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Orthopedic Associates of Abilene

Fellowship trained spine surgeon



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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:

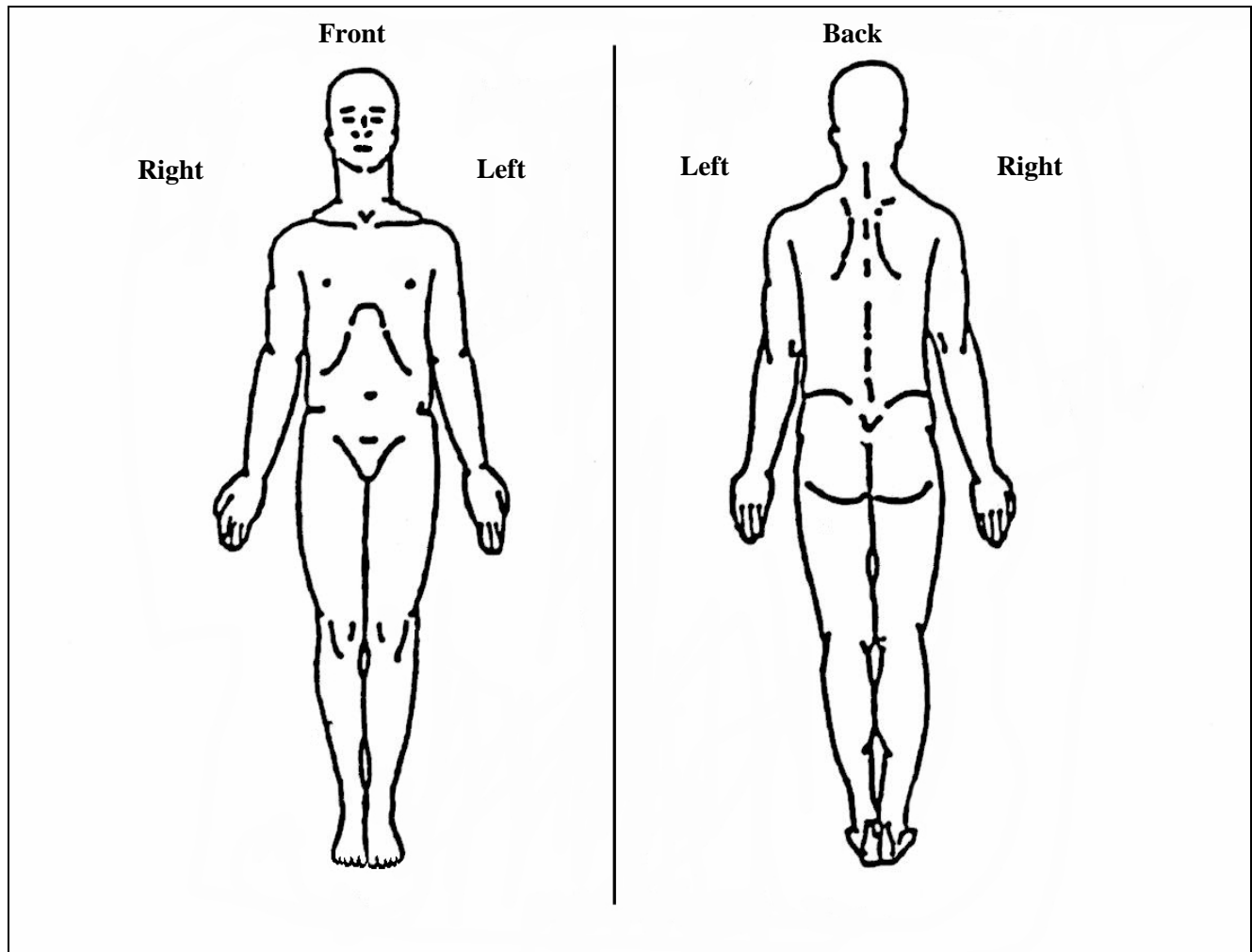
(None) 0---1---2---3---4---5---6---7---8---9---10 (Severe)

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
<input type="checkbox"/> Physical therapy	_____	_____	_____
<input type="checkbox"/> Injections	_____	_____	_____
<input type="checkbox"/> Brace	_____	_____	_____
<input type="checkbox"/> Pain medications	_____	_____	_____
<input type="checkbox"/> 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?

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma/ Breathing problems | <input type="checkbox"/> Phlebitis or blood clots | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Diabetes (years_____) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer (Type_____) | <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> AIDS or tested positive for HIV | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart attack/ Heart Disease | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Reaction to anesthetics | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pacemaker |

Other: _____

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

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

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

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 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:

- | | |
|--|-------|
| <input type="checkbox"/> Night sweats | _____ |
| <input type="checkbox"/> Unplanned weight loss | _____ |
| <input type="checkbox"/> Loss of appetite | _____ |
| <input type="checkbox"/> Excessive fatigue | _____ |
| <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Difficulty sleeping | _____ |
| <input type="checkbox"/> Unusual stress in home life | _____ |
| <input type="checkbox"/> Unexplained fevers | _____ |
| <input type="checkbox"/> Unusual stress in work life | _____ |
| <input type="checkbox"/> Easy bruising | _____ |
| <input type="checkbox"/> Excessive bleeding | _____ |
| <input type="checkbox"/> Lumps in neck, groin, armpits | _____ |
| <input type="checkbox"/> Persistent or unusual cough | _____ |
| <input type="checkbox"/> Trouble breathing with exercise | _____ |
| <input type="checkbox"/> Trouble breathing lying flat | _____ |
| <input type="checkbox"/> Coughing up blood | _____ |
| <input type="checkbox"/> Swollen ankles | _____ |
| <input type="checkbox"/> Persistent diarrhea | _____ |
| <input type="checkbox"/> Excessive constipation | _____ |
| <input type="checkbox"/> Dark black stools | _____ |
| <input type="checkbox"/> Blood in stools | _____ |
| <input type="checkbox"/> Pain or burning with urinating | _____ |
| <input type="checkbox"/> Difficulty urinating (starting, stopping) | _____ |
| <input type="checkbox"/> Blood in urine | _____ |
| <input type="checkbox"/> Generalized morning stiffness | _____ |
| <input type="checkbox"/> Dry eyes or mouth | _____ |
| <input type="checkbox"/> Skin rashes | _____ |
| <input type="checkbox"/> 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:** _____