SOUTHWEST
SPINE & PAIN CENTER

PATIENT INFORMATION

Name:	Date of Birth:	Age:	Sex:
Address: (Cit, State, Zip)			
Billing Address:	SSN:		
Primary Phone #:	Work Phone #:	Secondary Phone #:	
Email:	Employment: Full/Part/None	Employer:	
Referring Physician:	Primary Care Physician:		
How did you hear about us? (Referring doctor, friend, family, self referral, internet, magazine, newspaper, advertisement other)			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Cell Phone #:
Relationship:	Home Phone #:

INSURANCE INFORMATION

Primary Insurance: Copay:	Secondary Insurance: Copay:
Certificate#/Policy ID:	Certificate #:
Group Number:	Group Number
Subscriber Name:	Subscriber Name:
Subscriber DOB/Relationship:	Subscriber DOB:

Please circle the best option listed that describes your race and ethnicity.

Race: Asian, Native Hawaiian, Other pacific Islander, Black/African American, American Indian/Alaska Native, White, More than 1 race	Ethnicity: Hispanic/Latino, Not Hispanic/Latino, unreported/refuse to report	Primary Language:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.

Authorization To Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.

I certify that the above information is correct as of the date signed.

_____ _____

Signed (patient of parent if minor) Date

SOUTHWEST
SPINE & PAIN CENTER

(Please read and sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Southwest Spine and Pain Center** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Southwest Spine and Pain Center** will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice Privacy Practices.

A photocopy of this consent of this consent shall be considered as valid as the original.

I acknowledge that I am able to have access to a complete copy of the Southwest Spine and Pain Center "Notice of Privacy Practices". I understand that if I have questions or complaints that I should contact the Privacy Official. **Patient Initials: _____**

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable services to **Southwest Spine and Pain Center.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) signature **Date**

I, hereby, give permission to discuss my care or billing concerns, or release written information to:_____Relationship:_____

SOUTHWEST
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FINANCIAL AGREEMENT

Thank you for choosing us as your pain clinic. Our team of providers is committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. _____ ***(initial)***
2. **Patient payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company. _____ ***(initial)***
3. **Registration:** All patients must complete our patient information form, which will be entered into our medical records system to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Many insurance companies have a time limit as to when claims can be filed; For example, if a claim is not received within 30 days of the date of service, it can be deemed ineligible for payment and you will be responsible for the balance if you fail to provide us with complete and accurate information. _____ ***(initial)***
4. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company. _____ ***(initial)***
5. **Uninsured patients:** We offer a cash pay discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. __ ***(initial)***
6. **Credit and collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. In the event any amount is referred to a third party debt collection agency, you agree that in addition to any other amount allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc), you will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah code Annotated, sec.12-1-11. _____ ***(initial)***
7. **Missed appointments:** Our policy is to charge $25 for missed appointments (no shows) not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. _____ ***(initial)***

Thank you for reviewing our patient financial policy. Please let us know if you have any questions regarding the policy.

By signing below, you acknowledge the terms of the policy and agree to be bound by them.

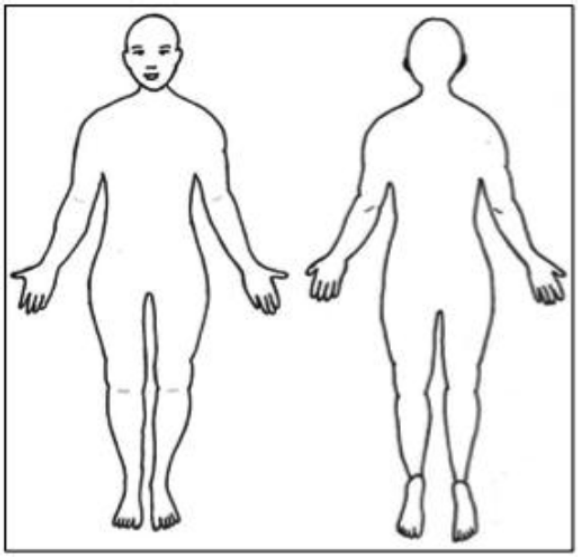
X_____ Date _____

SOUTHWEST
SPINE & PAIN CENTER

Referring Provider:_____

Location of Pain:_____

Shade the area of your WORST pain:



Height _____ **Weight** _____

Onset of Pain:

O Acute O Sudden O Gradual

Severity of Pain:

O Mild O Moderate O Severe

Intensity of Pain at Best: (circle #)

0 1 2 3 4 5 6 7 8 9 10

Intensity of Pain at Worst: (circle #)

0 1 2 3 4 5 6 7 8 9 10

Intensity of Pain on Average: (circle #)

0 1 2 3 4 5 6 7 8 9 10

Description of Pain:

O Burning O Deep O Stabbing
O Cramping O Shooting O Dull
O Sharp O Aching O Throbbing
O Pins and Needles

Pain Pattern:

O Episodic O Persistent O Intermittent

Course of Pain:

O Gradual worsening O Gradual improving
O Rapidly worsening O Rapidly improving
O Recurrent O Without Change

Duration of Pain:

O Years (How many?_____)
O Months (How many? _____)
O Weeks (How many? _____)

Pain Aggravated By:

O Sneezing O Lifting
O Coughing O Sitting
O Bowel Movements O Standing
O Bending O Walking
O Twisting O Lying Down
O Other:_____ O Nothing

Pain Relieved By:

O Rest O Ice
O Change in Position O Sitting
O Exercise O Standing
O Pain Medication O Bending Forward
O Heat O Physical Therapy
O Nothing O Other:_____

Daily Activities Impaired by Pain:

O Work O Intimacy
O Sleeping O Dressing
O Eating O Using toilet
O Bathing O Exercise
O Getting up from bed/chair O NONE

Tried & Failed:

O Bracing O Modification of Activity
O Heat / Ice O NSAIDS (i.e. ibuprofen, aspirin, naproxen)
O Massage O Other:_____

Associated Factors:

O Abdomen pain O Stool incontinence
O Arthritis O Urinary retention
O Chills O Leg weakness O L O R
O Dysuria O Arm weakness O L O R
O Fever O Numbness:_____
O Flank pain O Tingling:_____
O Hip pain O History of malignancy
O NONE O Unintentional weight loss

Assistive Devices:

O NONE O Cane O Walker
O Corset O Brace O Wheelchair

Accident/Injury:

1. Are you currently involved in litigation regarding your injury? Y/N
2. Is your pain a work related injury? Y/N
3. Workman's compensation involved? Y/N
4. Date of Accident/Injury? _____

SOUTHWEST
SPINE & PAIN CENTER

Review of Systems:

(Mark all that apply)

Constitutional:
O Fatigue
O Weight Gain
O Weight Loss
O Appetite Loss

Head:
O Headaches
O Vertigo
O Seasonal Allergies

Eyes:
O Blurry Vision
O Double Vision
O Glaucoma
O Pain with Light
O Vision Loss

ENT/Ears:
O Hearing Loss

Throat/Neck:
O Ulcer
O Swollen Glands
O Neck Pain
O Neck Mass

Respiratory:
O Shortness of Breath
O Sleep Apnea
O Chronic Cough
O Difficulty Sleeping

Cardiovascular:
O Chest pain
O High Blood Pressure
O SOB-lying flat
O Swelling of Legs
O Edema
O Leg Pain
O Irregular Heart Beat
O Rapid Heart Rate
O Heart Stent

Gastrointestinal:
O Abdominal Pain
O Constipation
O Diarrhea
O Black tarry stool
O Nausea
O Vomiting
O Bloody Stool

Musculoskeletal:
O Back pain
O Joint pain
O Back Problems
O Muscle weakness
O Muscle spasms
O Leg cramps
O Muscle atrophy

Psychiatric:
O Anxiety
O Depression
O Hallucinations
O Mood changes
O Panic attacks
O Anger
O Hearing voices

Skin:
O Itching
O Rashes
O Open Wound
O Ulcer
O Excessive Sweating
O Bruising

Neurological:
O Headaches
O Numbness
O Strokes
O Trouble walking
O Incontinence stool
O Incontinence urine
O Buttock numbness/ saddle anesthesia
O Leg weakness
O Seizures

Endocrine:
O Appetite Changes
O Thyroid Problems

Hematologic/Lymph:
O Blood clots
O Easy bruisability
O Nose bleeds
O Easy Bleeding

Allergies:

O Shellfish	O Contrast dye	O Iodine
O Codeine	O Sulfa drugs	O Latex
O Penicillin	O Seasonal allergies	O NONE

Other:_____

Medications:

Current Prescriptions: (Include ALL Rx's)

	Medication	*Dose(mg)*	*Frequency*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Are you taking blood thinners? Y/N

Previously Tried Pain Medications:
(explain why the medication was discontinued)

1._____
2._____
3._____
4._____

Family History: *Specify Family Member

O Diabetes:_____	O Alzheimer's:_____
O Migraine:_____	O Stroke:_____
O Cancer:_____	O Mental Illness:_____
O Heart Disease:_____	O Osteoporosis:_____
O High Blood Pressure:_____	

Past Medical History:

O Anemia	O Emphysema
O Anxiety	O GI Ulcer
O Arthritis	O Hepatitis
O Asthma	O HIV/AIDS
O Atrial Fibrillation	O Hypertension
O Benign prostatic Hyperplasia	O Kidney Disease
	O Liver Disease
O Breast cancer	O Myocardial Infarction
O Congestive heart Failure	O Osteoporosis
O Chronic Obstructive Pulmonary Disease	O Seizures
	O Shingles
O Coronary Artery Disease	O Stroke
	O Thyroid disease
O Depression	O NONE
O Diabetes	O Other:_____

SOUTHWEST
SPINE & PAIN CENTER

Previous Imaging:

O MRI----Date:_____ Area:_____
O EMG-- Date:_____ Area:_____
O X-ray--Date:_____ Area:_____
O CT-----Date:_____ Area:_____
O Bone Scan---Date:_____
O IHC O Coral Desert
O Other:_____

Previous Evaluations:

O Primary Care O Psychologist
O Urgent Care O Pain Management
O Neurologist O Orthopedic Surgeon
O Chiropractor O Emergency Room
O Rheumatologist O Neurosurgeon
O Physiatrist O NONE

Previous Procedures:

O NONE O Epidural injection
O Hip Injection O Vertebroplasty
O Facet Injection O Kyphoplasty
Other : _____
Relief : O Mild O Moderate O Significant
Duration: _____Days _____Weeks _____Months

Previous Physical Therapy:

O NONE O Yes- please indicate:
Dates:_____ # of Sessions:_____

Previous Spine Surgery:

O NONE O Yes- please indicate:
Type:_____
Date:_____
Surgeon:_____
Type:_____
Date:_____
Surgeon:_____
Relief : O Mild O Moderate O Significant
Duration: _____Days _____Weeks _____Months

Social History:

Alcohol Use:
Do you drink? Y/N If yes, servings per week:
Beer _____ Wine _____ Hard Liquor _____
Tobacco Use:
O Never Smoked O Former Smoker
O Current Smoker: O Light <10 O Heavy >10
Tobacco Type: (Cig/Chew/etc) _____
Has anyone in your family had a history of:
O Alcohol abuse (1-3) O Illegal drugs (2-3)
O Prescription drug abuse (4-4)
Have you ever had a history of: (F-M)
O Alcohol abuse (3-3) O Illegal drugs (4-4)
O Prescription drug abuse (5-5)
Please mark your age group: (F-M)
O 0-16 (0) O 16-45 (1-1) O 45+ (0)
Have you had a history of preadolescent sexual abuse? O Yes (3-0) O No
Have you ever been diagnosed with:
O Attention Deficit Disorder (ADD) (2-2)
O Obsessive Compulsive Disorder (OCD) (2-2)
O Bipolar Disorder (2-2)
O Schizophrenia Disorder (2-2)
O Depression(1-1)

Surgical History:

O Adenoidectomy
O Appendectomy
O Knee Arthroscopy
O Back Surgery
O Cervical
O Thoracic
O Lumbar
O Brain Surgery
O Carpal Tunnel
O L O R
O Cataract Surgery
O Heart Bypass Surgery
O Coronary artery dilation
O Detached retina repair
O Gallbladder
O Hemorrhoidectomy
O Hernia repair
O Other: _____
O Hysterectomy
O Lumpectomy
O Large Bowel res.
O Mastectomy
O Prostate surgery
O Plastic surgery
O Shoulder surgery
O L O R
O Small Bowel res.
O Thyroidectomy
O Tonsillectomy
O Hip Replacement
O L O R
O Knee Replace
O L O R
O Tubal Ligation
O Vasectomy
O Pace Maker

SOUTHWEST
SPINE & PAIN CENTER

Health Fusion #:_____ **Date of completion:** _____

Health and Wellness Questionnaire

At Southwest Spine and Pain Center, we believe in providing the best care possible. Answering the following questions will help us understand your needs in multiple areas of your life and how we can best help you to be well. Participation is voluntary. You are free to stop at any time, or to leave questions blank if you would prefer not to answer them. However, the more information we have, the better able we are to provide quality care.

1. In general, would you say your health is:

□ Excellent □ Very Good □ Good □ Fair □ Poor

2. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)

□ Excellent □ Very Good □ Good □ Fair □ Poor

3. In general, how would you rate your physical health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

4. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

□ Completely □ Mostly □ Moderately □ A little □ Not at all

5. How would you rate your fatigue on average?

□ None □ Mild □ Moderate □ Severe □ Very severe

6. How would you rate your pain on average?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)

7. In general, would you say your quality of life is:

□ Excellent □ Very Good □ Good □ Fair □ Poor

8. In general, how would you rate your mental health, including your mood and your ability to think?

□ Excellent □ Very Good □ Good □ Fair □ Poor

9. How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

□ Never □ Rarely □ Sometimes □ Often □ Always

10. In general, how would you rate your satisfaction with your social activities and relationships?

□ Excellent □ Very Good □ Good □ Fair □ Poor

Continue on next page →

SOUTHWEST
SPINE & PAIN CENTER

11. In the past 7 days, my sleep quality was:
□ Very Good □ Good □ Fair □ Poor □ Very Poor

12. In general, would you say your nutrition and fitness are:
□ Very Good □ Good □ Fair □ Poor □ Very Poor

Over the last 2 weeks, how often have you been bothered by any of the following problems?

13. Feeling nervous, anxious or on edge.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

14. Not being able to stop or control worrying.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

15. Little interest or pleasure in doing things.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

16. Feeling down, depressed, or hopeless.
□ Not at all □ Several Days □ More than Half Days □ Nearly Every Day

17. Are past or present experiences with any of the following impacting you in your life in a negative way?

□ Yes □ No Abuse
□ Yes □ No Violence (e.g., domestic, work, military)
□ Yes □ No Military service or combat
□ Yes □ No Unexpected death of a family member or friend (i.e. suicide, accidents, etc)

18. Please answer these questions based on the **last 12 months**. These questions refer to use of alcohol, illegal drugs, prescription drugs not prescribed to you, or misuse of your prescriptions. **Do not** check "yes" in reference to taking your prescription medications as prescribed by your doctor.

□ Yes □ No Have you felt you ought to cut down on your drinking or drug use?
□ Yes □ No Have people annoyed you by criticizing your drinking or drug use?
□ Yes □ No Have you felt bad or guilty about your drinking or drug use??
□ Yes □ No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?