: [ ] MALE [ ] FEMALE

ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

PHONE: H: _____ C: _____ Appt. Reminders By Text? Y / N

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____
PHONE #: _____

REFERRING PHYSICIAN: _____
PHONE #: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

EMPLOYER INFORMATION
EMPLOYER NAME: _____
EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PATIENT OCCUPATION: _____

EMERGENCY CONTACT
NAME: _____RELATIONSHIP: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____

PREFERRED PHARMACY
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE #: _____

HOW DID YOU HEAR ABOUT US? _____

Patient ID:

NEW PATIENT FORM

Name: _____ **Date of Birth:** _____

Reason For Visit: _____

When Did Symptoms Start: _____

HISTORY OF PRESENT ILLNESS: (Circle all that apply)

Pain is:	Constant / Improving / Intermittent / Stable / Worsening
Pain is due to:	Car Accident / Disease / Old Age / Sports Injury / Work injury / Other:
Is there a lawsuit or workers' compensation claim?	Yes / No
What worsens the pain?	Cough / Change In Weather / Driving / Leaning Forward / Leaning Backward Lying Down / Reaching / Sitting / Sneeze / Standing / Twisting / Walking Other:
What reduces the pain?	Cold / Driving / Heat / Leaning Backward / Leaning Forward / Lying Down Reaching / Sitting / Standing / Twisting / Walking / Other:
Is there new or different:	Bowel or Bladder Accidents / Loss-of-Feeling / Weakness (not pain-related)
Reduced sleep:	Yes / No
Prior treatments:	CT Scan / Discogram / EMG / Epidural / MRI / Narcotics / Physical Therapy / X-ray Other Injection(s):

PAST MEDICAL HISTORY:

Anxiety	Asthma	Cancer	Depression	Diabetes
Emphysema	Heart Disease	High Blood Pressure	Kidney Disease	Liver Disease
Stroke	Thyroid Disease	Ulcers	Other:	

PAST SURGICAL HISTORY: (Include year of surgery)

Appendix	Back Surgery	CABG/Angioplasty	Gall Bladder	Hysterectomy
Hernia Repair	Neck Surgery	Tonsillectomy	Other Surgery:	

FAMILY HISTORY:

Alcoholism or Illegal Substance Abuse / Genetic Diseases / Muscle Disease / Neurological Disease / Stroke

Patient ID:

MEDICATIONS: _____ _____
Incl. dose & frequency _____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PRIOR PAIN MEDICATIONS: _____
_____

OTC MEDICATIONS: Tylenol / Aspirin / Motrin / Advil / Aleve / Goody's / BC Powder / Other:

ALLERGIES: Drug: _____ **Reaction:** _____
_____ _____
_____ _____
_____ _____

REVIEW OF SYSTEMS: (Only circle if new complaint)

Black stools / Blood in the urine / Bloody stools / Chest pain / Constipation / Cough / Diarrhea / Dizziness
Easy bruising / Fatigue / Fever / Headache / Heartburn / Hot or cold temperature intolerance / IV drug abuse
Nausea / New-onset seizures / Rash / Recent change in vision or double vision / Recent memory loss
Sexual problems or decreased libido / Shortness-of-breath / Suicidal thoughts / Vomiting / Weight loss / Wheezing

SOCIAL HISTORY:

Single / Married / Divorced / Widowed Do you have any children (how many)? _____

Alcohol Use: None / Social / Daily (more than 2 drinks) Quit: _____

Tobacco: None or ___ packs per day x ___ years Quit: _____

Street Drugs: _____ Current / Prior

Education: Grade school / High School / GED / Trade school / College / Post-Graduate

Exercise Level: None / Occasional / Moderate / Heavy

If you are a female, are you currently pregnant? Yes / No

Occupation: _____ Last worked: _____)_

Hobbies: _____ Goals of treatment: _____

VITAL SIGNS: (Office use)

Height: _____ Weight: _____

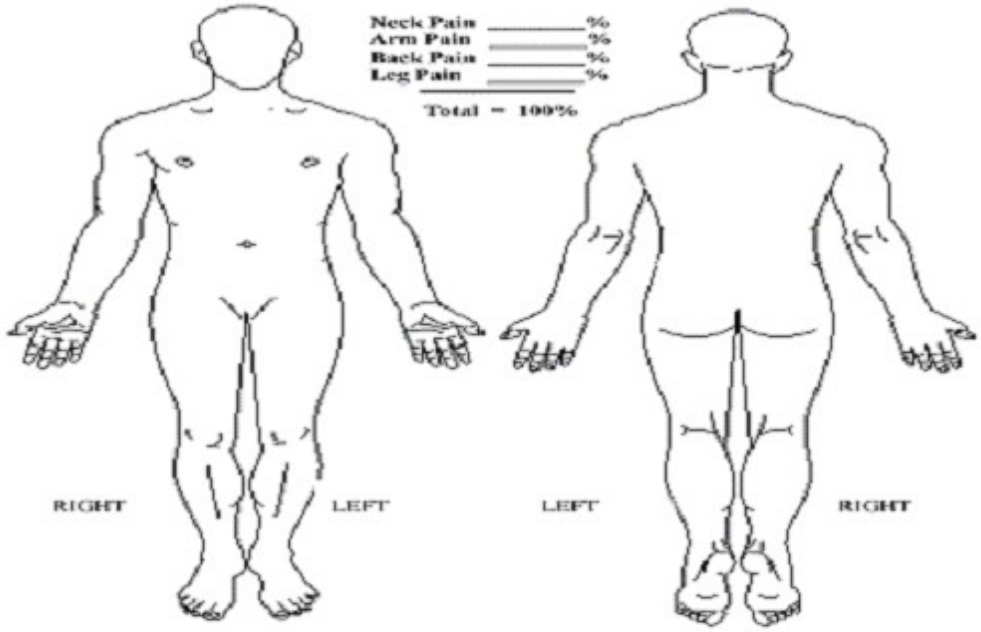
Heart Rate: _____ Blood Pressure: _____

Patient ID:

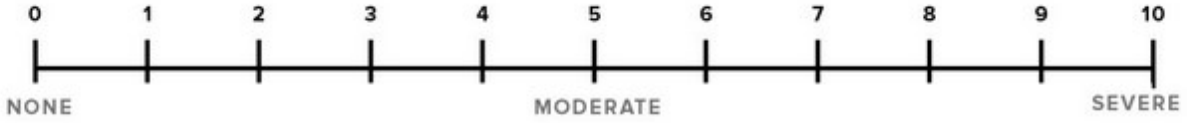
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations using the appropriate symbols

ACHE ^	NUMBNESS O	PINS & NEEDLES □	BURNING X	STABBING +



Please circle your current pain level on the below scale



Check Each Row That Applies For Your Gender	Female	Male
Family History of Substance Abuse		
Alcohol	____ 1	____ 3
Illegal Drugs	____ 2	____ 3
Rx Drugs	____ 4	____ 4
Personal History of Substance Abuse		
Alcohol	____ 3	____ 3
Illegal Drugs	____ 4	____ 4
Rx Drugs	____ 5	____ 5
Age Between 16 –45 Years	____ 1	____ 1
History of Preadolescent Sexual Abuse	____ 3	____ 0
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	____ 2	____ 2
Depression	____ 1	____ 1
Scoring Totals		

PAIN MANAGEMENT AGREEMENT

As part of your treatment, our medical staff at PAIN AND SPINE INSTITUTE may prescribe medications for you. As you may be aware, medications can have serious side effects if they are not managed appropriately. Your health and safety are our top priorities, and we need your assistance to make sure your treatment follows the prescribed guidelines. No prescriptions will be written unless you accept the following agreement in its entirety.

1. I agree to follow the dosing schedule prescribed by my physician.
2. I will never share, sell, or exchange my medications with anyone for any reason.
3. I understand that PAIN AND SPINE INSTITUTE reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED MEDICATIONS. PLEASE BE PREPARED TO GIVE A URINE SAMPLE AT EVERY VISIT. If you are unable to provide a urine sample when asked, we will not be able to prescribe any pain medication(s). If the results of the urine drug screen do not reflect medications prescribed by my physician or test positive for illicit drugs (marijuana, cocaine, heroin, methamphetamine, etc), I understand that I can be immediately dismissed from the practice. I also agree to pay any costs not covered by my insurance for these urine drug screens.
4. I understand that I am solely responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession such as cash. I know that PAIN AND SPINE INSTITUTE does not replace controlled medications that are lost. Exceptions may be made at the discretion of the prescribing physician for replacing controlled medications that are stolen, but only with a valid police report.
5. I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognition.
6. I agree that if I receive a prescription for controlled medication from PAIN AND SPINE INSTITUTE that I am not allowed to accept prescription(s) for controlled medication(s) from any other physician(s) without my prescribing physician's consent.
7. I agree to use only one pharmacy for my pain-related medications. In the event that circumstances require the use of another pharmacy, I will immediately notify PAIN AND SPINE INSTITUTE and provide them with all pertinent contact information.
8. I understand that prescriptions involving narcotics require a scheduled appointment in the office. Narcotic refills will not be called into the pharmacy. Narcotic dosages will not be increased over the phone.
9. I know that I can be asked to bring in any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (pill count).
10. I understand that abusive behavior or harassment toward any of the staff at PAIN AND SPINE INSTITUTE will not be tolerated. The physician will determine what actions qualify as harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
11. I understand that any forged, falsified, or altered prescription(s) will result in my immediate dismissal from PAIN AND SPINE INSTITUTE and may be reported to the local police.
12. I understand that if I have a problem or need to change my medication(s), I will need to make an appointment and bring in ALL MEDICATIONS PRESCRIBED BY my physician at PAIN AND SPINE INSTITUTE. If I fail to bring them back, PAIN AND SPINE INSTITUTE will not issue any new prescriptions.

By signing this agreement, you affirm that you have the full right and power to be bound by this agreement and that you have carefully read, understood, and accepted all of these terms. Non-compliance with this agreement will be terms for dismissal from the practice.

PRINTED PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY

RELEASE AND ASSIGNMENT

I, the undersigned, hereby authorize the release of all information necessary to secure the payment of benefits submitted for services rendered by the Physicians and Staff of PAIN AND SPINE INSTITUTE of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes PAIN AND SPINE INSTITUTE to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form and that I will be bound by this signature as though the undersigned had personally signed the particular claim form.

I, the undersigned, have coverage with the insurance company as listed on my insurance card and assign directly to PAIN AND SPINE INSTITUTE all claim benefits, if any, otherwise payable to me for services rendered. I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my physician, whether or not paid by the insurance company. If any portion of my account balance is not reimbursed by my insurance company, for any reason, I agree to cooperate and arrange prompt payment to clear my bill. I understand that payment is due upon receipt of my billing statement.

FEES AND INSURANCES

Payment is due at the time of service for all office visits and procedures. All estimated insurance deductibles, co-payments, and co-insurances are collected before services are rendered. If payment is not received from the insurance company within 60 days of the filing date, payment responsibility will be transferred to the patient. It is the responsibility of the patient to ensure that we have all of the correct insurance information and any referrals or authorizations required by your insurance company.

OFFICE POLICIES

Patient Cancellation and No-Show Policy

PAIN AND SPINE INSTITUTE requires at least a 24-hour notice of any appointment cancellation or rescheduling. A $25 no-show fee will be assessed each time 24-hours' notice is not given for appointment cancellation or rescheduling.

Disability and Medical Forms

Forms are completed at the discretion of your physician. Any forms that need to be completed should be discussed during your appointment. If your physician agrees to complete the forms, a fee will be assessed for each form that needs to be completed.

Medical Records

We will gladly send your medical records to another physician free-of-charge. If you would like a copy for your own records or any insurance company or lawyer's office requests a copy of your medical records with your consent, then you will be assessed a $25 fee for each such request.

Payment & Fees

All co-pays, deductibles, co-insurances, and any outstanding fees are collected in full at the time of service. We welcome cash, credit cards, debit cards, and checks as forms of payment.

Late Policy

You are expected to arrive 15 minutes before your scheduled appointment start time to check-in and fill out any necessary paperwork. If you arrive after your scheduled appointment time slot, you may have to either reschedule or be seen after other patients who have arrived on time.

I have read and agree to the above terms and conditions.

_____ _____

Signature of Patient or Legal Guardian Date

NOTICE OF PRIVACY POLICIES

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), established a Privacy Rule to help ensure that personal health care information is protected by privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of their personal health information to carry out treatment, payment, or healthcare operations.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients) and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are often not required to obtain the patient's consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give your consent in this document, at some future time, you have the right to request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or previously signed consent.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We always strive to take reasonable precautions to protect your privacy. When appropriate and necessary, we provide the minimal information necessary to only those who we feel are in need of your healthcare information and information about treatment, payment, or healthcare operation in order to provide your healthcare needs.

There are times when you may wish other family members and friends to inquire about your appointments or have access to your medical information. List any family member(s) or other(s) who you wish to have access to your records (i.e. who may call us regarding your condition or who may call for you). **We will not release any information to anyone including spouse or children unless you list them below.** We will require signed releases from you for anyone wanting access to your records other than the insurance companies you have listed with us, your healthcare provider as necessary for your care, or persons listed below.

Name	Relationship to You
_____	_____
_____	_____
_____	_____

If you wish for us to leave messages on your answering machine/voicemail other than to say "please call us back," please indicate so below.

Leaving Messages on Answering Machine/Voicemail:

_____ Do not leave messages other than to return our call
_____ We may leave messages with information regarding your medical care

I acknowledge that I have received a copy of PAIN AND SPINE INSTITUTE'S Notice of Privacy Practices. This notice describes how PAIN AND SPINE INSTITUTE may use and disclose my protected healthcare information, certain restrictions on the use and disclosure of my healthcare information, and rights that I may have regarding my protected healthcare information. I also understand that I may revoke this authorization at any time or receive a copy of this authorization upon request.

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____