PATIENT REGISTRATION

spine & orthopedic SPECIALISTS

Patient information *(please print)*				
PATIENT'S LEGAL NAME *(last, first, middle)*	SOCIAL SECURITY #	GENDER ☐ M ☐ F	DATE OF BIRTH	AGE
ADDRESS	CITY / STATE / ZIP CODE		MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED	
HOME PHONE # ( )	CELL PHONE # ( )	WORK PHONE # ( )	EMAIL ADDRESS	
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP CODE		
PRIMARY CARE PHYSICIAN & PHONE #	REFERRING PHYSICIAN & PHONE #	ETHNICITY		

Emergency contact			
NAME *(last, first, middle)*	RELATIONSHIP	HOME PHONE # ( )	CELL/WORK PHONE # ( )

Responsible Party *(complete this section only if someone other than the patient is financially responsible)*			
RESPONSIBLE PARTY NAME *(last, first, middle)*	SOCIAL SECURITY #	GENDER ☐ M ☐ F	DATE OF BIRTH
ADDRESS	CITY / STATE / ZIP CODE		RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER
HOME PHONE # ( )	CELL PHONE # ( )	WORK PHONE # ( )	OTHER PHONE # ( )
EMPLOYER	EMPLOYER ADDRESS	EMPLOYER CITY / STATE / ZIP CODE	

Primary & secondary insurance				
PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE
SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER NAME		SUBSCRIBER DATE OF BIRTH	SOCIAL SECURITY #
GROUP NAME	GROUP #	MEMBER ID / POLICY #	RELATIONSHIP ☐ SPOUSE ☐ PARENT ☐ CHILD ☐ OTHER	EFFECTIVE DATE

Authorization for release of information
I authorize SPINE & ORTHOPEDIC SPECIALISTS to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits and financial responsibility
I authorize the assignment of benefits payable to SPINE & ORTHOPEDIC SPECIALISTS and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.
I understand this office does not guarantee that my insurance company will pay for treatment I receive from this practice. They will perform routine insurance billing procedures upon verification of coverage. However, if my claim is denied, I will be responsible for paying the full amount at that time. This office will not enter into a dispute with my insurance company over any claim, although they will provide necessary documentation my insurance company requests to clarify any confusion or questions that may arise. This office will cooperate fully with the regulations and requests of my insurance company. I understand it is ultimately my responsibility to resolve any type of dispute over payments made or not made by my insurance company. If I feel the "patient responsibility" portion of the explanation of benefits (EOB) is inaccurate, I must resolve this issue directly with my insurance company.

Authorization for additional fees
In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment
I agree to any examination, treatment, and/or procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice
By signing below I agree I that have received a copy of the **Notice of Privacy Practices for Protected Health Information.**

X____|____________________
SIGNATURE (Patient or Responsible Party) DATE

PATIENT INFORMATION—ORTHO

spine & orthopedic SPECIALISTS

Today's Date:____________________________

PATIENT'S LEGAL NAME____

LAST FIRST MIDDLE DATE OF BIRTH AGE

____

PRIMARY CARE/FAMILY PHYSICIAN REFERRING PHYSICIAN

Chief Complaint:
Reason for Today's Visit: Date of Injury:

____

Factors of complaint
Explain circumstances of injury or onset in detail, state accident occurred, & date:

☐ Work comp injury ☐ Automobile accident ☐ Recent injury ☐ Other injury:_____________________________________

____

____

What do you want to happen as a result of this visit?

☐ Discuss surgical options ☐ Discuss non-surgical options ☐ Other:____

Pain chart
Mark the areas on your body where you find the described sensations using the appropriate symbol from the list below.

Please include all affected areas.

Numbness:	= = = =
Aches:	^ ^ ^ ^
Pins & Needles:	o o o o
Stabbing:	/ / / / /
Burning:	X X X
Cramping:	+ + + +

R L L R

Prior surgery for this problem: ☐ Yes ☐ No

Time off work due to this problem: ☐ Yes ☐ No
How long? _______________

Have you had previous occurrences? ☐ Yes ☐ No

FOR OFFICE USE ONLY

DX: PLAN:	HEIGHT:___________ WEIGHT:__________	B/P:______________ PULSE:___________

PATIENT INFORMATION—ORTHO

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Current pain levels
Please indicate your current pain level by placing an x on the line
"0" = no pain & "10" = worst pain imaginable

Example *0* __X________|_____________ *10*

How bad is your pain now?

Pain on average *0* _____________|_____________ *10*
Pain at its worst *0* _____________|_____________ *10*
Pain at its best *0* _____________|_____________ *10*

Current pain profile

List anything that increases your pain (ex. temperature changes, activities, positions, etc.):

____

Family history (Please check all that apply) ☐ **No significant family history**

☐ Scoliosis	☐ High blood pressure	☐ Mental illness
☐ Spine disease	☐ Diabetes	☐ Alcoholism
☐ Arthritis	☐ Cancer_________________	☐ Kidney disease
☐ Heart disease	☐ Bleeding problems	☐ Other:____________________________

Tests & treatment (Any previous tests, examinations or treatments for your current condition?) ☐ Yes ☐ No

Medications

Anti-inflammatories	________________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief
Muscle relaxants	________________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief
Pain medications	________________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)	________________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief

Therapies

Physical therapy		☐ Temporary relief	☐ Lasting relief	☐ No relief
Other(s)	________________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief

Injections
(i.e. steroid injections, trigger-point injections)

Date_________________	Injection type___________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief
Date_________________	Injection type___________________________	☐ Temporary relief	☐ Lasting relief	☐ No relief

Are you under a doctor's care for any other medical condition? ☐ Yes ☐ No
If yes, please explain ____

Imaging history
Please indicate whether you have had any of the following studies and write when & where the most recent was

☐ Yes	☐ No	Regular x-ray	When______________________	Where____________________
☐ Yes	☐ No	CT scan	When______________________	Where____________________
☐ Yes	☐ No	EMG	When______________________	Where____________________
☐ Yes	☐ No	Bone scan	When______________________	Where____________________
☐ Yes	☐ No	Myelogram	When______________________	Where____________________
☐ Yes	☐ No	MRI	When______________________	Where____________________

Medical history (Please check all current & past medical conditions)

☐ Alzheimer's	☐ Emphysema	☐ Tuberculosis	☐ Diabetes
☐ High blood pressure	☐ Liver disease	☐ Kidney failure	☐ Anxiety
☐ Heart attack	☐ Hepatitis	☐ Kidney stones	☐ Depression
☐ Heart failure	☐ Thyroid disease	☐ Osteoporosis	☐ Schizophrenia
☐ Abnormal heart rhythm	☐ Stomach ulcers	☐ Osteoarthritis	☐ Alcoholism
☐ Lung disease (COPD)	☐ Irritable bowel	☐ Rheumatoid arthritis	☐ Seen a psychiatrist
☐ Cancer__________	☐ CVA/Stroke	☐ Bleeding disorders	☐ AIDS/HIV
☐ Asthma/bronchitis	☐ Seizures	☐ Blood clots/DVT	☐ Sleep apnea (use CPAP? Y or N)

Surgical history
Please list all surgeries you have had:

Type of surgery_________________________________ Date(s)_________________________________
Type of surgery_________________________________ Date(s)_________________________________
Type of surgery_________________________________ Date(s)_________________________________
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Type of surgery_________________________________ Date(s)_________________________________
Type of surgery_________________________________ Date(s)_________________________________

PATIENT INFORMATION—ORTHO

spine & orthopedic SPECIALISTS

Current medications (may attach a list) Medication Name	Dose	# per day (SIG)

Allergies (may attach a list) Substance	☐ **No known medical allergies** Reaction

Review of systems (Please check all that apply) ☐ **No significant history**

General
- ☐ Unexplained weight loss
- ☐ Appetite change
- ☐ Fevers or chills
- ☐ Night sweats
- ☐ Marked fatigue
- ☐ Difficulty sleeping

Lung
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Productive cough or sputum

Psychiatric
- ☐ Depression
- ☐ Nervous exhaustion
- ☐ Anxiety
- ☐ Paranoia
- ☐ Obsessive/compulsive behavior
- ☐ History of sexual abuse
- ☐ History of physical abuse

Cardiovascular
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Poor heart function

Neurological
- ☐ Seizures
- ☐ Blackouts/fainting
- ☐ Tremor
- ☐ Headaches/migraines
- ☐ Chronic pain syndrome
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Reflex sympathetic dystrophy
- ☐ Loss of balance
- ☐ Increased clumsiness
- ☐ Difficulty buttoning shirt
- ☐ Dropping things

Skin
- ☐ Easy bruising
- ☐ Swollen ankles

Digestive
- ☐ Nausea or vomiting
- ☐ Stomach pain or ulcers
- ☐ Heartburn/acid stomach
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Uncontrolled loss of stool
- ☐ Blood in stool

Genitourinary
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Incontinence
- ☐ Pelvic pain
- ☐ Urinate at night more than once
- ☐ Unable to completely empty bladder

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle aches

Social history

☐ Married ☐ Divorced ☐ Significant other ☐ Single ☐ Widow/Widower

Number of children ___________________________

Highest educational level attained ☐ Grade school ☐ High school ☐ College ☐ Post graduate

Do you drink? ☐ Yes ☐ No
Frequency ☐ Heavy ☐ Moderate ☐ Occasionally ☐ Never
Do you smoke? ☐ Yes ☐ No *I quit* (when?________) *Frequency*______________
Type ☐ Cigarettes ☐ Chew ☐ Cigar ☐ Pipe
Do you exercise? ☐ Yes ☐ No *Frequency*______________

Employment : ☐ Full time ☐ Part time ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

Occupation:____ Describe duties:____

How much weight do you lift?__________pounds

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. (Examples of use of your PHI would be a nurse obtaining treatment information about you and recording it in your chart, a bill submitted to your insurance company for services rendered and/or when an outside medical transcription service is utilized by our practice in order to complete your medical chart.)

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office – we are not required to grant the request but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.
- Request that you be allowed to inspect and copy your medical record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments)
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. We may charge a cost-based fee for more than one accounting in a 12-month period.
- Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken b delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact a staff member of Spine and Orthopedic Specialists at (480) 353-0446 during normal business hours, or in writing to P.O. Box 19060, Fountain Hills, AZ 85269-9060. Our staff will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

This office is required to:

Maintain the privacy of your health information as required by law; provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you; abide by the terms of this Notice; notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, want to report a problem regarding the handling of your information; or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact a staff member at Spine and Orthopedic Specialists at (480) 353-0446, P.O. Box 19060, Fountain Hills, AZ 85269-9060. You may also file a complaint by mailing it or e-mailing is to the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
- We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties.
- If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.
- As required by law, we may disclose your health information to public health authorities or law enforcement agencies.
- We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
- We may provide your employer with your health status regarding your ability to return to work and/or any work restrictions you may have during your treatment.
- We work with physician and physician assistant training programs and from time to time a medical student will have access to your health information as part of their training.
- Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in the Notice.
- This Notice will be on our website at www.spineandorthodocs.com.

Original Effective Date: April 14, 2003

WHAT TO BRING TO APPOINTMENT:

__ **NEW PATIENT REGISTRATION AND MEDICAL HISTORY FORMS**

__ **MEDICATION LIST / DRUG ALLERGIES**

Make list of any medications you are currently taking, including dosages and frequency. Include a list of any drug allergies that you have.

__ **INSURANCE COMPANY INFORMATION**

Please have your insurance card and insurance company information, including the group number and address where claims should be sent.

__ **WORKERS COMPENSATION INFORMATION**

Bring the claim number, insurance carrier, claims address, contact person (claim's adjustor) and phone number if you are covered by workers compensation. *Your claim will have to be verified and authorized with your adjustor prior to your appointment.*

__ **CO-PAY** - If your insurance has a co-payment, you must pay this amount at the time services are rendered (i.e. office visit).

__ **INSURANCE AUTHORIZATION / PHYSICIAN REFERRAL**

We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company - if this is required. We will not see you if we don't have a required referral and/or authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Have your authorization number when you make your appointment with us.

__ **X-RAYS, MRI SCAN, CT SCAN, OTHER STUDIES**

Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiology reports. Bring all pertinent studies that have been done.

__ **IF YOU REQUIRE DISABILITY FORMS -**

We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration - free of charge. However, if you require disability forms completed for privately-held policies such as those that protect your car, wages, home, or credit cards - *we charge a minimum of $35 and a maximum of $50/form(s).* Your insurance plan will not reimburse you for the preparation of these forms, nor will it reimburse Spine & Orthopedic Specialists; therefore, we require payment before completing the forms. Upon receipt of payment in full and your signature, which acknowledges your understanding of our policy, we will complete your forms.

Authorization for release of information

I authorize SPINE & ORTHOPEDIC SPECIALISTS to release any medical information necessary for purposes of administration, review, investigation, or evaluation of claim coverage and utilization of services.

Assignment of benefits

I authorize the assignment of benefits payable to SPINE & ORTHOPEDIC SPECIALISTS and/or its designee for physician services and supplies by government and/or other private third party payer. I understand that I will be held responsible for payment of all co-payments, co-insurance, deductibles, and non-covered services.

Authorization for additional fees

In the event any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for any and all costs, not limited to attorney's fees, court costs, collection fees, interest, and any additional costs that this action may incur.

Authorization for treatment

I agree to any examination, treatment, and procedures that may be performed during office visits, including emergency treatment considered necessary by the physician and/or his/her providers.

Acknowledgement of Receipt of Privacy Notice

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X____|_______________

SIGNATURE (Patient or Responsible Party) DATE