SpineXpress Back and Neck Clinic

PATIENT REGISTRATION

Patient Information

Last Name ______________________ First ______________________ MI ________

Address ______________________ City/State/Zip ______________________

Phone-Home ______________________ Cell Phone ______________________

Date of Birth ______________________ SS No. ______________________

Email Address ______________________

Physician ______________________

Referred By: Physician ____ Friend/Relative ____ Emergency Room ____ Yellow Pages ____ Other ____

Referring Physician ______________________ Physician Phone ______________________

Physician Address ______________________ City/State/Zip ______________________

Employer ______________________ Employer Phone ______________________

Employer Address ______________________ City/State/Zip ______________________

Emergency Contact ______________________ Contact Phone ______________________

Relationship ______________________ ______________________

Contact Address ______________________ City/State/Zip ______________________

Preferred Pharmacy ______________________ Pharmacy Phone ______________________

Responsible Party

Last Name ______________________ First ______________________ MI ________

Address ______________________ City/State/Zip ______________________

Phone-Home ______________________ Date of birth ____________ SS No. ______________________

Sex: M F Marital Status S M D W Sep

Employer ______________________ Employer Phone ______________________

Employer Address ______________________ City/State/Zip ______________________

Insurance Information

Primary Insurance Co. ______________________ Policy No. ____________ Group No. ____________

Policy Holder ______________________ SS No. ____________ Date of birth ____________

Policy Holder Address ______________________ City/State/Zip ______________________

Relation to Patient ______________________ Referral No. ____________ Copay ____________

Other Insurance Co. ______________________ Policy No. ____________ Group No. ____________

Policy Holder ______________________ SS No. ____________ Date of birth ____________

Policy Holder Address ______________________ City/State/Zip ______________________

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to SpineXpress, (b) release of information including protected health information to insurance companies as needed to file for payment for services incurred, (c) SpineXpress to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible for payment to SpineXpress for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party) ______________________ Date ____________

SpineXpress Back and Neck Clinic

HEALTH HISTORY

Date: ________________________

Name ____ Age ___________ Were you referred by a Physician? Yes _____ No _____

Who requested our services? ______________________________ Family Physician ____

Reason for seeking medical attention ____ Right Left Both

Date of injury or duration of symptoms _____________ Work related? Yes _____ No _____ Are your right or left handed? _______________

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list ____

Have you seen anyone else regarding this condition? Yes _____ No _____ If yes, list names and dates ______________________________

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	_____	_____	Rheumatoid Arthritis	_____	_____	Osteoarthritis	_____	_____
Kidney Disease	_____	_____	Anemia	_____	_____	Alcoholism	_____	_____
Lupus	_____	_____	Migraines	_____	_____	Sickle Cell Disease	_____	_____
Bleeding Tendencies	_____	_____	Cancer	_____	_____	Colitis	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____	Stroke	_____	_____
Epilepsy	_____	_____	Goiter	_____	_____	Stomach Ulcers	_____	_____
High Blood Pressure	_____	_____	Lung Disease	_____	_____	Depression/Anxiety	_____	_____
Polio	_____	_____	Nervous System Disorder	_____	_____	Pelvic Radiation	_____	_____
Hepatitis	_____	_____	Tuberculosis	_____	_____	COPD (Chronic Obstructive Pulmonary Disease)	_____	_____

Other Medical Conditions: ____

Are there law suits pending on your orthopaedic condition? ____

Please list any orthopaedic surgeries and dates:

____

____

____

Please list any other surgeries and dates:

____

____

____

Please list all current medications and dosages:

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Are you allergic to: (check if you are)

Latex ____ Penicillin____ Cephalosporin ____ Mycins ____ Sulfa ____ Tetanus ____ Iodine __

Dyes ____ Aspirin ____ Codeine ____ Morphine ____ Adhesive Tape ____ Arthritis Medicine ____

Foods (please list)____

Others: ____

Please explain allergic reaction: ____

Do you currently use tobacco: Cigarettes ____ Pipe ____ Smokeless ____ Amount per day:_____ Quit when?_____

Do you drink alcohol: Beer ____ Liquor ____ Wine ____ Amount per day:_______ or per week: _____

What is your current occupation?____

Has anyone in your family had:

High Blood Pressure ____ Heart Disease ____ Cancer* ____ Diabetes ____ Bleeding Problems ____ Lung Disease ____

*If yes, what type of cancer?

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	_____	_____	Irregular Heart Beat	_____	_____	Fainting Spells	_____	_____
Breathing Difficulties	_____	_____	Cough	_____	_____	Cough with Blood	_____	_____
Numbness or Tingling	_____	_____	Dizziness	_____	_____	Headaches or Migraines	_____	_____
Vision Changes	_____	_____	Fever or Chills	_____	_____	Unexpected Weight Loss	_____	_____
Abdominal Pain	_____	_____	Nausea or Vomiting	_____	_____	Diarrhea	_____	_____
Bloody or Black Tarry Stools	_____	_____	Loss of Control of Bowels	_____	_____	Difficulty Starting Urine	_____	_____
Pain or Burning on Urination	_____	_____	Blood in Urine	_____	_____	Loss of Control of Bladder	_____	_____

Patient Signature ____________________________ Physician's Signature ____________________________ Date: ______________

(I have reviewed this information with the patient)

Ht. _________ Wt. _________ Blood Pressure: _____/______ Pulse ___________

PATIENT NOTICE

Date: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF THE PATIENT PRIVACY NOTICE

I, ______________________________, do hereby acknowledge receipt of SpineXpress's Patient Privacy Notice on
Patient Name (please print)

______________________.
Date

Patient Signature

____

Patient# ______________________

SpineXpress Back and Neck Clinic

Date: ______________________________

Request for release of information

I hereby request that my medical records be released to SpineXpress.

Patient name:____________________________
Date of Birth: ____________________________

Patient Signature : ____________________________ Date: _______________

Please fax records to __________________ . Attn: Medical records department

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Consent to Destroy X-RAY and Graphic Data

I hereby authorize the physicians and/or staff at SpineXpress to dispose/retire at its discretion xray film and any other graphic data which may be generated during my evaluation four (4) years after they are generated if a proper report is in my medical record.

Date: _____________ Patient signature : ____________________________

SpineXpress Back and Neck Clinic

AUTHORIZATION TO DISCLOSE INFORMATION

Date: ______________________

For information about how your medical information may be used or disclosed, please see the patient notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer of SpineXpress. The notice is also posted at the offices of SpineXpress.

YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED. WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPETED BY PATIENT OR PATIENT REPRESENTATIVE

By my request, I hereby authorize SpineXpress to disclose information regarding my treatment, insurance issues and payment issues to the people listed below. These individuals will be asked to identify themselves and state the patient's social security number and zip code.

Name (please print)	Relationship (please print)

I understand that this authorization is voluntary. I understand that the person to whom I authorize disclosure of my personal data is not a health plan, health care provider or clearinghouse and that the released information, in their possession, may no longer be protected by federal privacy regulation. I understand that I may withdraw my authorization in writing to the Privacy Officer of SpineXpress Back and Neck Clinic at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire 10 years from this date. I have carefully read this statement.I understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about my condition to those persons or agencies listed above.

______________________ ______________________

Signature of patient or patient's representative Date

Printed name of patient's representative______________________

Description of the Representative's authority to act for the patient______________________

Relationship to the patient ______________________

Patient #: ______________________