Welcome to Spine & Neuro Center

****** Please return this paperwork to the front desk within 30-45 minutes ******

Today's Date ____/____/____ **Which physician are you here to see? _____**

PATIENT INFORMATION

Patient's First Name	M.I.	Last Name	Date of Birth	Gender Male Female	Race

Ethnicity (Circle One) Hispanic or Latino Not Hispanic or Latino Declined to specify	Primary Language	SSN

Street Address	City	State	Zip Code	Marital Status

Employment Status (Circle One) Employed Unemployed Full Time Student Part Time Student Retired Child	Employer	How long employed?	Occupation

Home Phone # ( )	Business Phone # ext ( )	Cell Phone # ( )	Email Address

Preferred Primary Contact? (Circle One) Home Business Cell

EMERGENCY CONTACT

Authorization to release medical information to your emergency contact? □ Yes □ No

First Name	Last Name	Emergency Phone # ( )	Relationship

Street Address	City	State	Zip Code

REFERRING PHYSICIAN

First Name	Last Name	Specialty	Phone # ( )	Fax # ( )

Street Address	City	State	Zip Code

PRIMARY CARE PHYSICIAN

First Name	Last Name	Specialty	Phone # ( )	Fax # ( )

Street Address	City	State	Zip Code

PHARMACY - What is your preferred pharmacy?

Name	Street Address	City	State	Zip Code	Phone # ( )

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Does your pain spread? □ Yes □ No If **YES**, where does it spread to? _____

When did you first notice the pain for which you are coming in for? Date: _____/_____/_____

Current problem is a result of: □ Car accident □ Work accident □ Other accident

Other accident description: _____ Date of accident: _____/_____/_____

Type of pain: □ Pressure □ Throbbing □ Tension □ Sharp □ Burning
□ Dull ache □ Stabbing □ Drawing □ Boring □ Excruciating

Have you had any of the following studies regarding your current problem? **(CIRCLE ALL THAT APPLY)**

X-ray CT Scan MRI Scan EEG EMG Nerve Conduction Studies Doppler Studies Arteriogram

When & Where were these studies done? _____

REVIEW OF SYSTEMS

Please mark all that apply to you

Constitutional

□ Good health lately □ Fatigue □ Fevers □ No change from prior visit □ Recent weight change

Eyes

□ Blurred or double vision □ Eye disease or injury □ Glasses, contact lenses □ Glaucoma

ENT

Nose □ Nosebleeds □ Sinus problems

Mouth □ Bleeding gums

Ears □ Earaches or drainage □ Hearing loss □ Ringing in ears

Throat/Neck □ Swollen glands in neck

Respiratory

□ Asthma □ COPD/Emphysema □ Frequent coughing □ Shortness of breath □ Sleep apnea
□ Spitting up blood □ Tuberculosis □ Wheezing

Cardiovascular/Heart

□ Bradycardia □ Chest pains □ Heart attack □ Heart trouble □ High blood pressure
□ Pacemaker □ Sudden heartbeat changes □ Swelling of feet, ankles, hands

Gastrointestinal

□ Bowel incontinence □ Change of bowel movements □ Constipation □ Frequent diarrhea □ GERD
□ Hepatitis/Jaundice □ IBS □ Loss of appetite □ Nausea or vomiting □ Painful bowel movements
□ Stomach ulcers

Musculoskeletal/Bones/Joints

□ Cold extremities □ Difficulty walking □ Joint pain □ Joint stiffness or swelling □ Joint weakness
□ Muscle pain or cramps □ Muscle weakness □ Osteoporosis

Psychiatric

□ Bipolar disorder □ Depression □ Memory loss □ Nervousness □ Psychiatric illness
□ Sleep problems

Skin

□ Change in skin color □ Dry skin □ Itching □ Psoriasis □ Rash

Neurological

□ Balance problems □ Blackouts/fainting spells □ Convulsions/tremors/shaking □ Dementia
□ Frequent/recurring headaches □ Head injury □ Lightheaded or dizzy □ Numbness/tingling sensation
□ Seizures □ Stroke

Endocrine/Hormones

□ Change in hair □ Change in nails □ Diabetes or sugar □ Excessive thirst or urination
□ Heat or cold intolerance □ High cholesterol □ Thyroid disease
□ Glandular/hormone problems

Hematological/Lymphatic

□ Anemia □ Easily bruise or bleed □ History of DVT/blood clot □ Past transfusion(s) □ Phlebitis
□ Slow to heal after cuts

Genitourinary/Kidney/Bladder

Urinary □ Bladder dribbling □ Bladder incontinence □ Blood in urine □ Burning or painful urination
□ Frequent urination □ Irregular menstrual periods □ Kidney stones □ Sexual difficulty □ Unusual discharge

ALLERGIES

Allergic to adhesives? □ Yes □ No Allergic to latex? □ Yes □ No Allergic to the flu vaccine? □ Yes □ No
Allergic to shellfish? □ Yes □ No Allergic to eggs? □ Yes □ No

List any medications you are allergic to and the reaction: □ **No known allergies**

Medication Name	Reaction	Medication Name	Reaction
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

MEDICATIONS - Please list all prescription & over-the-counter medications you are currently taking and the dosage

□ **I am NOT currently taking any medications**

Medication Name	Dosage/Frequency	Reason for taking this medication
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

BLOOD THINNING MEDICATION

Are you on any blood thinning medication? □ Yes □ No

(i.e.: Aspirin, Plavix, Coumadin, Pletal, Effient, Aggrenox, Ticlid)

HERBAL SUPPLEMENTS

Do you take herbal supplements? □ Yes □ No If yes, please list:

Herbal Supplement Name	Dosage/Frequency	Herbal Supplement Name	Dosage/Frequency
1)		3)	
2)		4)	

FAMILY HISTORY

□ Unknown / Adopted	Father	Mother	Brother	Sister	Son	Daughter
Diabetes	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Tuberculosis	□	□	□	□	□	□
Bleeding Tendency	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Allergies	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□
Brain Aneurysm	□	□	□	□	□	□
Tumors (non-malignant)	□	□	□	□	□	□
Malignant Hyperthermia	□	□	□	□	□	□

MEDICAL HISTORY - Check all that apply

Are you currently being treated or have you ever been treated for the following: □ Diabetes □ Tuberculosis

□ Cancer Type of cancer: _____ □ Stroke □ Migraines □ Arthritis □ Ulcers □ Fibromyalgia

□ HIV/AIDS □ Hepatitis □ Heart Attack □ Chronic Fatigue □ Psychiatric Illness □ Claustrophobia

Please list other conditions not mentioned above:

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

PAIN MANAGEMENT

Do you use a medication patch (transdermal)? □ Yes □ No If YES, what is the name: _____

Are you currently seeing a pain management specialist? □ Yes □ No If YES, whom? _____

Do you have any of the following? □ Pain Pump □ Spinal Cord Stimulator □ Metallic Fragment □ Pacemaker

□ Foreign Body □ Defibrillator □ Aneurysm Clip or Coil □ Stent

SOCIAL HISTORY

Do you live alone? □ Yes □ No Are you currently homeless? □ Yes □ No
Do you consume caffeine? □ Yes □ No Amount: _____

Do you consume alcohol? **Beer** - □ No □ Social □ Occasionally □ Light □ Heavy
Wine - □ No □ Social □ Occasionally □ Light □ Heavy
Hard Liquor - □ No □ Social □ Occasionally □ Light □ Heavy

Do you use tobacco? **Cigarettes** - □ Yes □ No
Cigars - □ Yes □ No
Pipe - □ Yes □ No
Chewing Tobacco - □ Yes □ No
Dipping Tobacco - □ Yes □ No

Please circle one: Never smoked Current every day smoker Current some day smoker Former smoker

Do you use illegal drugs? □ Yes □ No Type: _____ Do you have difficulty sleeping? □ Yes □ No
Do you exercise regularly? □ Yes □ No Height: _____feet _____ inches Weight: _____ pounds

MEDICAL QUESTIONNAIRE

1) Did you receive an influenza vaccination? □ Yes □ No If YES, what month/year? _____
If NO, circle one of the following:
Declined for personal reason Declined for medical reason Declined for no certain reason

2) Have you received a colorectal cancer screening? □ Yes □ No Date? _____
Which screening did you receive? □ Sigmoidoscopy □ Colonoscopy □ Fecal Occult Blood Test

3) Have you received your pneumonia vaccination? □ Yes □ No Date? _____

4) The following Morse Fall Scale will assess a patient's likelihood of falling
History of falling? □ Yes □ No If YES, how many falls? _____ Any injuries from falling? □ Yes □ No
Ambulatory aid? □ Bed rest / Nurse Assist □ Crutches / cane / walker □ Furniture
IV or IV access - □ Yes □ No
Gait (how you walk) - □ Normal / bed rest / immobile □ Weak □ Impaired
Mental Status - □ Knows own limits □ Overestimates or forgets limits

5) Women - Have you received your annual mammogram? □ Yes □ No Date? _____

SURGICAL HISTORY

SURGERY	DATE	SURGEON	SURGERY	DATE	SURGEON
1)			6)		
2)			7)		
3)			8)		
4)			9)		
5)			10)		

ANESTHESIA

Have you had general anesthesia? □ Yes □ No
Have you had any problems with anesthesia? □ Yes □ No If YES, please describe: _____

The above information, as provided by me, is correct to the best of my knowledge.

X _____ _____/_____/_____
Signature of Patient and/or Authorized Representative Date

ASSIGNMENT OF INSURANCE BENEFITS / AGREEMENT TO PAY

I hereby authorize the Spine & Neuro Center or hospital to release to my insurers full information, including copies of records and operative notes relative to this illness. I authorize payment directly to Spine & Neuro Center for the benefits payable under the terms of my policy for this period of illness. I understand that I am financially responsible for any charges billed but not covered by my insurance or by this authorization.I also understand that I am financially responsible for any copays, deductibles, and/or coinsurance not paid by my insurance company and and any charges for which they deny payment. These copays, deductibles, and/or coinsurances are due at the time of your visit. If there is any remaining balance, you will be billed for that amount.

X _____ / /

Signature of Patient and/or Authorized Representative — Date

ADDITIONAL CHARGES

After Hour Phone Calls

Spine & Neuro Center encourages all patients to call during normal business hours. There will be a $15 fee assessed for phone calls that occur when the office is closed if the call is not an emergency.

Paperwork Fee

There is a $20.00 fee for paperwork to be filled out or any letter to be written by our office.

Returned Check Fee

There is a $30.00 fee for returned checks.

X _____ / /

Signature of Patient and/or Authorized Representative — Date

Credit Card Authorization and Consent

This consent gives Spine & Neuro Center permission to charge balances and/or down payments on future procedures to your credit/debit card that you call and request to be charged over the phone. You will have to provide your card information when you call as Spine & Neuro Center does **NOT** keep credit/debit card information on file for any patient.

Choose one of the options below:

Option 1) I, _____, give Spine & Neuro Center permission to charge my debit/credit card for balances and/or future procedures per my request by phone. I understand that this applies to the charge that I specifically call and request and that if other payments need to be made in the future, I will have to call Spine & Neuro Center prior to each payment.

Option 2) I, _____, decline the option to make a payment with my debit/credit card by phone and understand that I will need to mail my payment or come into the office if I wish to pay with a debit/credit card.

X _____ / /

Signature of Patient and/or Authorized Representative — Date

X _____ / /

Witness (Spine & Neuro Staff) — Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge and have been offered a copy of the "Notice of Privacy Practices" adopted by Spine & Neuro Center. I understand that if I have any questions about the "Notice of Privacy Practices", I may contact the Center's Compliance Officer at (256) 533-1600.
The address of Spine & Neuro Center is: 201 Governors Dr., First Floor, Huntsville, AL 35801.

X _____ / / _____
Signature of Patient and/or Authorized Representative — Date

X _____ / / _____
Witness (Spine & Neuro Staff) — Date

□ **Good faith attempt has been made to provide the patient with our "Notice of Privacy Practices"**

X _____ / / _____
Spine & Neuro Staff Signature — Date

DISCLOSURE - Please read carefully before signing

The Physicians and Staff of Spine & Neuro Center are proud to partner with many health care companies to improve the quality and control the cost of health care for our patients. The physicians of Spine & Neuro Center want to make you aware of relationships with medical related companies.

Many of our physicians have significant relationships with spinal implant companies which provide metal implants for the spine such as cervical and lumbar plates, rods and screws, pedicle screws, and cages. These relationships have significant financial value and may include consulting agreements, reimbursement for development ideas and intellectual properties, and ownership or investor roles. These companies include Spinal USA, PDP Spine, Globus Medical and Medtronic.

Should you have any questions or concerns, please discuss them with your physician or our office staff.

X _____ / / _____
Signature of Patient and/or Authorized Representative — Date

RELEASE OF MEDICAL INFORMATION

I, _____, give permission to Spine & Neuro Center to release information regarding medical care at this office, including my prescriptions, my appointments, and other medical information to my referring physician and/or family physician and to the following people. I also give permission for message to be left on the answering machine at my home phone and/or my cellphone voicemail.

Name	Relationship	Home Number/Cell Phone Number
Name	Relationship	Home Number/Cell Phone Number
Name	Relationship	Home Number/Cell Phone Number

I understand that every effort will be made by Spine & Neuro Center to contact me with this information, but in order to provide me with the best medical care possible, it may be necessary, in my absence, to give information to others. This release will remain in effect indefinitely or until revoked by me.

X _____ / / _____
Signature of Patient and/or Authorized Representative — Date