THE SPINE & PAIN CENTER

Date: _____

Patient name: _____ Date of Birth: _____

Age:_____ Sex: ( ) Male ( ) Female Weight:_____ Height:_____ R/L Handed:_____

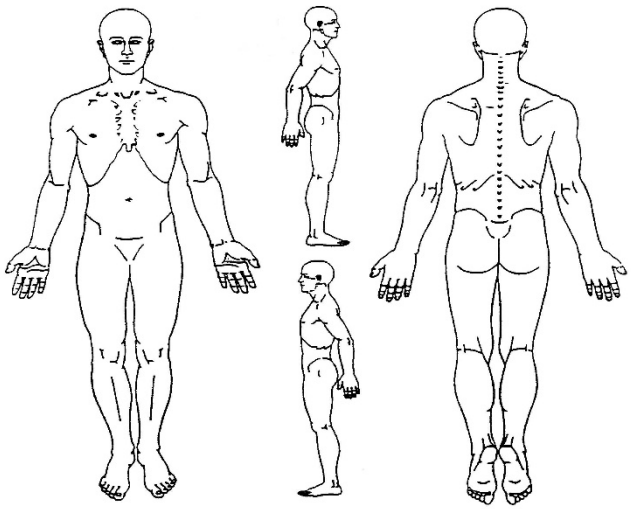
Referring Physician: _____ Primary Care Physician:_____

Briefly describe your main problem: _____

When/How did your pain start? (approximate date)_____
Is your pain constant or does it come and go? _____

Do you have pain that shoots down your arms or legs? ( ) Yes ( ) No

Indicate on the diagram below the area(s) of your pain. Use "X" for pain and "O" for numbness.



Do you have any increasing weakness in your arms or legs? ( ) Yes ( ) No
Do you have any loss of control of you bowels or bladder? ( ) Yes ( ) No

Present level of pain intensity (circle one)

0 1 2 3 4 5 6 7 8 9 10
No pain Mild Moderate Severe Excruciating

What words best describe your pain? (circle as many that apply)

Sharp Burning Throbbing Shooting Aching Cramping Stabbing Crushing

Dull Tingling Coldness Hotness Electricity

What brings on the pain or makes it worse? (circle as many that apply)

Sitting Standing Walking Twisting Lifting Sneezing Coughing Using arms

Bending Forward Bending Backward Other: _____

What eliminates the pain? (circle as many that apply)

Lying down Standing Exercise Arthritis Medication Pain medication

Muscle Relaxants Nothing Other: _____.

Please list all **current medications** you are taking:

MEDICATION	**DOSE**	**FREQUENCY**

Do you have any **medication allergies**? (If yes, **please list severity**): ( ) Yes ( ) No

_____

_____

Do you or have you ever had an allergic reaction to **IODINE** or **INJECTABLE DYE**? ( ) Yes ( ) No

Do you take any of the following medications (please circle any that apply):

Coumadin Aspirin Plavix Lovenox Heparin

Have you received/tried any of the following to treat your pain? (please circle any that apply)

Tens Unit Chiropractic Therapy Physical Therapy Biofeedback

Injection Therapy

Please note injections: _____

_____

*****Attention: in the event you need a prior authorization for medications in the future this information is very helpful in getting approvals.**

Please list all **pain medications** you have **previously tried**. _____

_____

Please list all **muscle relaxants** you have **previously tried**. _____

_____

Please list all **sleep medications** you have **previously tried**. _____

_____

Work History:

What is/was your occupation? _____.

( ) Work full time ( ) Work part time ( ) Unemployed ( ) Homemaker ( ) Retired ( ) Disability

When did you last work? _____

If your pain is work related, what was the date of injury? _____.

Do you currently have an attorney regarding your pain condition? ( ) Yes ( ) No

If yes, please provide the name and phone number. _____.

Social History:

Are you: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widow

Do you have any children? _____ If yes, how many? _____

Who lives in your home with you? _____.

Do you smoke? ( ) Yes ( ) No If yes, how many packs of cigarettes per day? _____ Are you a former smoker? _____

If yes, when did you quit? _____ Do your drink alcohol? _____ If yes, how much in one week? _____

Have you ever been abused physically? ( ) Yes ( ) No

Do you feel threaten in your home? ( ) Yes ( ) No

Do you fear for your children in the home? ( ) Yes ( ) No

Sleep and Mood:

How many hours a night do you sleep? _____

Have you experienced any of the following? (please check all that apply)

( ) Snoring ( ) Restless Sleep ( ) Chronic Fatigue ( ) Witnessed pauses in breathing ( ) Poor Concentration

( ) Choked or gasped for air during sleep ( ) Frequent visits to the bathroom ( ) Early morning headaches

( ) Sleepiness during routine activities

Have you ever been diagnosed with depression, psychosis, schizophrenia, or bipolar disorder? _____

If yes, please note all that apply: _____

Are you seeing a Psychiatrist or Psychologist? ( ) Yes ( ) No If yes, for what? _____

Do you have any thoughts of hurting yourself or others? ( ) Yes ( ) No

If yes, please explain: _____

Do you have a family history of any of these problems? (circle as many that apply)

Alcoholism Depression Substance Abuse Mental Illness Cancer

Heart Problems Stroke Other: _____

Please circle all the following <u>medical problems</u> that you have had (circle as many that apply):

Heart problems Heart attack High Blood Pressure Stroke Blood Clots Diabetes

Asthma Kidney Failure Kidney Infections Liver Problems Thyroid Problems Ulcers

Lung Problems COPD Depression Headaches Seizures Glaucoma Hepatitis

HIV/AIDS Cancer: _____ Other: _____

Please indicate which **<u>diagnostic studies</u>** you have had to evaluate your present pain (with date):

MRI _____ CT Scan _____ Myelogram _____

Bone Scan _____ Discogram _____ EMG _____.

Other: _____

Please list all **past surgeries** you have had (include year of surgery):

_____ _____

_____ _____

_____ _____

Please circle any that apply to you:

Pregnant: ( ) Yes ( ) No

General: Fever Weight loss/gain Poor Appetite Sexual Problems Insomnia

Neurological: Headache Seizures Paralysis Confusion Disorientation

Eye, Ear, Nose, Throat: Blurry Vision Trouble Swallowing Loss of Hearing Voice Changes

Respiratory: Emphysema Bronchitis Asthma Tuberculosis Shortness of Breath

Cardiovascular: Chest Pain Abnormal Heart Beats Heart Failure Heart Murmurs

Gastrointestinal: Nausea Vomiting Hepatitis Pancreatitis Blood in Stool Constipation

Genitourinary: Blood in Urine Recurrent Urinary Infections Kidney Stones Trouble Urinating

Musculoskeletal: Rheumatoid Arthritis Lupus Erythematosus

Skin: Rash Open Sores Recurrent Infections Tumors Skin Cancer

Endocrine: Diabetes Thyroid Problems Adrenal Dysfunction Pituitary Problems

Hematologic: Leukemia Lymphoma Anemia Bleeding Gums

Other: _____

THE SPINE & PAIN CENTER

Patient History Questionnaire

Please complete the following questions by marking the appropriate answers.

1. Does your family have any history of substance abuse? If yes, please mark all that apply.

   ( ) Alcohol ( ) Illegal Drugs ( ) Prescription Drugs

2. Do You have any personal history of substance abuse? If yes, please mark all that apply.

   ( ) Alcohol ( ) Illegal Drugs ( ) Prescription Drugs

3. Are you between the ages of 16-45 years old? ( ) Yes ( ) No

4. Do you have a history of preadolescent sexual abuse? ( ) Yes ( ) No

5. Do you currently suffer from any of the following? If yes, please mark all that apply.

   ( ) Attention Deficit Disorder

   ( ) Obsessive Compulsive Disorder

   ( ) Bipolar disorder

   ( ) Schizophrenia

   ( ) Depression

Patient Registration and Information

Referring Doctor: _____ Today's Date: _____

Name: _____ Date of Birth: _____
Social Security Number: _____ Sex: ( ) Male ( ) Female Email: _____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Address: _____ City, State, Zip: _____
Employer: _____ Occupation: _____ Employer Number: _____
Emergency Contact: _____ Phone Number: _____

Spouse Information

Name of Spouse: _____ Social Security Number: _____ DOB: _____
Spouse's Employer: _____ Phone Number: _____

Responsible Party

Person Responsible for Payment:_____ Date of Birth: _____
Relationship to Patient: _____Social Security Number: _____
Address(if different from patient)_____Phone Number: _____
Responsible Partly Employer: _____ Occupation:_____ Work Number: _____

Insurance Information

Primary Insurance:_____ Insurance ID: _____ Group #: _____
Subscriber: _____ Date of Birth: _____
Billing Address: _____State: _____ Zip: _____
Employer/Address: _____ State: _____ Zip: _____
Secondary Insurance: _____ Insurance ID: _____ Group #: _____
Subscriber: _____ Date of Birth: _____
Billing Address: _____State: _____ Zip: _____
Employer/Address: _____ State: _____ Zip: _____

I, the undersigned certify that I (or my dependent) have the above stated insurance coverage and assign directly to The Spine and Pain Center all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize The Spine and Pain Center to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office to any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the physicians of The Spine and Pain Center, the staff and employees cannot be responsible for the confidentiality of the information disclosed after medical records have been released. Therefore, the physicians, staff and employees of The Spine and Pain Center are released from any liability arising from such disclosure.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

THE SPINE & PAIN CENTER

Authorization and Consent for release of information

*****Please do NOT fill out BOTH releases of information*****

I, being competent, eighteen (18) years of age or older and duly authorized, do willfully and voluntarily authorize the release of information to the following family member(s) or person(s) on my behalf. I understand that this release will remain in effect until a new Authorization and Consent for Release of Information is updated.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Name (please print)	Patient Signature	Date

*****If you do not wish to add anyone to this release, please sign below*****

Waiver of Release of Information

I, being competent, eighteen (18) years of age or older and duly authorized, do willfully and voluntarily request that NO family member(s) or person(s) receive any information regarding my medical care.

Patient Name (please print)	Patient signature	Date

THE SPINE & PAIN CENTER

Acknowledgement of Notice of Privacy Practices

I acknowledge receipt and understanding of The Spine and Pain Center's Privacy Practices. I understand that if I would like a copy of this notice, I am to request a copy from the office or may view it on www.thespineandpaincenter.com.

Date:_____ Patient's Date of Birth: _____

Patient Name (please print): _____

Patient's Signature: _____

Responsible Party's Signature: _____

Disclosure of Physician Ownership Notice to Patients

The Spine and Pain Center is committed to providing the best quality healthcare to every patient we treat. As a patient of The Spine and Pain Center, we are please to inform you of the following:

1. The physicians of The Spine and Pain Center have ownership interest in Tulsa Spine and Specialty Hospital.

2. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other that Tulsa Spine and Specialty Hospital.

3. You will NOT be treated differently by your physician if you choose to obtain healthcare services at a facility other than Tulsa Spine and Specialty Hospital.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Tulsa Spine and Specialty Hospital. We welcome you as a patient and value our relationship with you.

Acknowledgement of Disclosure

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Tulsa Spine and Specialty Hospital.

_____
Date

_____
Printed Name of Patient

_____

Signature of Patient

Financial Policy

Thank you for choosing The Spine and Pain Center for your healthcare needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following statement is our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT OF OFFICE COPAYS ARE DUE AT THE TIME OF SERVICE. You are responsible for deductibles and coinsurance as directed by your insurance policy. We accept cash, money orders, Visa/Mastercard, Discover and American Express.

Insurance

Your office copay is due at the time of your visit. For your convenience, we will file insurance claims with all insurance carriers. You will be responsible for any deductibles, coinsurance and any non-covered or excluded services as explained in your policy. Payment of any patient portion due after insurance is expected upon receipt of a statement. We can not bill your insurance company unless you provide us with all information, so please bring your insurance cards to your appointment. You are responsible for notifying us of any change in insurance coverage each visit. If no insurance is presented, you will be treated as a cash pay patient and will need to pay for services as they are rendered. Once the card is presented, we will gladly file a claim and refund any money due to you.

Private Pay

If you do not have insurance, payment is due at the time if service. We accept cash, money orders, Visa/Mastercard, Discover and American Express. Please be prepared to pay in full at the time of your visit unless prior payment arrangements have been made.

Workers Compensation

Only authorized referrals will be accepted. If notification is not received prior to the appointment the patient will be responsible for charges incurred. Patients must notify The Spine and Pain Center prior to scheduled appointments with the following information: attorney's name and phone number, employer name, contact person and phone number, work comp carrier name, adjuster's name and phone number, the date of injury and the claim number.

Personal Injuries and Motor Vehicle Accidents

Patients must notify The Spine and Pain Center prior to their scheduled appointments with the following information: Personal injury case number, company and contact information.

No-Show Policy

A $30.00 no-show fee will be charged in the event you fail to show for an appointment without contacting our office 24 hours in advance of the scheduled appointment time. Payment of the no-show fee will be required prior to rescheduling any future appointments or processing medication refill requests. In the case of repeated no-shows, you may be required to pre-pay a nonrefundable administrative fee of $100-

$300 prior to rescheduling your next appointment. If the rescheduled appointment is not kept, the fee will be considered a no-show charge. You are also at risk for being discharged from the practice in the event of reoccurring tardiness/no-shows.

Form Completion Charges

Pre-payment is required before forms will be processed. Form completion is at the discretion of your physician. The fee is $25.00 for the first page and $10.00 for each additional page.

Patient Name (please print)	Patient Signature	Date