THE SPINE & PAIN CENTER

Date: _____

Patient name: _____ Date of Birth: _____

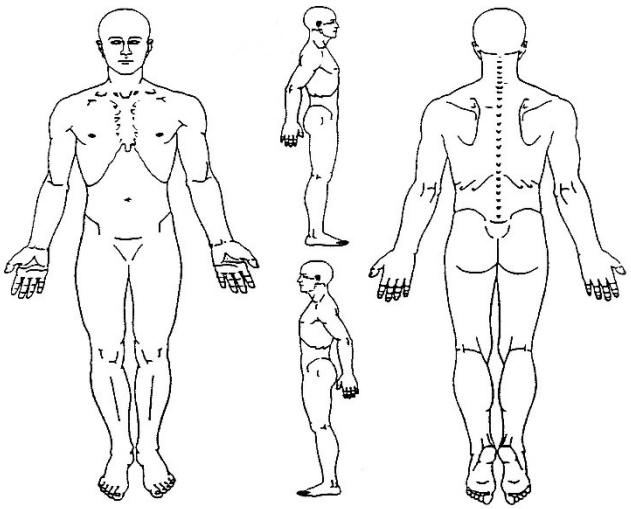
Age: _____ Sex: ( ) Male ( ) Female Weight:_____ Height:_____ R/L Handed:_____

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? _____

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



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 helps/eases the pain? (circle as many that apply)

Lying down Standing Exercise Arthritis Medication Pain medication

Muscle Relaxants Nothing Other: _____

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): _____

Work History:

What is/was your occupation? _____

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

If not currently working, when was the last time you worked? _____

Social History:

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

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? _____

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 list all <u>past surgeries</u> 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: _____

PATIENT NAME: _____ **DOB:** _____

CURRENT MEDICATIONS (include vitamins/supplements)

Medication	Dose/Frequency	Medication	Dose/Frequency
1.		10.	
2.		11.	
3.		12.	
4.		13.	
5.		14.	
6.		15.	
7.		16.	
8.		17.	
9.		18.	

ACTIVE ALLERGIES

[ ] No Known Allergies

[ ] Allergy to IODINE/INJECTABLE DYE?

Name	Reaction	Name	Reaction
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please check all the following medical problems that you have been **diagnosed** with:

[ ] Heart problems
[ ] High Blood Pressure
[ ] Blood Clots
[ ] Asthma
[ ] Kidney Infections
[ ] Thyroid Problems
[ ] Lung Problems
[ ] Depression
[ ] Seizures
[ ] Hepatitis

[ ] Heart attack
[ ] Stroke
[ ] Diabetes
[ ] Kidney Failure
[ ] Liver Disease
[ ] Stomach Ulcers
[ ] COPD
[ ] Headaches
[ ] Glaucoma
[ ] HIV/AIDS

[ ] Cancer: _____

[ ]Other: _____
_____
_____
_____
_____
_____
_____
_____

PATIENT SIGNATURE: _____ **DATE:** _____

Patient Registration and Information

Referring Doctor: _____ Today's Date: _____

Name: _____ Date of Birth: _____

SSN: _____ Sex: ( ) Male ( ) Female Email: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Employer: _____ Occupation: _____ Employer Number: _____

Emergency Contact: _____ Phone Number: _____

Insurance Information

Primary Insurance:_____ Insurance ID: _____ Group #: _____

Secondary Insurance: _____ Insurance ID: _____ Group #: _____

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.

_____

Date

_____

Patient/Responsible Party Signature

Authorization and Consent for release of information

[ ] YES, I 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

[ ] NO, I request that NO family member(s) or person(s) receive any information regarding my medical care.

Patient Name (please print)	**Patient/Responsible Party Signature**	**Date**

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 Date of Birth**

_____

Printed Name of Patient

_____

Signature of Patient/Responsible Party

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 pleased 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/Responsible Party

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 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.

After Hour Calls

If you are having a life-threatening emergency, call 911 or go to the nearest hospital emergency room. After clinic hours, patients with other non-life-threatening issues that need immediate attention may speak to one of our on-call physicians. The answering service will receive your call and forward it to the appropriate on-call physician. Please be aware that charges may apply.

_____	_____	_____
Patient Name (please print)	**Patient/Responsible Party Signature**	**Date**

THE SPINE & PAIN CENTER

Authorization and Consent for Release of Medical Records

In order for The Spine and Pain Center to provide you with the best possible care, we may require copies of your medical records. For us to obtain this information, we will need your written permission. Please review the Authorization and Consent for Release of Medical Records below. Your signature on this form will allow us to obtain the necessary information.

Being competent, eighteen (18) years of age or older and duly authorized; do willfully and voluntarily authorize the release of all medical records and information to The Spine and Pain Center.

I further understand and acknowledge the information authorized for release may include information which may be considered a communicable or venereal disease which may or may not include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome or AIDS.

_____

Full Name of Patient (Please print)

XXX-XX-_____/___/_____

Last 4 Social Security Number Date of Birth

_____/___/_____

Authorized Signature Today's Date

For medical records use only, please DO NOT complete this section.

Record Holder: _____ Fax Number: _____

The Spine and Pain Center requests the following information at this time:

_____ All dictated reports _____ All radiology reports

_____ All anesthesia reports _____ All therapy records

Other: _____

Please fax this information to The Spine and Pain Center at 918-255-7000. If you are unable to fax the chart due to it's size, please contact our office so that other arrangements can be made.