

PATIENT REGISTRATION (Please Print)

PATIENT INFORMATION

PATIENT NAME _____

BIRTHDATE _____ AGE _____ SOC. SEC. # _____ MALE FEMALE
MM / DD / YY

RESPONSIBLE PARTY _____ Name _____ Date of Birth _____ Relationship _____
(if other than patient)

MAILING ADDRESS _____ Street _____ APT # _____

City _____ State _____ Zip _____ +4 _____ Social Security Number _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____ EMPLOYER _____

REFERRED BY _____ PRIMARY CARE DR _____

MARITAL STATUS: SINGLE 1 MARRIED 2 WIDOWED 4 DIVORCED 5 SEPARATED 6 OTHER 3

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PLAN COPAY \$ _____

Subscriber Name _____ MALE FEMALE BIRTHDATE _____

Social Security Number _____ Relationship to Patient _____

Subscribers Employer _____ Insurance Company Address _____

SUBSCRIBER ID # _____ GROUP ID # _____

SECONDARY INSURANCE _____ PLAN COPAY \$ _____

Subscriber Name _____ MALE FEMALE BIRTHDATE _____

Social Security Number _____ Relationship to Patient _____

Subscribers Employer _____ Insurance Company Address _____

SUBSCRIBER ID # _____ GROUP ID # _____

(WORKER'S COMPENSATION ONLY)

DATE OF INJURY: _____ CLAIM # _____

EMPLOYER AT _____ ADJUSTOR _____
TIME OF INJ _____ NAME _____

INSURANCE _____ CLAIM MAILING _____
ADDRESS _____

INS. PHONE _____ INS FAX _____ CITY/STATE/ZIP _____

ATTORNEY'S _____ ADJ.. PHONE _____ ADJ. _____
NAME _____ FAX _____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY _____ () _____ Home Phone _____
Name

Relationship to Patient _____ () _____ Work Phone _____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by provider or insurance company required for this account. Release of information to include: (1) alcohol and / or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) Treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release PrimeCare from all legal responsibility or liability that may arise from disclosure of my record as provided by this paragraph.

Payment: I am financially responsible for any balance due. I agree to make payment arrangements; pay \$5 or 1% interest per month (whichever is greater) on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

I'VE VERIFIED THAT MY PATIENT DEMOGRAPHICS ARE THE SAME.

SIGNED DATE

SIGNED DATE

SPINE AND SPORTS MEDICAL GROUP/SURGERY CENTER

429 LLEWELLYN AVE, CAMPBELL, CA 95008
PHONE (408) 364-1616 • FAX (408) 378-6775

HIPPA Privacy Rule - Written Acknowledgement of Privacy Practices Receipt

**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, the Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR CENTER USE ONLY

[] Consent received by _____ on _____.

[] Consent refused by patient, and treatment refused as permitted.

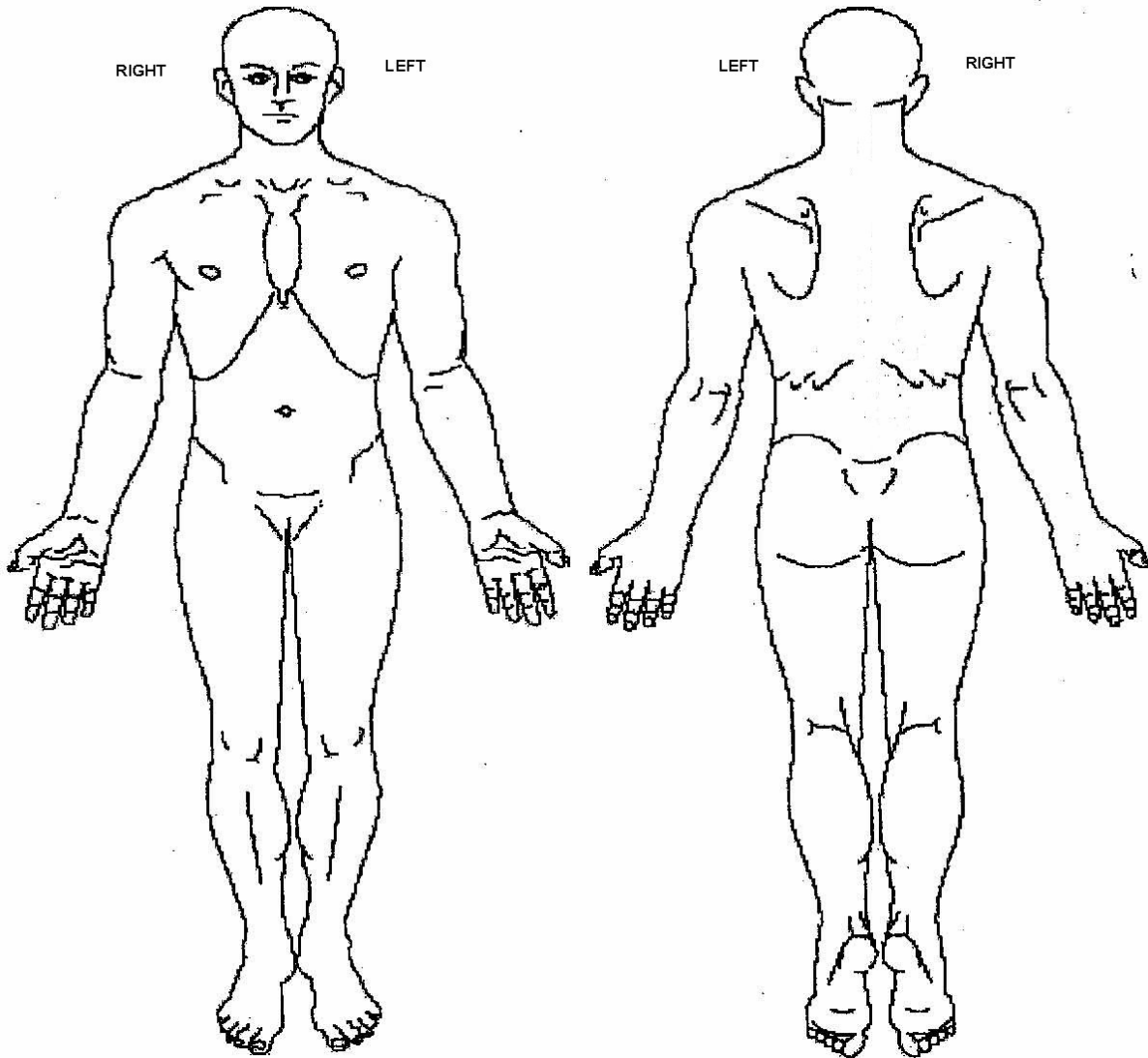
PAIN DIAGRAM

Name: _____

Date: _____

Draw the location of your pain on the body outlines below. Use the following keys

Ache	Burning	Numbness	Pins & needles	Stabbing	Other
/////	BBBBB	XXXXX	+++++	ZZZZZ	OOOOO



Circle Your Level of Pain (0 – 10)										
0	1	2	3	4	5	6	7	8	9	10
No pain					Intolerable					

HEALTH QUESTIONNAIRE

NAME: _____ Date of Birth : _____ Age: _____

Height: _____ Weight: _____ Right Handed ____ Left Handed ____ Ambidextrous ____

Date of Injury: _____ Describe what happened? _____

What is your employment? _____ Describe your duties: _____

Company name: _____ Years of employment? _____

Are you still working? Yes ____ No ____ If no, date last worked? _____

Are you working full time? _____ If not, how many hours/day? _____

Regular duty? Yes ____ No ____ If no, describe your Modified duty and restrictions? _____

What activities increase your pain?

Standing ____ Walking ____ Sitting ____ Lifting ____
Bending ____ Lying ____ Reaching ____
Others _____

What activities reduce your pain?

Lying ____ Sitting ____ Standing ____ Walking ____
Ice ____ Heat ____ Massage ____
Others _____

Have you had?

Xrays ____ MRI ____ EMG ____

Others _____

What treatments have you had for this injury?

PT: ____ # times ____ Is it effective? ____ Chiropractor: ____ # times ____ Is it effective? ____

Acupuncture: ____ # times ____ Is it effective? ____

Injections ____ What kind? _____

Surgery ____ What kind? _____

Others _____

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6. GENERAL MEDICATIONS:

Drugs recently taken, within the past six months, have you taken (circle No or Yes or Don't Know):

Cortisone	No	Yes	Don't know
Anticoagulants	No	Yes	Don't know
Tranquilizers	No	Yes	Don't know
Hypotensives (high blood pressure medications).....	No	Yes	Don't know

List ALL GENERAL (i.e. NOT for your current spine condition) MEDICATIONS you are **currently** taking

1. _____ Dose (mg): _____ Frequency (how many times a day): _____
2. _____ Dose (mg): _____ Frequency (how many times a day): _____
3. _____ Dose (mg): _____ Frequency (how many times a day): _____
4. _____ Dose (mg): _____ Frequency (how many times a day): _____
5. _____ Dose (mg): _____ Frequency (how many times a day): _____
6. _____ Dose (mg): _____ Frequency (how many times a day): _____

7. MEDICATIONS FOR YOUR SPINAL CONDITION

List ALL PAIN/ANTI-INFLAMMATORIES, etc. you are **currently** taking for your spinal condition

1. _____ Dose (mg): _____ Frequency (how many times a day): _____
2. _____ Dose (mg): _____ Frequency (how many times a day): _____
3. _____ Dose (mg): _____ Frequency (how many times a day): _____
4. _____ Dose (mg): _____ Frequency (how many times a day): _____
5. _____ Dose (mg): _____ Frequency (how many times a day): _____
6. _____ Dose (mg): _____ Frequency (how many times a day): _____

8. ALLERGIES AND SENSITIVITIES:

Is there a history of any reaction or sickness following injection or oral administration of:

				Describe Reaction
Penicillin or other antibiotics (please specify).....	No	Yes	Don't know	_____
Morphine, codeine, Demerol or other narcotics (please specify).....	No	Yes	Don't know	_____
Novocain or other anesthetics (please specify).....	No	Yes	Don't know	_____
Aspirin, Empirin or other pain remedies (please specify).....	No	Yes	Don't know	_____
Sulfa drugs	No	Yes	Don't know	_____
Tetanus antitoxin or other serums (please specify).....	No	Yes	Don't know	_____
Any other drug or medication (please specify).....	No	Yes	Don't know	_____
Any x-ray contrast material (dye, etc.)	No	Yes	Don't know	_____
Seasonal/environmental allergies (e.g. hay fever, perfumes, etc.)	No	Yes	Don't know	_____
Any foods, such as eggs, milk, or chocolate (please specify).....	No	Yes	Don't know	_____

REVIEW OF SYSTEMS:

Do you have, or have you had, any of the following:

9. General:

Recent weight gain	No	Yes
Have you been in good general health.....	No	Yes

10. Skin:

Acne.....	No	Yes
Dry skin/itching	No	Yes
Eczema.....	No	Yes
Rash	No	Yes

11. Head-Eyes-Ears-Nose-Throat:

Blurry vision/double vision (please specify)	No	Yes
Cataracts	No	Yes
Contact lenses/glasses (please specify).....	No	Yes
Dizziness.....	No	Yes
Ear problems (drainage, earache, etc.).....	No	Yes
Eye problems (drainage, infection, etc.)	No	Yes
Hearing loss	No	Yes
Loss of balance	No	Yes
Neck stiffness.....	No	Yes

12. Breast:

Discharge.....	No	Yes
Infection.....	No	Yes
Mass/lump	No	Yes
Surgery	No	Yes

13. Cardiac:

Angina	No	Yes
Cardiac surgery.....	No	Yes
Chest pain	No	Yes
Murmur.....	No	Yes
Palpitations	No	Yes
Shortness of breath	No	Yes
Swelling of extremities (arms/legs)	No	Yes

14. Pulmonary:

Asthma.....	No	Yes
Frequent cough.....	No	Yes
Pain with breathing	No	Yes
Wheezing	No	Yes

15. Gastrointestinal:

- Abdominal pain No Yes
- Appetite change No Yes
- Blood in stool..... No Yes
- Change in bowel habits..... No Yes
- Constipation No Yes
- Diarrhea No Yes
- Gallbladder problems..... No Yes
- Indigestion/heartburn No Yes
- Hemorrhoids or piles No Yes
- Nausea/vomiting No Yes
- NSAID intolerance No Yes
- Rectal bleeding No Yes
- Ulcers No Yes

16. Urologic:

- Dribbling No Yes
- Dysuria (pain or burning with urination) No Yes
- Frequency No Yes
- Incontinence No Yes
- Hematuria (blood in urine) No Yes
- History of stones No Yes
- Infection No Yes
- Nocturia (night time urination) No Yes
- Stress incontinence No Yes
- Urgency No Yes

17. Ob-Gyn:

- # of pregnancies _____ # of miscarriages _____
- Date of last Pap smear _____
- Results (negative or positive) _____
- Frequency of periods, every _____ days
- Any pain with periods No Yes
- Menopausal..... No Yes
(if yes, at what age _____)

18. Musculoskeletal:

- Any other problems other than your reason.....
- For your visit today No Yes
- IF YOU ANSWERED "YES" PLEASE SPECIFY BELOW:**
- Arthritis..... No Yes
- Joint pain..... No Yes
- Joint swelling..... No Yes
- Osteopenia No Yes
- Rheumatoid arthritis No Yes
- Other pains/problems..... No Yes
- Please specify below:.....
-
-
-
-

19. Neurological:

- Dizziness/fainting spells..... No Yes
- Headaches..... No Yes
- Loss of consciousness..... No Yes
- Memory loss No Yes
- Paralysis No Yes
- Seizures No Yes

20. Vascular:

- Abnormal bleeding or bruising..... No Yes
- Aneurysm No Yes
- Are you a Jehovah's Witness No Yes
- Phlebitis No Yes
- Varicose veins No Yes

21. Endocrine:

- Blood transfusion..... No Yes
- Hormone therapy No Yes
- Thyroid problems No Yes
- Varicose veins No Yes

22. Immune System:

- AIDS..... No Yes
- Diabetes No Yes
- History of infections No Yes
- Immunosuppressive disorders No Yes

23. Surgery:

- Anesthetic allergy/problem No Yes
- Iodine allergy..... No Yes
- Postoperative infections/complications No Yes
- Suture reaction..... No Yes
- Tape allergy..... No Yes
- Severe nausea/vomiting after general anesthesia No Yes
- Waking-up problem after anesthesia No Yes

Any other information we should be aware of:

Thank you for filling out the questionnaire. It will assist us in providing the best care to you.