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**: ____________

ARE YOU PREGNANT? ☐ Yes ☐ No

INSURANCE INFORMATION:

☐ **INDUSTRIAL / WORKMAN'S COMPENSATION**

PRIMARY INSURANCE
INSURANCE CO. NAME: ____

INS CO. ADDRESS: ________

____

POLICY HOLDER NAME: ____

RELATIONSHIP TO PT: ____

EMPLOYER: ____________

POLICY NO. ____________ GROUP/CLAIM NO.: _

POLICY HOLDER SEX: ☐ F ☐ M BIRTHDATE: ____

SECONDARY INSURANCE:
INSURANCE CO. NAME: ____________

INS CO. ADDRESS: ____________

____

POLICY HOLDER NAME: ____________

RELATIONSHIP TO PT: ____________

EMPLOYER: ____________

POLICY NO. ____________ GROUP/CLAIM NO.: ____________

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, 1/09

SPINE INSTITUTE
of Arizona

9735 NORTH 90TH PLACE
SCOTTSDALE, ARIZONA 85258
PHONE: 602-953-9500
FAX: 602-953-1782

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 onlyaccepted 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 $40.00 charge for each form. By signing this agreement, you understand that you will need to prepay the $40.00 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

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

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

Spine Institute of Arizona

CONTROLLED SUBSTANCES

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 require 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 medication is lost, misplaced, or stolen, or used up sooner than prescribed, I understand it will not be replaced.
2. I will not request or accept controlled substance medication from any other physician or 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. Refills requested on Friday will be filled the following week.
4. 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.
5. 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. If confusion, mental changes or excessive sleepiness occur, report this to your physician or present to the nearest emergency room immediately.
    B. Constipation. Notify your physician if you are experiencing constipation. People over the age of 60 are especially at risk for this complication. You should aim towards consuming eight 8-oz glasses of water per dat. In addition, you make take daily doses of Senokot-S or Dulcolax. Alternatively, Milk of Magnesia may be used once every three days (follow package instructions). Continue in the manner until bowel movement is achieved.
    C. Urinary retention. 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.

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.

I have read this agreement and I understand the above cautions and 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

SPINE INSTITUTE OF ARIZONA

I acknowledge that I have received a copy of SpineInstitute 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 healthcareinformation, and rights I may have regarding my 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 any time. 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, mail or email 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. 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.

I hereby authorize that my Spouse / Significant Other / Parent / Family Member(s) listed below 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
______________________________	____________
______________________________	____________
______________________________	____________
______________________________	____________
______________________________	____________

______________________________ Patient's Printed Name

______________________________ Print Name of Patient or Legal Guardian

______________________________ Patient's Printed Name

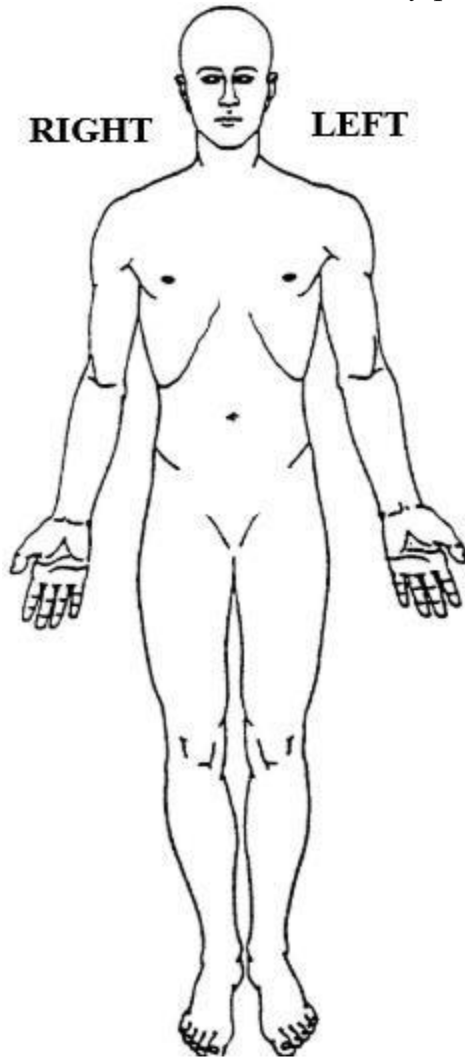
______________________________ Date

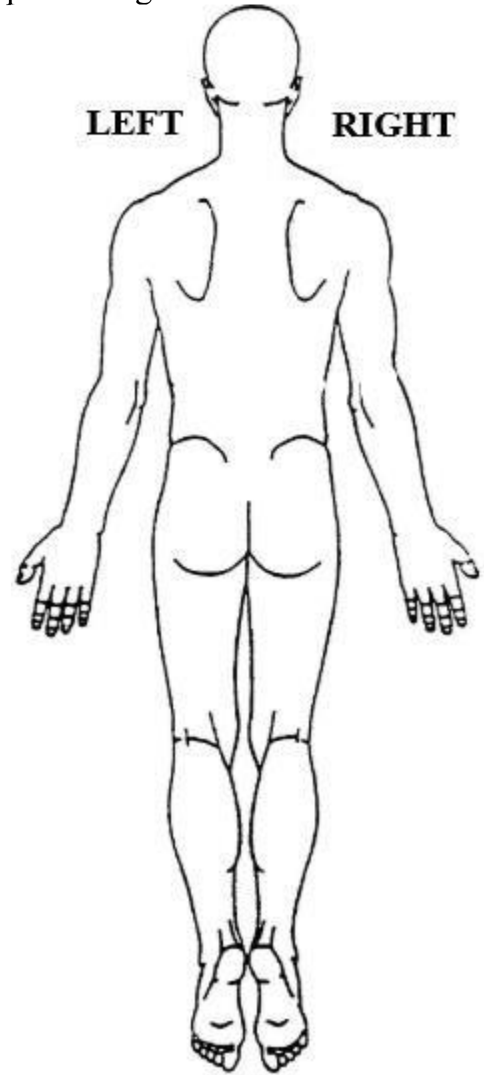
SPINE INSTITUTE *of Arizona*

Patient Name: ______________________________

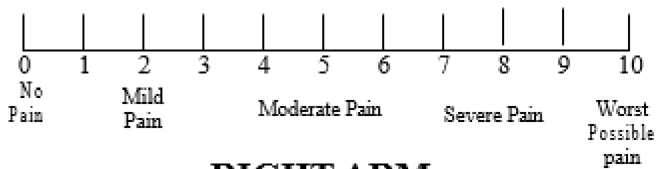
Date: ______________________________

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.

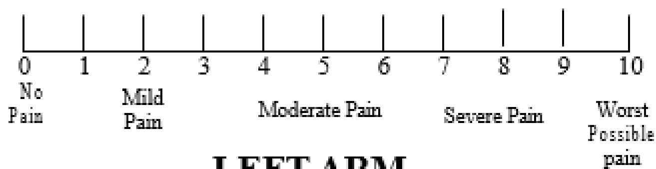




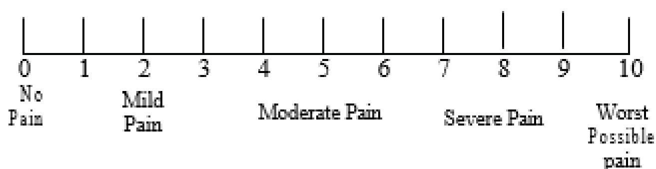
NECK



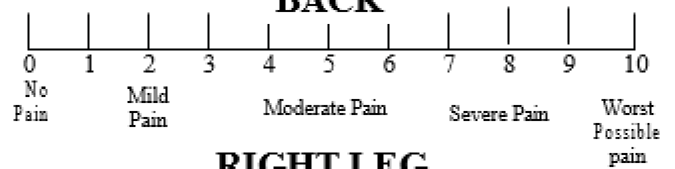
RIGHT ARM



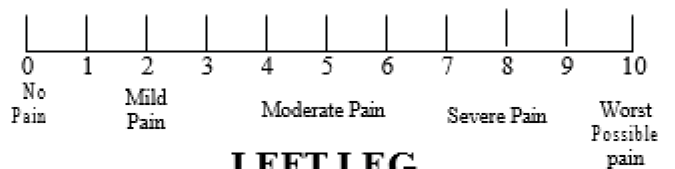
LEFT ARM



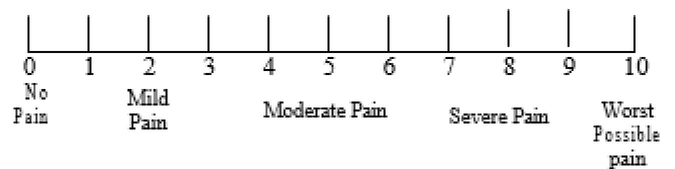
BACK



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:____

____

____

____

SPINE INSTITUTE of Arizona

Patient Name: ______________________________

Date: ______________________________

This form must be <u>fully completed</u> 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:

SPINE INSTITUTE
of Arizona

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 ☛

© *Spine Institute of Arizona Reviewed 06/2019*

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 ❒ High School ❒ Associates degree ❒ Bachelor's degree ❒ Graduate School

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:

Illness	Relative/Family Member (i.e., Mom, Grandfather)
❒ Arthritis	
❒ Back or Neck Surgery	
❒ Back Pain/Sciatica	
❒ Cancer	
❒ Diabetes	
❒ Heart Attack/Heart Disease	
❒ High Blood Pressure	
❒ Mental Illness	
❒ Muscle Disease	
❒ Neck Pain	
❒ Nerve Disease	
❒ Stroke	

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

© *Spine Institute of Arizona Reviewed 06/2019*

SPINE INSTITUTE of Arizona

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 ❐ WORSENED ❐ 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 ☛

© *Spine Institute of Arizona, Reviewed 06/2019*

HISTORY OF TREATMENT OF THIS PROBLEM

DIAGNOSTIC HISTORY

TEST	RECEIVED	DATE OF TEST/LOCATION
X-ray	❐ YES ❐ NO	______
MRI	❐ YES ❐ NO	______
CT Scan	❐ YES ❐ NO	______
Bone Scan	❐ YES ❐ NO	______
EMG	❐ YES ❐ NO	______
Other:______	❐ YES ❐ NO	______

MEDICATIONS *(If yes, please circle the medication below.)*	EXAMPLES	RECEIVED	DID THIS HELP?
Anti-Inflammatories or Cox-2 Inhibitors	Naprosyn, Ibuprofen, Vioxx Voltaren, Celebrex, Bextra	❐ YES ❐ NO	❐ YES ❐ NO
Muscle Relaxers	Soma, Flexeril, Skelaxin, Zanaflex	❐ YES ❐ NO	❐ YES ❐ NO
Pain Medication	Tylenol w/ Codeine, Vicodin, Darvocet, Percocet	❐ YES ❐ NO	❐ YES ❐ NO
Oral Steroid	Prednisone, Medrol Dose Pak,	❐ YES ❐ NO	❐ YES ❐ NO
MAOI/SSOI	Zonegram, Nerutonin, Amitriptyline, Nortriptyline Prozac, Elavil, Paxil, Pamelor	❐ YES ❐ NO	❐ YES ❐ NO
Other *Please list:*	______	❐ YES ❐ NO	❐ YES ❐ NO

TREATMENTS	RECEIVED	DID THISHELP?
Physical Therapy/ Exercise	❐ YES ❐ NO	❐ YES ❐ NO
Chiropractic Care	❐ YES ❐ NO	❐ YES ❐ NO
Injections in Muscle or other injections in office	❐ YES ❐ NO	❐ YES ❐ NO
Epidural Steroid Injections	❐ YES ❐ NO	❐ YES ❐ NO
Facet Blocks	❐ YES ❐ NO	❐ YES ❐ NO
Braces/Corsets	❐ YES ❐ NO	❐ YES ❐ 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…*

PHYSICIANNAME	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:______

© Spine Institute of Arizona, Reviewed 06/2019