

PATIENT REGISTRATION FORM

IF FORM IS NOT COMPLETE WE CANNOT BILL YOUR INSURANCE

ACCOUNT # _____

Billing Code: _____ Resp Dr. # _____ New Pt. Update

PATIENT NAME: _____ RESPONSIBLE PARTY FOR MINOR: _____

ADDRESS: _____ APT # _____ CITY, ST, ZIP: _____

PRIMARY PH: _____ CELL / ALT PH: _____ EMAIL: _____ SEX: Male Female

PT. SS # _____ RESP PARTY SS #: _____ RELATIONSHIP TO PT: Self Spouse Parent Other

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

PRIMARY CARE PHYSICIAN & ADDRESS: _____

IF INJURY IS RELATED TO AN ACCIDENT, Was it an: Auto Accident Job Related Injury DATE OF INJURY: _____

IS PATIENT: SINGLE MARRIED OTHER IS PATIENT: EMPLOYED STUDENT RETIRED

PT. EMPLOYER NAME AND ADDRESS: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE / ADDRESS OF PERSON ABOVE: _____

WHAT ARE YOU BEING SEEN FOR: : _____ FIRST DATE OF SYMPTOMS: _____

INSURANCE INFORMATION:

ARE YOU PREGNANT? Yes No

INDUSTRIAL / WORKMAN'S COMPENSATION

PRIMARY INSURANCE
INSURANCE CO. NAME: _____

SECONDARY INSURANCE:
INSURANCE CO. NAME: _____

INS CO. ADDRESS: _____

INS CO. ADDRESS: _____

POLICY HOLDER NAME: _____

POLICY HOLDER NAME: _____

RELATIONSHIP TO PT: _____

RELATIONSHIP TO PT: _____

EMPLOYER: _____

EMPLOYER: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

POLICY NO. _____ GROUP/CLAIM NO.: _____

POLICY HOLDER SEX: F M BIRTHDATE: _____

POLICY HOLDER SEX: F M BIRTHDATE: _____

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS: I hereby authorize this physician/clinic to release and/or obtain any information required in the course of my examination or treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

SIGNED (patient or parent, if minor): _____ **DATE:** _____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED: _____ **DATE:** _____

AUTHORIZATION TO TREAT MINOR: I hereby authorize the physician (s), physician assistants, technicians or other authorized medical personnel of Spine Institute of Arizona to treat the above patient.

SIGNED Patient (or Legal Guardian): _____ **DATE:** _____



SPINE INSTITUTE OF ARIZONA

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Spine Institute of Arizona's 'Notice of Privacy Practices'. This Notice described how Spine Institute of Arizona may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Patient or Legally Authorized Individual Signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)



SPINE INSTITUTE OF ARIZONA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Spine Institute of Arizona may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Spine Institute of Arizona's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Spine Institute of Arizona reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Spine Institute of Arizona's Privacy Officer at 9735 North 90th Place, Scottsdale, Arizona 85258.

With my consent, Spine Institute of Arizona may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Spine Institute of Arizona may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Spine Institute of Arizona may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Spine Institute of Arizona restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Spine Institute of Arizona's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Spine Institute of Arizona may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Printed Name

Date

Print Name of Patient or Legal Guardian



**SPINE
INSTITUTE
OF ARIZONA**

9735 North 90th Place
Scottsdale, Arizona 85258
TEL 602/953.9500
FAX 602/953.1782

**Authorization for Disclosure of My Health Information to
My Spouse / Significant Other / Parent / Family Member**

I, _____, hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) may obtain or receive copies of my Protected Health Information to include, but is not limited to; office notes, prescriptions, imaging films.

Unless I revoke this authorization earlier, this authorization will expire six years from the date signed.

Name(s) of Spouse/Significant Other/Parent/Family Member(s)

Relationship

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE NOTE: *Your Spouse/Significant Other/Parent/Family Member(s) will be required to show legal I.D. prior to being able to obtain your Protected Health Information.*

Signature of Patient or Legal Guardian

Date

Patient or Legal Guardian's Printed Name

FINANCIAL STATEMENT

It is the policy of the Spine Institute of Arizona to collect co-pays and any outstanding patient balances before each visit. If you cannot pay your co-pay and any outstanding balance your appointment will be rescheduled.

Our business office will bill your medical insurance for the services rendered in our office. Payment is not guaranteed by your insurance. You are ultimately responsible for all charges. The insurance process normally takes approximately 60-90 days. You will receive monthly financial statements to include any outstanding charges on your account. Once insurance has processed payment, your financial statement will reflect any deductibles and/or co-insurance due from you as per your insurance.

It is your responsibility to know and understand your insurance policy and benefits. We will bill secondary insurance as a courtesy.

Our providers are not contracted with any AHCCCS / Medicaid insurance programs. You will be responsible for outstanding balances.

If your insurance has lapsed, is inactive, or for any reason does not cover the expenses that you have incurred at the Spine Institute of Arizona, you will be responsible for the full charges that have been billed to your insurance company. Payment for these charges must be received within 30 days from receipt of your bill.

If you choose to pay by check and your check does not clear, you will be responsible for paying the bank administrative charge of \$25.00 plus the amount of your original check.

If we have had no response or contact from you within 60 days to pay off your balance, the Business Office will turn your account over to our collection agency. The collection agency will assess a 25% collection fee due in addition to your original balance.

SELF-PAY PATIENT POLICY:

We do see patients on a self-pay basis. The charge for services will be collected prior to the service being rendered. Cash, debit card with VISA/MasterCard guarantee, or credit card payment is the only accepted form of payment for self-pay patients. Sorry, no personal checks are accepted.

INJECTIONS/SURGICAL PROCEDURE POLICY:

If you become a candidate for injections or surgery, it is our policy to collect any deductible or co-insurance that may be due in advance. Cash, debit card with VISA/MasterCard guarantee, or credit card payment are the only accepted forms of pre-payment for these services. Sorry, no personal checks are accepted. Payment must be received no later than 48 hours prior to the injection or one (1) week prior to surgery or your procedure will be cancelled. To determine any financial responsibility to the facility, please contact the facility prior to your procedure.

DISABILITY / MEDICAL LEAVE FORM POLICY:

If you need a disability / medical leave form filled out there will be a \$20.00 charge for each form. By signing this agreement, you understand that you will need to prepay the \$20.00 charge for this form to be completed and subsequently released.

Thank you for your understanding of our financial policies at the Spine Institute of Arizona. If you have any questions, please do not hesitate to give our Business Office a call at 602-953-9500.

Patient Signature

Date



Spine Institute of Arizona

Edward J. Dohring, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Paul R. Gause, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Ryan J. Godinsky, M.D.
Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Keven S. Burns, M.D.
Board Eligible Orthopaedic Surgeon
Fellowship Trained Spine Surgeon

Allan L. Rowley, M.D.
Board Certified
Physical Medicine and Rehabilitation
Interventional Pain Management

Vibhooti H. Dave, D.O.
Board Certified
Physical Medicine and Rehabilitation
Electrodiagnostic Medicine (EMG's)

Brock P. Auten, D.C.
Board Certified Chiropractic Physician
Board Certified Physiotherapist

Bill Balogh, P.A.
Physician Assistant

Donna M. Lahey, R.N.F.A.
CEO
Registered Nurse First Assist

Jennifer R. Watry, PA-C
Certified Physician Assistant

Tel. 602/953.9500
Fax 602/953.1782
www.spineaz.com

CAUTIONS REGARDING THE USE OF LONG TERM NARCOTICS

1. Narcotics are drugs that act like morphine. These include drugs: Lortab, Percocet, Demerol, Darcon, Ultram, Tylenol #3, and others.
2. The drug you have been prescribed is extremely dangerous, capable of being abused, and an over-dose can be lethal
3. When taken in excess, the individual will first become sleepy, fall asleep, will be difficult or unable to arouse and finally, will stop breathing. The level of sedation depends upon the amount of drug ingested.
4. Keep these drugs in a locked box.
5. Be responsible for the drug. No early refill will be given.
6. These drugs can cause physical dependence. This means when you stop taking the drug you will experience a withdrawal reaction. Physical dependence occurs after approximately one week on the drug. This does not mean the drug cannot be stopped, however, it usually must be tapered in order to avoid withdrawal symptoms. A withdrawal reaction can be characterized by severe nausea, vomiting, diarrhea, abdominal pain, muscle aches, low-grade fever, tremor, rapid heart rate, sweating, and chills.
7. Physical dependence is not the same as addiction. Physical dependence means that if you stop the drug suddenly, you will develop a withdrawal reaction (nausea, diarrhea, sweats, shaky, and flu-like symptoms). Addiction is a psychological diagnosis characterized by cravings for the drug, uncontrollable use of the drug even when it causes harm to you and others.
8. There are numerous side effects, which can occur as a consequence of the use of these medications. These include:
 - A. Sedation. If you experience this side effect, even slightly, you should not be driving an automobile until the effect wears off. It generally takes one to two weeks for this side effect to wear off. You should then be safe to operate an automobile. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
 - B. Constipation. If this occurs you will not adapt to this effect. You should drink eight 8 ounce glasses of water per day, take daily doses of Senokot S or Dulcolax, use milk of Magnesia no more than every third day for no bowel movement and notify your physician that you are experiencing this complication. People over the age of 60 are especially at risk for this complication.
 - C. Urinary retention. This means it is difficult to start your stream. Males over the age of 60 are especially at risk for this complication.
 - D. Itching. These drugs can cause itching in some patients.
 - E. Sweating. Profuse sweating can occur at any time with the use of these medications.
 - F. Nausea and vomiting. If this occurs, notify your physician.
 - G. Decreased sex drive.
 - H. Mild suppression of the immune response.

I understand these cautions and am willing to take the drugs as prescribed by my doctor.

Patient

Date



Spine Institute of Arizona

AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

Edward J. Dohring, M.D.
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As a patient at the Spine Institute of Arizona, you may or may not be prescribed a controlled substance. If you are prescribed a controlled substance, we ask that you agree to our controlled substance protocol. If you will not accept our protocol, we cannot treat you and you will need to work with another physician.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but they have high potential for misuse and are therefore closely controlled by the local state and federal government. They are intended to relieve pain, to improve function and/or ability to work, not simply to feel good. If I am prescribed such medication, I agree to the following:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from the Spine Institute of Arizona physicians.
3. Refills of controlled substance medication:
 - A. Will be made only during regular office hours Monday through Friday 9 am to 4 pm. Refills will not be made at night, on holidays, or weekends. I will call at least seventy-two (72) hours ahead for all prescription refill requests. Refill calls made on Friday will be filled the following week.
 - B. Will not be made if I "run out early." I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
 - C. Will not be made as an "emergency", such as on Friday afternoon because I suddenly realize I will "run out tomorrow."
4. If requested, I will bring in the containers of all medications prescribed by my physician, even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
5. Upon request from my physician, if narcotic abuse is suspected, I may be asked to submit to a urine drug screen. If I decline, it will be the sole discretion of the Spine Institute of Arizona to discontinue my narcotic pain medication.
6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following my doctor's instructions regarding my health care.

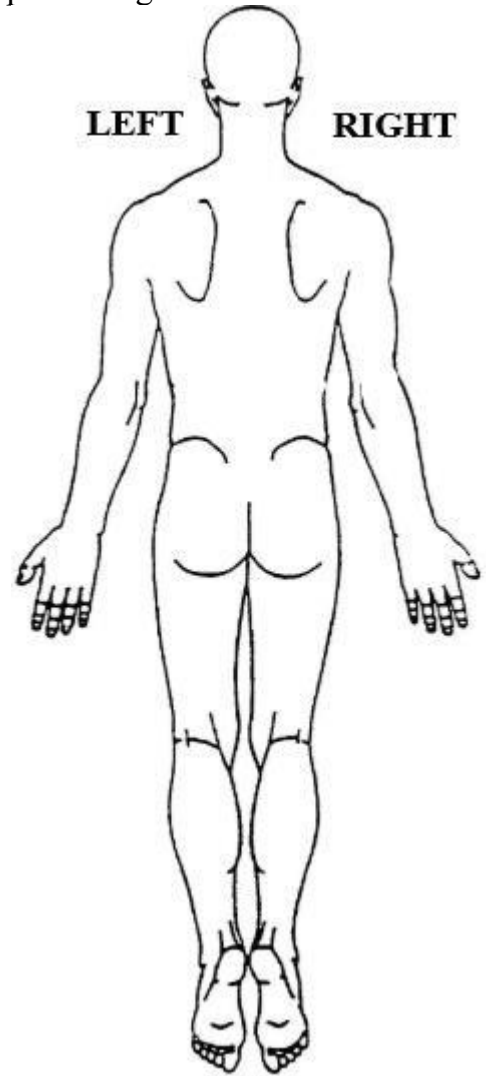
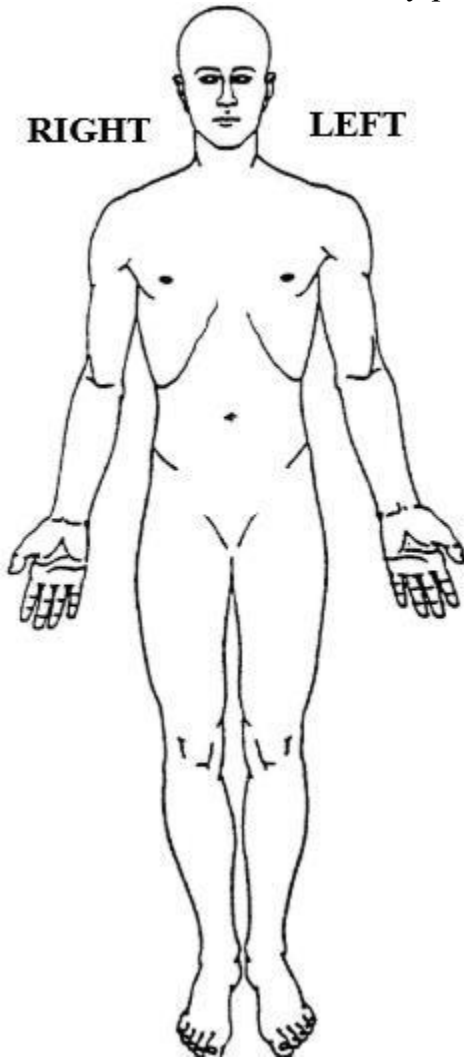
Controlled substances are known to cause psychological dependence (addiction), which I understand is real. I know that some persons may develop a tolerance to medications in which my body does not respond as well to the medication, and I feel the need to have more or a higher dose of the medication. I know that I can become physically dependent on the medication. This will occur if I am on the medication several weeks, and when I stop the medication I must do so under medical supervision, or I may have withdrawal symptoms.

Effective April 26, 2018 all medical prescribers must comply with the 2018 Arizona Opioid Epidemic Act. This means that any medication that you are prescribed must meet the requirements of this new law. If you have been receiving medication from the Spine Institute of Arizona the quantity, dosage, or frequency of your prescription may be adjusted to meet these new requirements.

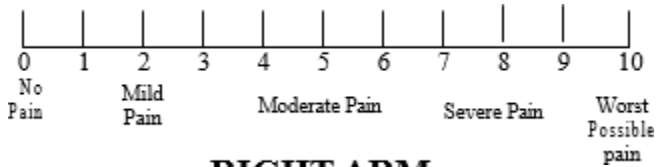
I have read this agreement. I understand that if I do not follow the rules of this agreement, I will no longer be able to obtain medications from the Spine Institute of Arizona.

Patient _____ Date _____

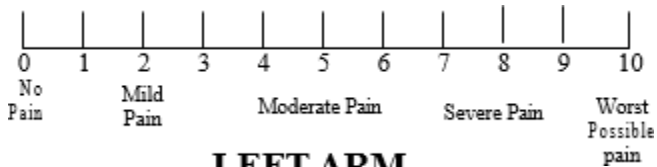
Place an "X" on the body part(s) where you are experiencing pain.
Place a "0" on the body part(s) where you are experiencing numbness.



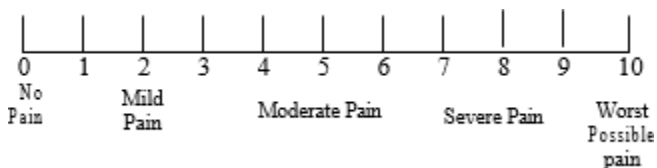
NECK



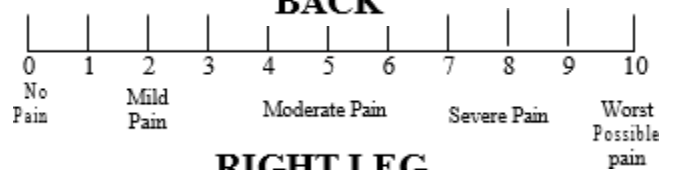
RIGHT ARM



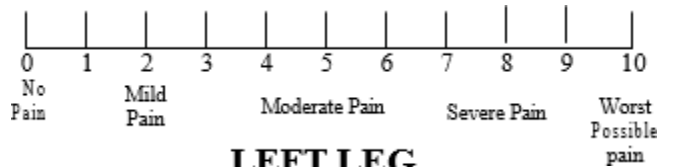
LEFT ARM



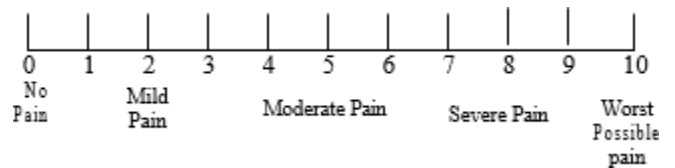
BACK



RIGHT LEG



LEFT LEG



SYMPTOM REVIEW

Have you experienced any of the following conditions in the past month?
If so, please place a check mark in front of any/all of the following you have experienced.
If you have experienced any of these symptoms, please consult with your family doctor.

H.E.E.N.T.

- Blurred vision
- Dry eyes
- Hard of hearing
- Nasal congestion
- Sore throat
- Cough
- Other: _____

PULMONARY

- Shortness of breath
- Other: _____

ABDOMINAL

- Abdominal pain
- Other: _____

INTEGUMENTARY

- Moles
- Skin Rash
- Other: _____

NEUROLOGIC

- Tremors
- Other: _____

GASTROINTESTINAL

- Abdominal pain
- Other: _____

CARDIOVASCULAR

- Chest pain
- Other: _____

GENERAL

- Fevers
- Chills
- Night sweats
- Stress
- Poor sleep
- Swelling of feet
- Swollen glands
- Problem with blood clots
- Weight loss
- Weight gain
- Other: _____

CURRENT WORK STATUS

- Full Time
- Regular Duty
- Other: _____
- Restrictions: _____
- _____
- _____
- _____

Patient Name: _____

Date: _____

**This form must be fully completed at each office visit.
We are required to have documentation of medications and allergies for each office visit.
Due to those requirements, we are unable to accept forms with “no change” or “same”
answers on this form.**

CURRENT MEDICATIONS	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES

1.
2.
3.
4.
5.
6.
7.

PHARMACY

Pharmacy Name:
Address:
Phone:

PATIENT MEDICAL HISTORY

Name: _____ Date: _____

Height: _____ Weight: _____ Birthplace: _____

Reason for your visit: Pain Disability Medication Other: _____

Have you been seen here within the past 3 years? YES NO

Hand Dominance: Left Right

PAST MEDICAL HISTORY: (Please circle any/all of the following that you have experienced.)

- | | | | |
|--------------------------|-------------------|--------------------------|-----------------------------------|
| AIDS | Depression | Heart Attack/Angina | Pacemaker |
| Anemia | Diabetes | Hepatitis C | Peripheral Vascular Disease |
| Anxiety Problem | Diverticulosis | High Blood Pressure | Polio |
| Arthritis | Ear Trouble | HIV | Psychological/Psychiatric Problem |
| Asthma | Endometriosis | Irregular Heartbeat | Rheumatic Fever |
| Bipolar Disease | Enlarged Prostate | Irritable Bowel Syndrome | Scoliosis |
| Cancer Type: _____ | Fibromyalgia | Jaundice | Seizures |
| Colon Polyp | Gastritis | Kidney Disease | Sexually Transmitted Disease |
| Congestive Heart Failure | Glaucoma | Kidney Stones | Stroke |
| COPD/Emphysema | Gout | Liver Disease | Thyroid Disease |
| Deep Venous Thrombosis | Head Injury | Lupus | Tuberculosis |
| | | Osteoporosis | Ulcers |

Other Medical Problems: _____

Injuries: Please list all fractures, injuries, and motor vehicles accidents.

Year Injured	Nature of Injury	Year Injured	Nature of Injury
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations/Surgeries:

Year	Reason for Hospitalization/Surgery	Year	Reason for Hospitalization/Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please continue the other side

Have you ever had a blood transfusion? YES NO

SOCIAL HISTORY:

Do you smoke now? NO YES _____ packs/day _____ # of yrs.

Did you smoke in the past? NO YES _____ packs/day _____ # of yrs.

Do you drink alcohol? NO YES _____ number of drinks/wk.

Do you have a history of drug/ alcohol abuse? NO YES

Your level of education: Grade School Associates degree Graduate School
 High School Bachelor's degree

FAMILY HISTORY:

Please check the box of any/all the following problems that your blood relatives (e.g., parents, brothers, sisters, grandparents, aunts, uncles, children), have had:

<u>Illness</u>	<u>Relative/Family Member (i.e., Mom, Grandfather)</u>
<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Back or Neck Surgery	_____
<input type="checkbox"/> Back Pain/Sciatica	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Attack/Heart Disease	_____
<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Muscle Disease	_____
<input type="checkbox"/> Neck Pain	_____
<input type="checkbox"/> Nerve Disease	_____
<input type="checkbox"/> Stroke	_____

Relation	Age	State of Health/ Medical Problems	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Brothers and Sisters				
Spouse				
Children				



PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

JOB DESCRIPTION

Occupation: _____ Number of years at this job: _____

Are you currently working? YES NO If yes: Part-time Full-time

Regular Duty Modified Duty Hours per week: _____

What are your restrictions, if any? _____

Does your job require you to: (please check all that apply)?

- lift or carry greater than 15 lbs.?
- bend or twist repetitively?
- work overhead?
- use repetitive motion of the arms or legs?

HISTORY OF PROBLEM FOR WHICH YOU ARE SEEING US

Date problem/symptoms began: _____

Location of symptoms/pain when the problem began: _____

HOW DID THE PROBLEM START?

Home/Leisure At Work Motor Vehicle Accident Fall Other: _____

Please briefly describe: _____

Location of symptoms/pain now: _____

Frequency of symptoms/pain: (please check one)

CONSTANT INTERMITTENT RARE

Since the onset of symptoms, has the problem: (please check one)

IMPROVED WORSENERD NO CHANGE

Does coughing or sneezing cause any pain? YES NO

If so, where? _____

Do any of the following activities make your symptoms worse? (please check all that apply)

- WALKING LYING BENDING/TWISTING WORKING OVERHEAD
- SITTING KNEELING LIFTING/CARRYING OTHER: _____
- STANDING TYPING PUSHING/PULLING

List anything (i.e. activities, positions, or treatments) that make the pain better:

Do you have any weakness, if so, which arm, leg or muscle? _____

Have you had any new or recurrent problems with: Control of urination? YES NO
Bowel movements? YES NO

Have you experienced recent weight loss or fevers? YES NO

Please continue the other side ♡

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

<u>TEST</u>	<u>RECEIVED</u>	<u>DATE OF TEST/LOCATION</u>
X-ray	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
MRI	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
CT Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Bone Scan	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
EMG	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Other: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

MEDICATIONS

(If yes, please circle the medication below.)

<u>EXAMPLES</u>	<u>RECEIVED</u>	<u>DID THIS HELP?</u>
<u>Anti-Inflammatories or Cox-2 Inhibitors</u> Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Muscle Relaxers</u> Soma, Flexeril, Skelaxin, Zanaflex	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Pain Medication</u> Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Oral Steroid</u> Prednisone, Medrol Dose Pak,	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>MAOI/SSOI</u> Zonegram, Nerutonin, Amitriptyline, Nortriptyline Prozac, Elavil, Paxil, Pamelor	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<u>Other</u> <i>Please list:</i> _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

TREATMENTS

	<u>RECEIVED</u>	<u>DID THIS HELP?</u>
Physical Therapy/ Exercise	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractic Care	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Injections in Muscle or other injections in office	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epidural Steroid Injections	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Facet Blocks	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Braces/Corsets	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Back Surgery: Cervical Thoracic Lumbar When: _____

Prior to the onset of your current problem, did you ever visit a health care provider for problems with your spine? YES NO *If yes, please list...*

PHYSICIANNNAME

MONTH/YEAR OF TREATMENT

LEGAL ADVICE

Do you have an attorney regarding this injury/problem? YES NO

If yes, please list your attorney's name: _____

C E R V I C A L

Name: _____ Age: _____ Date: _____

Please read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE just circle the one which most closely describes your problem right now.**

SECTION 1 – Pain Intensity

- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

SECTION 2 – Personal Care (Washing, Dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very heavy weights.
- F. I cannot lift or carry anything at all.

SECTION 4 – Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

SECTION 5 – Headache

- A. I have no headaches at all.
- B. I have slight headaches which come frequently.
- C. I have moderate headaches which come in-frequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

SECTION 6 – Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentrating when I want to.
- E. I have a great deal of difficulty in concentrating when I want to.
- F. I cannot concentrate at all.

SECTION 7 – Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

SECTION 8 – Driving

- A. I can drive my car without neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive my care at all because of severe pain in my neck.
- F. I cannot drive my car at all.

SECTION 9 – Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - Recreation

- A. I am able to engage in all recreational activities with no pain in my neck at all.
- B. I am able to engage in all recreational activities with some pain in my neck.
- C. I am able to engage in most, but not all recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.

CERVICAL index score: _____



Spine Institute of Arizona

Dear Patient,

Spine Institute of Arizona and its providers participate in an electronic health information exchange with other health care providers, hospitals, labs, and radiology centers. The Health Information Exchange, or HIE, is a way of sharing health information through secure, electronic means. With your permission our participation in the HIE does two things:

- Allows Spine Institute of Arizona to disclose our confidential health information about you to other providers who are treating you and request your information through the HIE.
- It allows other providers to electronically disclose your confidential health information to the Spine Institute of Arizona through the HIE for treatment and care coordination.

This consent is to obtain your permission to share and receive a limited summary of your medical health record from and to healthcare providers and facilities who are involved with your treatment via the HIE. The summary may include (as applicable) the following information:

- Patient Demographics
- Vital Signs
- Medications & Allergies
- Lab Tests & Results
- Procedures
- Immunizations
- Implanted Devices
- Functional Status
- Miscellaneous Orders & Advice
- Referral Information
- Diagnosis
- Care Team Members

This information is sent over the internet in a secure, encrypted and reliable way among health care professionals and it can be compared to sending a secured email. The HIE enables medical professionals to coordinate care, benefitting both providers and patients. Your choice to opt-out of the HIE will not affect your ability to access medical care. Opting out will not prevent Spine Institute of Arizona from sharing your health information with authorized entities when necessary or required by federal and state law. If you chose to opt out of the HIE the Spine Institute of Arizona will still have the authority to use and disclose protected health information to carry out treatment, payment and healthcare operations through other non-HIE mediums to coordinate your treatment.

- Opt-In - The Spine Institute of Arizona may share and receive my health information via the HIE
- Opt-Out – The Spine Institute of Arizona may not share or receive my health information through the HIE

Patient Name

Date

Patient Signature

Edward J. Dohring, M.D.
*Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon*

Paul R. Gause, M.D.
*Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon*

Ryan J. Godinsky, M.D.
*Board Certified Orthopaedic Surgeon
Fellowship Trained Spine Surgeon*

Keven S. Burns, M.D.
*Board Eligible Orthopaedic Surgeon
Fellowship Trained Spine Surgeon*

Allan L. Rowley, M.D.
*Board Certified
Physical Medicine and Rehabilitation
Interventional Pain Management*

Vibhooti H. Dave, D.O.
*Board Certified
Physical Medicine and Rehabilitation
Electrodiagnostic Medicine (EMG's)*

Brock P. Auten, D.C.
*Board Certified Chiropractic Physician
Board Certified Physiotherapist*

Bill Balogh, P.A.
Physician Assistant

Donna M. Lahey, R.N.F.A.
CEO
Registered Nurse First Assist

Jennifer R. Watry, PA-C
Certified Physician Assistant

Tel. 602/953.9500 Fax
602/953.1782
www.spineaz.com



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Edward J. Dohring, M.D.
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Dear Patient:

We are pleased to announce that the Spine Institute of Arizona Patient Portal is now available. This online tool gives you the flexibility to access your health information and other resources at your leisure – any time of day and from any location.

As a patient of Spine Institute of Arizona enrolling in the Patient Portal will allow you to:

- Update your personal information
- View medications, allergies and vital signs
- Send and receive direct messages with your provider
- View certain chart documents
- Upload files to your medical record
- Share portal documents to other health providers you select
- We are always working on new enhancements to the portal and new features will be added as they become available.

Also, the Patient Portal is completely secure, so you can be confident that your private information is protected.

Please enroll me in the patient portal. A portal invitation will be sent to my email address that I provide below.

Patient Name

Date

Email

Patient Signature

I elect to Opt-out of the patient portal at this time.

Patient Name

Date

Tel. 602/953.9500
Fax 602/953.1782
www.spineaz.com