



Patient Information

Please complete the following questionnaire. It is designed to assist our providers with your care and better understand your medical information. **Please answer every section.**

Patient Name: _____ Date of Birth: _____ Age _____ Sex _____ SS# _____
 Local Address: _____ City: _____ State _____ Zip _____
 Permanent Address: _____ City: _____ State _____ Zip _____
 Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____ Email: _____
 Name of closest relative not living with you: _____ Phone #: _____
 Relative's Address: _____ City: _____ State _____ Zip _____

Visit Reason:

Complaint/Symptoms: _____

When did your complaint start? Gradually Suddenly Date: _____ Cause of Injury: _____

Can you walk without pain? Yes No When is your pain the worst? Morning Afternoon Evening

Do you feel unsteady walking? Yes No Do you have difficulty buttoning a shirt or combing hair? Yes No

Have you ever been treated for this problem? Yes No Treating physician/hospital? _____

List treatments that have helped? _____ List treatments that have made it worse? _____

Did you have Xrays taken? Yes No If so, what type and where? _____

Consulting Physician: _____ MD DO DC

Primary Care Physician: _____ MD DO DC

Other Physicians: _____ MD DO DC

Past Medical History: (Check all that apply)

- Diabetes High Blood Pressure Heart Attack Heart Disease Emphysema Neurological Disease Hepatitis Seizures
 Thyroid Disease Asthma Reflux HIV/AIDS Stroke/TIA TB
 Phlebitis Kidney Disease Infection Cancer (type) Other _____

Past Surgical History: (Check all that apply)

- Cardiac Bypass Angioplasty/Stents Pacemaker Appendectomy Tonsillectomy Prostate Cataract Spine
 (Cervical/Thoracic/Lumbar) Carpal Tunnel Gallbladder Hysterectomy
 Other _____

Medications: See Attached List

DRUG	STRENGTH	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Social History:

Married Single Divorced Widow

Number of Living Children: _____

Occupation: _____

Do you Smoke? Yes No Never

If yes, how much do you smoke per day? _____

Alcohol Intake? Never Occasional Mod/Heavy

Drug Use? Never Present Past

Do you presently live alone? Yes No

Allergies: None Known Penicillin Aspirin Sulfa Other _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Family History: (Check all that apply to your family)

- Diabetes High Blood Pressure Heart Attack Heart Disease Emphysema Neurological Disease Hepatitis Seizures
 Thyroid Disease Asthma Reflux HIV/AIDS Stroke/TIA TB
 Phlebitis Kidney Disease Infection Cancer (type) _____ Other _____

Review of Systems: (Check all that apply)

- Fever Night Sweats Weight Loss Double Vision Glasses Dizziness Deafness Sinus Problems Ear Ringing Chest Pain
 Palpitations Shortness of Breath Coughing Blood Appetite Change Diarrhea Constipation Abdominal Pain Nausea
 Vomiting Bloody Stools Urinary Hesitancy Incontinence Painful Urination Fractures Painful Joints Swollen Joints Swollen
 Arms/Legs Weak Arms/Legs Skin Color Changes Rashes Scars Masses Ulcers Eczema Hives Hair Changes Speech
 Problems Difficulty Swallowing Numbness Tingling Seizures Balance Problems Memory Problems Coordination Problems
 Depression Excessive Drinking Abnormal lymph nodes

Previous Treatment Modalities:

Have you had any of the following for this particular complaint?	YES	NO	Would you like to try any of the following for this particular complaint?	YES	NO
Physical Therapy			Physical Therapy		
Heat or Ice			Heat or Ice		
Massage			Massage		
Ultrasound			Ultrasound		
Accupuncture			Accupuncture		
Tens/Electrical Stimulation			Tens/Electrical Stimulation		
Chiropractic Care			Chiropractic Care		
Epidural Steroid Injections			Epidural Steroid Injections		
Pain Management			Pain Management		

Have you taken any of the following medication? Please list them.

Anti-Inflammatories (Aleve, Motrin, Ibuprofen, Celebrex): _____

Pain Medications: _____

Muscle Relaxers: _____

Patient Name: _____ Date: _____

Please complete the following questionnaire. It is designed to assess pain intensity, description, and location.
Please answer every section.

Please mark on the diagram the type and location of your pain.

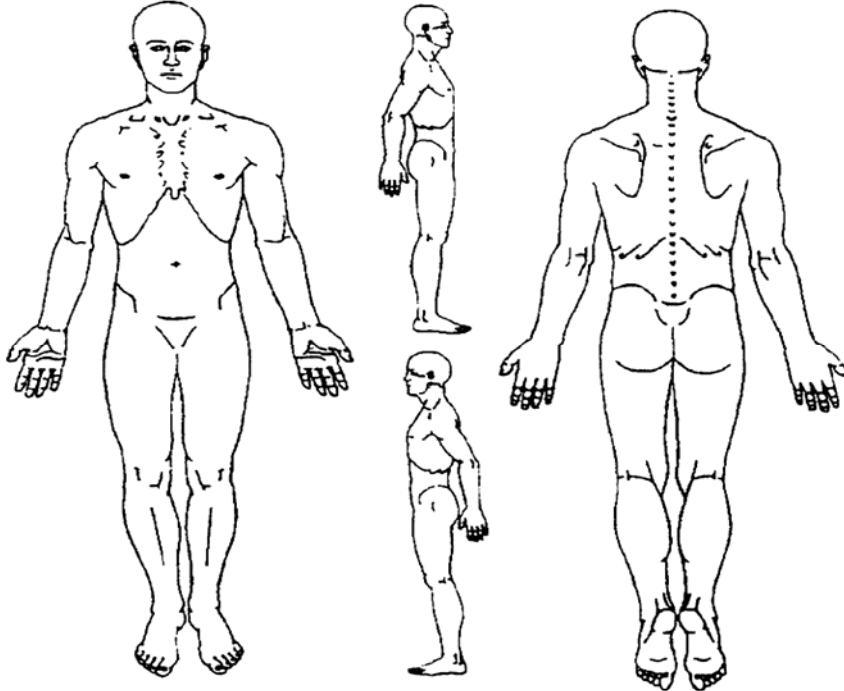
Please describe the **type of pain** or sensation you are currently experiencing by marking the pain diagram with the appropriate symbol using the descriptive words below.

Dull/Aching Pain XXXXX

Sharp/Stabbing Pain ^^^^

Burning Pain ::::

Numbness/Tingling NNNNN



BACK PAIN

Circle the **intensity** of **BACK** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

LEG PAIN

Circle the **intensity** of **LEFT LEG** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Circle the **intensity** of **RIGHT LEG** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

NECK PAIN

Circle the **intensity** of **NECK** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

ARM PAIN

Circle the **intensity** of **LEFT ARM** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Circle the **intensity** of **RIGHT ARM** pain discomfort during the past week.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Employment Information:

Patient's Employer: _____ Position: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Spouse or Parent's Employer: _____ Phone #: _____

Insurance Information:

Primary Insurance Co. _____ ID# _____ Group # _____
 Policy Holder _____ Relationship _____ Policyholder's DOB _____
 Insurance Claim Address _____ Policyholder's SS# _____

Secondary Insurance Co. _____ ID# _____ Group # _____
 Policy Holder _____ Relationship _____ Policyholder's DOB _____
 Insurance Claim Address _____ Policyholder's SS# _____

I understand and agree that health and accidental insurance policies are an agreement between an insurance carrier and me. I authorize payment from my insurance carrier, attorney and/or other parties to Southeastern Spine Center with the understanding that all monies will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. If Southeastern Spine Center is required to attain the service of an attorney or other collection agency to collect sums which I owe, I will be required to pay for all legal fees and cost incurred by Southeastern Spine Center. I authorize Southeastern Spine Center to furnish me or my insurance company, and physicians or health care providers with my medical records or information requested regarding my past or present condition(s) or treatment(s).

Financial Policy:

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other Orthopedic Physicians in the area.

Insurance "Usual & Customary": Our fees are generally considered to fall within acceptable range of usual and customary by most companies and therefore are normally covered up to the maximum allowances determined by each carrier. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Our Policy: Our policy requires payment at time of services. All charges are your responsibility from the date services are rendered. We will assist you in filing your own insurance claim and will provide you with an itemized charge ticket that you can simply send to your insurance carrier to expedite your reimbursement. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

HMO & PPO Members: If you are a member of a HMO or PPO, in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current authorization for each visit if your insurance carrier requires one. If you come to the office for an appointment without a valid authorization, your appointment will be rescheduled.

Private Insurance: Our office files insurance claims to all insurance carriers with whom we participate with (in network). Please check with our office personnel to be sure that your insurance is one that we file. All services we submit on your behalf are still your responsibility. We expect monthly payments on all services 30 days or older.

Non-Participating Provider: (Out of Network) If your insurance carrier does not recognize our practice, or a particular provider within our practice, your appointment will be considered an Out of Network appointment. Therefore, it would be solely your responsibility to pay Southeastern Spine Center and all of the Out of Network Yearly Deductible plus the co-pay required for services rendered. Additionally, your insurance company would reimburse you for services which you would then be required to sign the Insurance Company check over to Southeastern Spine Center for payment of your account.

Medicare: We are participating with Medicare. Our office submits all charges to Medicare. We also, as a courtesy, file to your supplementary insurance in most cases.

Medicaid: We do not accept Medicaid at Southeastern Spine Center. If you have Medicaid as a secondary insurance to your Medicare, you will be responsible for the 20% payment to Southeastern Spine Center.

Patient/Guardian Signature: _____ **Date:** _____

Financial Disclosure:

The physicians/surgeons of Southeastern Spine Center & Research Institute frequently provide educational seminars and participate in educational meetings for a number of medical device companies to educate surgeons and sales staff for these companies. Your physician/surgeon at Southeastern Spine Center & Research Institute may have participated in the development of spinal instrumentation & techniques through which he may be awarded a royalty if they are used. These implants and techniques may be used during your surgical procedures should you have surgery through Southeastern Spine Center & Research Institute. Implants & techniques may be used during your care, specifically during a surgical procedure, which are provided by a company that your physician or surgeon may have financial interest in. If you have any questions or concerns regarding this disclosure, please feel free to have a discussion with your medical provider.

Medication Renewal Policy:

Renewing prescriptions must be done during regular office hours which are Monday through Friday, 8:00 a.m. to 4:00 p.m. To expedite the renewal of prescription medication, call your pharmacist first. They will then place a call to our office for renewal authorization. Prescription renewals are always called in at 5:00 p.m., once we complete office hours.

We realize that emergencies arise that cannot be anticipated. We must insist that our patients anticipate routine medication renewals and abide by our policy of renewals during regular office hours. Additionally, you are required to call your renewal request in to our office 48 hours in advance. Renewals called in to our office after 3:00 p.m. will be handled the next business day.

Appointment Cancellation Policy:

Our office has implemented a policy regarding appointment cancellations. If you can not make your scheduled appointment, please notify us within 24 hours so your appointment can be cancelled or rescheduled. Failure to cancel or reschedule your appointment 24 hours in advance will result in your account being charged a fee of \$25.00. This fee is charged directly to you, as your insurance carrier does not reimburse this fee. We are sorry for any inconvenience this may cause. Thank you in advance for your cooperation.

I have thoroughly reviewed through the above listed disclosures and policies and by signing below I indicate that I understand these policies and agree to them.

Patient Signature: _____ **Date:** _____

HIPAA-Summary of Privacy Practices:

The summary of our privacy practices is a condensed version of our Notice of Privacy Practices. Our complete notice is available by request at the reception desk.

This notice describes how medial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your medication information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your health plan remains provide.

Here are a few examples of how we may use of disclose your information:

- For medical treatment
- To avert a serious threat to health or safety
- To obtain payment for our services
- In response to certain requesting arising out of lawsuits or other disputes
- In emergency situations
- For appointment reminders
- To inform other healthcare providers as a part of your care
- Workers' compensation

If you believe that your privacy rights have been violated, you may file a complaint with the Practice or the Secretary of the Department of Health and Human Services. To file a complaint to the practice, contact **Ellen Jomisko**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect & copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures

For more information about these rights, please see the detailed Notice of Privacy Practices, available at our front desk.

Due to HIPAA regulations, we will be unable to release your Private Health or Financial Information to your family, friends, or advisor without your permission. If you wish to have such information made available to any of the above, you will need to indicate this in writing on the HIPPA Notice of Privacy Practices Acknowledgement of Receipt form. As an added security measure, you will need to give this individual(s) the last four digits of your SS# if you wish for us to speak to them by telephone. If we speak to them in person, they will need a photo ID.

Release of Information

Release of Information:

I authorize the following individual(s) to receive written and/or oral communications about my medical conditions, care, appointments, and the status of my account. I understand that they will need to be able to provide the last four digits of my SS# for oral communication. If they should come to pick up a prescription or to discuss my care or the status of my account, they will need to bring a photo I.D.

_____	_____
_____	_____
_____	_____

Mail & Telephone Messages:

Do we have your permission to?	Yes	No
Send a yearly appointment reminder or test reminders to your home?		
Call you at home?		
Call you at work?		
Leave messages on your home phone?		
Leave messages on your work phone?		
Leave messages on your home answering machine?		
Leave messages on your work answering machine?		
Share your medical and/or appointment information with another person?		
Share your medical information with another person during hospitalization?		
Share your billing information with another person? (list below)		

1. Name of Person: _____ Relationship: _____
2. Name of Person: _____ Relationship: _____
3. Name of Person: _____ Relationship: _____

Acknowledgement of Receipt:

I, _____ (Printed Patient Name), have been given a copy of the Southeastern Spine Center & Research Institute Summary Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipts of our Notice of Privacy Practices, but acknowledgement could not be obtained because of: Individual Refused to Sign Communication Barrier prohibited obtaining acknowledgement Emergency situation prevented us from obtaining acknowledgement Other (specify) _____

Automobile Accident

Date of Accident: _____

What complaints are due to this accident?

What was your position in the vehicle? Driver Passenger

Have you ever had these complaints before? Yes No

Have you ever had any previous neck or back surgery? Yes No

Were you having any neck or back problems 6 months prior to the accident? Yes No

Were you wearing a seat belt? Yes No

Did you hit your head? Yes No

Did you lose consciousness? Yes No

Did the air bag deploy? Yes No

Were you burned by the air bag? Yes No

Did you immediately go to the hospital? Yes No

If not, when? _____ Name & Location? _____

How were you hit? Front Behind Right Side Left Side

What Doctors have you seen due to this accident? _____

Did you have any imaging studies after the accident? Yes No

If so, what type of studies (CT, MRI, X-rays, etc)? _____

Patient Signature: _____ **Date:** _____