

NORTHWEST SPINE & SPORTS PHYSICIANS, P.C.

Andrew J. Cole, M.D. ♦ Nelson A. Hager, M.D., M.S. ♦ Garrett S. Hyman, M.D., M.P.H. ♦ Yung J. Lee, D.O.
Carolyn Marquardt, M.D. ♦ Llewellyn N. Packia Raj, M.D. ♦ David E. Spanier, M.D.
Alison A. Stout, D.O. ♦ Irene A. Young, M.D.

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PATIENT INFORMATION SHEET

PATIENT'S NAME: _____ Male Female
FIRST INITIAL LAST

Mailing Address: _____

City: _____ State: _____ Zip: _____

PHONE-Home: _____ Business: _____ Cell: _____

Birth date: _____ Social Security #: _____

Employer: _____ Occupation: _____

SPOUSE'S OR PARENT'S NAME: _____ Contact Number: _____

PERSON RESPONSIBLE FOR BILL (If under 18 years):

Name: _____ Phone: _____

Relationship: _____ Address: _____

EMERGENCY CONTACT: Name: _____ Phone: _____

Relationship: _____

REFERRING PHYSICIAN : _____ Phone: _____ City: _____

PRIMARY PHYSICIAN: _____ Phone: _____

► **WAS THIS AN L&I OR MVA ACCIDENT?** Yes No If **YES**, provide following:

L&I INJURY	MOTOR VEHICLE ACCIDENT (We do not bill third party auto claims.)
Claim Number: _____	Claim Number: _____
Date of Injury: [month/day/year] _____	Date of Accident: [month/day/year] _____
Ins. Carrier Name: _____	Your PIP Ins. Co.: _____
Claim Manager's Name: _____	Claim Adjustor's Name: _____
Claim Manager's Phone #: _____	Claim Adjustor's Phone #: _____

► **HEALTH PLAN INFORMATION:** FILL IN COMPLETELY USING YOUR INSURANCE CARD.

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
I.D. # _____	I.D. # _____
Does your insurance require a referral? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, you must bring a copy with you to your appointment.)	Does your insurance require a referral? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, you must bring a copy with you to your appointment.)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information to referring/consulting physicians or other health care providers as your physician deems appropriate to facilitate my/our care. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the \$35.00 fee on checks returned per RCW 62A.3 515 & 520. In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and any other costs.

Patient's Signature/Parent's Signature

Date

YEARLY UPDATE

▪ I certify that I have reviewed the information on this form in its entirety, and there are **no changes**.

Patient's Signature/Parent's Signature

Date

▪ I certify that I have reviewed the information on this form in its entirety, and there are **no changes**.

Patient's Signature/Parent's Signature

Date

PHOTO ID: (For office use)

Which of the following have you had for your low back / mid-back / neck?	Did the treatment make you:					
	Low Back	Mid-Back	Neck	Better	No Change	Worse
Physical Therapy						
Occupational Therapy						
Chiropractic / Osteopathic						
Massage						
Brace						
Biofeedback						
Acupuncture						
Herbs						
Injections:						
Trigger Point						
Epidural / Facet						
Nerve Root						
Regular X-rays						
MRI Scan						
Myelogram						
CT Scan						
Bone Scan						
EMG / NCV						

Check all of those that apply to you:

- Bowel Function: ___ Normal ___ Loss of control or accidents ___ Constipation
- Bladder Function: ___ Normal ___ Loss of control or accidents ___ Difficulty starting or stopping urination ___ Sense of urgency
- Leg / Foot: ___ Normal ___ Weakness (Right / Left)
- Arm / Hand: ___ Normal ___ Weakness (Right / Left)

It is normal for patients faced with daily pain to experience emotional reactions such as worry, frustration and sadness. Please circle the appropriate number to indicate the extent that you are troubled by the following:

	NONE					SEVERE					
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10

I currently take medications for anxiety or depression: Yes No

I have received counseling for anxiety or depression: Yes No

PRIOR MEDICAL HISTORY

List **ALL** allergies to medications:

MEDICATION	REACTION	MEDICATION	REACTION

List **ALL** medications (**prescription and non-prescription**) you currently take:

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

List all medications **previously** taken for your pain _____.

Gastrointestinal: Do you have ulcers? ___ Yes ___ No Has your ulcer bled? ___ Yes ___ No
 Do you have reflux, hiatal hernia or GERD? ___ Yes ___ No

Alcohol / Drugs: What is your approximate weekly use of alcoholic beverages?

- ___ I don't drink alcohol
- ___ Less than 1-2 drinks a week
- ___ 3-6 drinks a week
- ___ Drink some alcohol on a daily basis

Have you or a parent ever had a problem with:

Alcoholism: ___ You ___ Parent ___ No • Drug Abuse: ___ You ___ Parent ___ No

Tobacco: What is your approximate daily use of tobacco?

- ___ I don't smoke
- ___ 1 pack per day
- ___ More than 2 packs per day
- ___ 1/2 pack per day
- ___ 1-2 packs per day

OB/GYN: (Women Only)

Date of last period: _____ ___ Normal ___ Abnormal ___ Hysterectomy / Postmenopausal/Premenopausal
Date of last pelvic exam: _____ ___ Normal ___ Abnormal
Date of last PAP Smear: _____ ___ Normal ___ Abnormal
___ Yes ___ No Pregnant or possibly pregnant • ___ Yes ___ No Breast-feeding

CURRENT MEDICAL PROBLEMS: Please list

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____

PRIOR SURGERY: Please list

TYPE	DATE	TYPE	DATE

FAMILY HISTORY:

	Living (Yes / No)	Present health issues or cause of death
Father	Yes No	_____
Mother	Yes No	_____
Spouse	Yes No	_____
Brothers	# Living ___	_____
	# Deceased ___	_____
Sisters	# Living ___	_____
	# Deceased ___	_____
Children	# Living ___	_____
	# Deceased ___	_____

Review of Systems: Please put an "X" next to any of the symptoms you have had during the past year.

- | | | |
|---------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Unusual stress in home life | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Unusual stress in work life | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Any lumps in neck, armpits or groin | <input type="checkbox"/> Excessive constipation |
| <input type="checkbox"/> Problems with sexual function | <input type="checkbox"/> Chest pain or tightness | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Loss of sensation around groin or buttocks | <input type="checkbox"/> Persistent or unusual cough | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Unexplained fevers | <input type="checkbox"/> Trouble breathing with exercise | <input type="checkbox"/> Pain or burning when urinating |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Weight loss of 10 pounds or more | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Need to urinate more at night |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Swollen ankles | |
| <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Persistent eye redness |
| <input type="checkbox"/> Problems with depression | <input type="checkbox"/> List joints: _____ | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Muscle tenderness | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Generalized morning stiffness | |
| <input type="checkbox"/> Decreased Concentration | <input type="checkbox"/> Easy bruising | |
| <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Excessive bleeding | |

Work: Employer: _____ Your job title: _____ Date last worked: _____

Work status at the time of:	<u>Injury Onset</u>	<u>Currently</u>
On disability	_____	_____
Regular: full-time	_____	_____
Regular: part-time	_____	_____
Permanent light duty	_____	_____
Temporary light duty	_____	_____
Temporarily totally disabled (not working)	_____	_____
Retired	_____	_____

- How physically demanding is your job?
- Very heavy (frequently lifting > 100 pounds)
 - Heavy (frequently lifting > 60 pounds)
 - Moderate (frequently lifting > 30 pounds)
 - Light (frequently lifting < 30 pounds)
 - Sedentary (essentially no lifting)

- How satisfied are you with your job?
- Very satisfied
 - Satisfied
 - Dissatisfied
 - It is the worst job I've ever had

Social: What are some of your usual recreational activities that you had participated in the **YEAR BEFORE** your current problem? **Place an "X" in front of those you currently cannot perform.**

() _____ () _____
 () _____ () _____

Education: (Circle highest level attained) Did Not Finish High School / High School / College / Post Graduate

Attorney: Does an attorney assist you with your injury claim? ___ Yes ___ No Name: _____

Primary Care Physician: Name: _____

Address: _____

Please inform me if any portion of the physical examination that I will perform causes you pain. Please do not perform any motion that causes your symptoms to worsen. An initial evaluation will occasionally increase your symptoms since painful structures are being evaluated.

Please sign and date this form.

 Patient's signature
Record Review: Yes / NO

 Date

 Physician's signature
X-Ray Review: Yes / NO

 Date

Northwest Spine & Sports Physicians, P.C.

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

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

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

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

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

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

I further understand that Northwest Spine & Sports Physicians, P.C. reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Northwest Spine & Sports Physicians, P.C. change their notice, I will receive a revised notice at the next visit.

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

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

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

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

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____.