Advanced Microsurgery of the Spine

Patient Check In

Patient Last Name ______________________ Home Phone ______________________
First Name ______________ Middle ____ Work Phone ______________ Ext. ______
Address ______________________ Date of Birth ______________________
______________________ Apt. No. ________ Gender ___ Marital Status ___
City ____________ State ____ Zip ____ Social Security No. ______________________
Emer. Contact/Phone (Not Home #) __________ Driver's license ______________________
Primary Physician ______________________

Employer Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
______________________ E-mail ______________________
City ____________ State ____ Zip ____ Contact ______________________

Provide the following information if guarantor is different from patient.

Guarantor's Last Name ______________________ Phone ______________________
First Name ______________ Middle ____ Work Phone ______________ Ext. ______
Address ______________________ Patient's Relationship to Guarantor ______________
City ____________ State ____ Zip ____

Primary Insurance

❑ PPO ❑ HMO ❑ Other ❑ Don't Know

Company Name ______________________
Plan Name ______________________
Claims Address ______________________
City ____________ State ______ Zip ______
Phone ____________ Fax ____________
Policy No. ____________ Group No. ____________
Insured Name ______________________
Insured Address ______________________
City ____________ State ____ Zip ______
Phone ____________ DOB ________ Gender ____
Insured's Employer ______________________
Employer Address ______________________
Phone ____________ Fax ____________
Patient's Relationship to Insured ______________

Secondary Insurance

❑ PPO ❑ HMO ❑ Other ❑ Don't Know

Company Name ______________________
Plan Name ______________________
Claims Address ______________________
City ____________ State ______ Zip ______
Phone ____________ Fax ____________
Policy No. ____________ Group No. ____________
Insured Name ______________________
Insured Address ______________________
City ____________ State ____ Zip ______
Phone ____________ DOB ________ Gender ____
Insured's Employer ______________________
Employer Address ______________________
Phone ____________ Fax ____________
Patient's Relationship to Insured ______________

Referring Doctor ____

I authorize the Attending Physician to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand I am responsible for all medical fees during my treatment with the Attending Physician. If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to the Attending Physician.

Print Name ______________________ Signature ______________________ Date ____________

Advanced Microsurgery of the Spine

New Patient Registration Disclosure Form

Patient Name (Please print) ______________________________ Date ______________

Dear Patient:

In order for us to handle the increasing requests for information concerning your medical care, progress, and medical history, it is necessary for us to obtain your permission, in advance, to transmit such information. Thank you for your assistance.

Authorization for Disclosure of Health Care Information

I hereby authorize Advanced Microsurgery of the Spine and its employees to release any information acquired in the course of my examination or treatment to insurance carriers, self-insured plans, third-party administrator, case managers, attorneys, employers, and healthcare providers as requested.

Assignment of Benefits and Agreement to Pay

I hereby authorize you to furnish all information necessary to file a health insurance claim, or to obtain payment for your services. And I hereby assign all medical benefits to which I am entitled, relating to fees for your services, including Medicare and other government-sponsored programs, private insurance, group insurance, and health benefits to Advanced Microsurgery of the Spine.

I acknowledge and understand that I am responsible for all the charges for all the services rendered to me. **I agree to pay out-of-pocket deductibles, and/or co-pays, and/or non-covered services as may be require under health insurance plan when I receive treatment.**

If I do not have insurance coverage, I agree to pay my account in full or make arrangements for prompt payment of the outstanding balance. **(We accept MasterCard, Visa and American Express.)**

Patient/Guarantor's Signature ______________________________ Date ______________

Advanced Microsurgery of the Spine

Patient Consent to Disclose Medical Information/Records

Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations.

You have the lawful right to request that Advanced Microsurgery of the Spine, P.A. restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations.

Please print below any requested restrictions on your health information.

____

____

____

During my treatment with Advanced Microsurgery of the Spine, P.A., you have my permission to discuss and or release my medical information to:

____

____

____

Advanced Microsurgery of the Spine, P.A. is authorized to send me notices/reminders via

Mail ☐ Yes ☐ No
E-mail ☐ Yes ☐ No
Phone/cell ☐ Yes ☐ No

Signature ________________________________ Date ________________

Advanced Microsurgery of the Spine

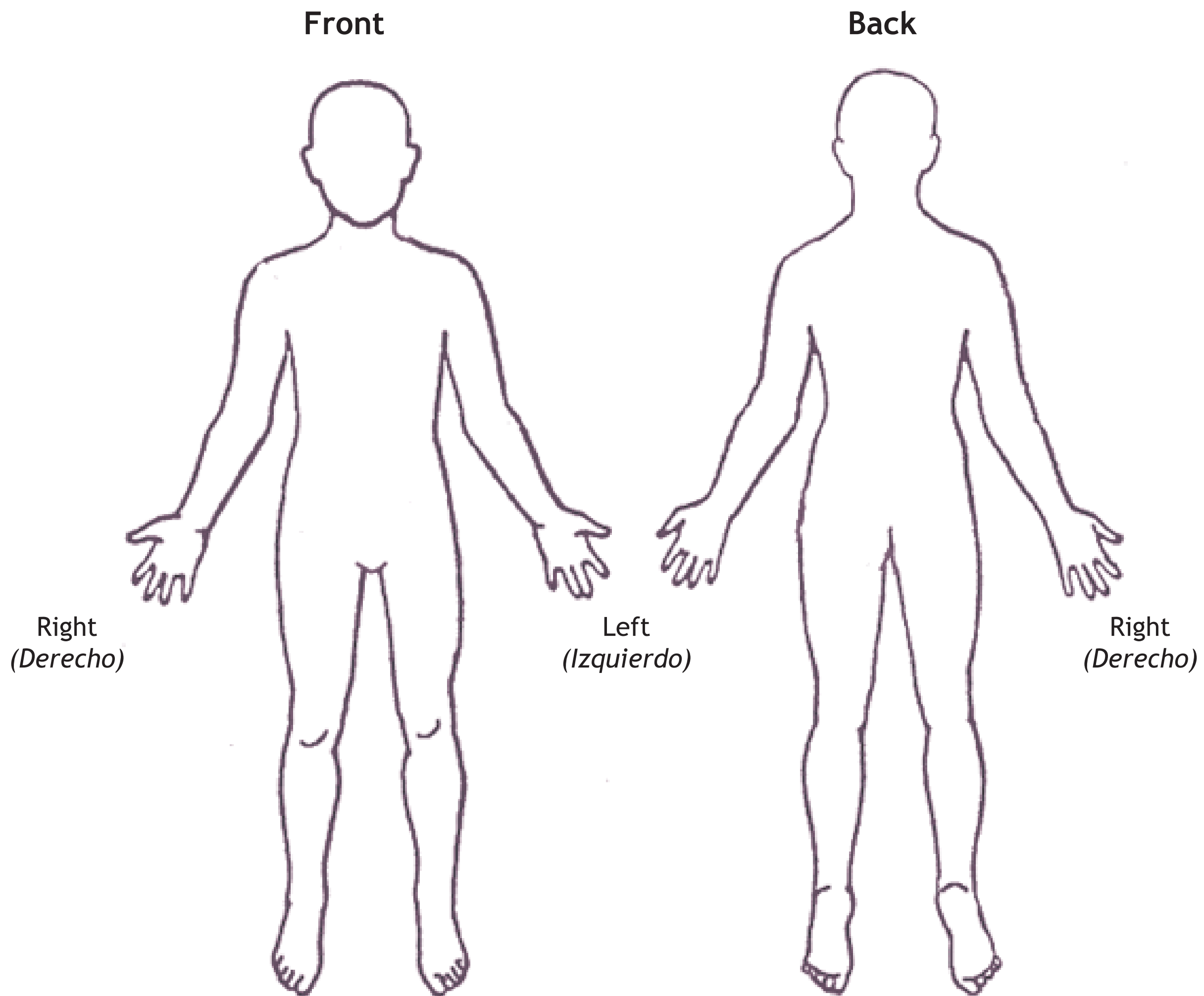
Pain Drawing Assessment

Date *(Dia)* ______________________ Name *(Nombre)* ____

The problem that brought me to the doctor today is *(La problema que fue causa detraer me al doctor hoy es)*:

❑ Back pain ❑ Neck pain	❑ Dolor de espalda
❑ Leg pain ❑ right ❑ left	❑ Dolor de pierna ❑ derecha ❑ izuierda
❑ Arm pain ❑ right ❑ left	
❑ Abnormal curvature of the spine (scoliosis)	❑ Abnormal curvature de la espina (scoliosis)

Please draw where your pain is *(Ensene en donde tiene dolor)*



Mark your pain estimate
(Ensene en donde tiene dolor)

No pain 0 . . . . 2 . . . . 4 . . . . 6 . . . . 8 . . . . 10 . . . . Intolerable pain
(No tiene dolor) *(Dolor insoportable)*

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Patient History (Spine)

Date ______________________________

Name______________________________ Age __________ Race ______________________________

Date of Birth ______ /______ /______ Male Female

Highest grade completed in school ______ Marital status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation ______________________________ Are you currently employed? ❑ Yes ❑ No

Employer at time of injury ______________________________ Is this a work-related injury? ❑ Yes ❑ No

How long did you have the job before your injury? ______________________________

Date last worked ______ /______ /______ Date accident occurred ______ /______ /______

Please provide a brief description of your accident: ______________________________

____

____

____

____

How long have you had these symptoms? ______________________________

Please describe your symptoms: ______________________________

____

____

____

Have your symptoms improved? ❑ Yes ❑ No Worsened? ❑ Yes ❑ No

Who is treating you? ______________________________

Have you been treated for your present problem by other doctors or hospitals? ❑ Yes ❑ No

If yes, please list all ______________________________

____

Have you ever had a similar back or neck problem before? ❑ Yes ❑ No

If yes, please give dates and places of treatment ______________________________

____

Does the pain limit your activity? ❑ Yes ❑ No

If yes, check the activities that it keeps you from doing

❑ Working ❑ Exercising ❑ Having fun ❑ Having sex

Which activities **INCREASE** the pain?

❑ Sitting ❑ Standing ❑ Walking ❑ Working ❑ Driving ❑ Sleeping ❑ Lifting

❑ All of the above

Which activities **DECREASE** the pain?

❑ Sitting ❑ Standing ❑ Lying down ❑ Walking ❑ Physical therapy ❑ Medications

Do you have numbness? ❑ Yes ❑ No

Where? ______________________________

Have you had any of the following tests related to your current problem? (*Please provide date and location*)

- ❑ Myelogram Date ________ /________ /________ Location ____________________
- ❑ CAT scan Date ________ /________ /________ Location ____________________
- ❑ MRI scan Date ________ /________ /________ Location ____________________
- ❑ EMG Date ________ /________ /________ Location ____________________
- ❑ Discogram Date ________ /________ /________ Location ____________________
- ❑ Physical therapy Start date ________ /________ /________ End date ________ /________ /________

Kinds of physical therapy treatment

- ❑ Heat
- ❑ Massage
- ❑ Ultrasound
- ❑ Exercises
- ❑ Traction
- ❑ Ice
- ❑ Chiropractic manipulation

Have you had **BACK** or **SPINE** surgery? ❑ Yes ❑ No

If yes, please provide the following information about your back or spine surgery

Surgical procedure	Date	Hospital	Doctor

List all surgeries you have had

Surgical procedure	Date	Hospital	Doctor

List all medications you are taking

____

____

____

Primary care physician name ____________________

Address and city ____________________

Phone ____________________

Are you **allergic** to any medications, food, or other items? ☐ Yes ☐ No

If yes, please list all allergies

____

____

____

Review of Systems

Please check any of the following that you have or have had in the past:

- ❑ Diabetes
- ❑ Heart attack ❑ heart disease ❑ high blood pressure
- ❑ Blood clot ❑ anemia ❑ leukemia ❑ bleeding disorder
- ❑ Ulcer ❑ colitis ❑ Crohn's disease
- ❑ Stroke ❑ seizures ❑ migraine headaches
- ❑ Bronchitis ❑ pneumonia ❑ emphysema ❑ asthma ❑ tuberculosis
- ❑ Kidney disease ❑ kidney stones ❑ difficulty in urination
- ❑ Hepatitis A, B, or C ❑ liver disease ❑ HIV or AIDS ❑ thyroid problems
- ❑ Rheumatoid arthritis ❑ osteoarthritis ❑ lupus
- ❑ Cancer (please explain) ______________________________

Have any of your parents, brothers, or sisters had diabetes, kidney disease, tuberculosis, cancer, heart disease, stroke, or back problems? ❑ Yes ❑ No

If yes, please explain ______________________________

____

____

____

____

Ob/Gyn History (Female patients only)

How many times have you been pregnant? ______________________________

How many living children do you have? ______________________________

Have you had a hysterectomy? ❑ Yes ❑ No Date ______ /______ /______

Are you on hormone therapy? ❑ Yes ❑ No

Date of last menstrual period ______ /______ /______ Date of last pap smear ______ /______ /______

Do you think you might be pregnant? ❑ Yes ❑ No

Tobacco

Do you smoke? ❑ Yes ❑ No

For how long? ______________________________

How many packs per day do you smoke? ______________

Caffeine

Do you drink coffee or tea? ❑ Yes ❑ No

Number of cups per day ______________________________

Drugs

Do you smoke marijuana? ❑ Yes ❑ No

Do you use street drugs other than marijuana? ❑ Yes ❑ No

Alcohol

Do you drink alcoholic beverages? ❑ Yes ❑ No

Number or drinks per day ______________________

Diet

Check those that best describe your diet.

❑ High meat ❑ Low meat

❑ Junk food and soft drinks ❑ High vegetable

❑ Fad diets ❑ Average American

Exercise

Do you exercise on a regular basis? ❑ Yes ❑ No

How many times per week? ❑ 1-2 ❑ 3-4 ❑ 5-6

Outside films brought for review? ❑ Yes ❑ No