



**Back Pain Center**  
2520 Highway K  
O'Fallon, MO 63368

*Welcome to our office!*

Patient Name: \_\_\_\_\_ MARITAL STATUS SEX DATE OF BIRTH AGE  
S M W D SEP. M/F \_\_\_\_/\_\_\_\_/\_\_\_\_  
LAST FIRST MI

Patient Address: \_\_\_\_\_  
STREET CITY STATE ZIP

Phone: Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_

SSN: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Referred by: \_\_\_\_\_

Do you have health insurance:  Yes  No

Is condition related to an auto accident:  Yes  No Date of accident: \_\_\_\_\_

Describe the reason for your visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Injury/Date symptoms first appeared: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the pain:  Constant  Intermittent  Occasional  Rare

Have you had other treatment for this condition  Yes  No \_\_\_\_\_  
DESCRIBE

Have you had X-RAYS or MRI taken:  Yes  No

List current medications you are taking: \_\_\_\_\_  
\_\_\_\_\_

Smoking:  Yes  No Alcohol use:  Yes  No

Previous Surgeries: \_\_\_\_\_

Previous Fractures/Injuries: \_\_\_\_\_

Serious Illness: \_\_\_\_\_

PAST MEDICAL HISTORY	SELF	FAMILY	PAST MEDICAL HISTORY	SELF	FAMILY
Heart Disease			Asthma		
High Blood Pressure			Emphysema		
Stroke			DVT		
Rheumatic Fever			Hepatitis C		
Lung Problems			Hiatal Hernia		
Diabetes			Epilepsy/Seizures		
Cancer			<b>REVIEW OF SYMPTOMS</b>		
What Part of the Body?			Chest Pain		
Ulcers			Shortness of Breath		
Vascular Problems			Easy or Prolonged Bleeding or Bruising		
Kidney Disease			Nervous Disorders		
Bladder Infection			Prostate Trouble		
Rheumatoid Arthritis			Urinary Frequency		
			Blood Clots		

#### Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: <http://www.cms.hhs.gov/SecurityStandardDownloads/securityproposedrule.pdf>

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Assignment of Benefits:** I hereby assign all medical benefits to include Major Medical benefits to which I am entitled, private insurance and any other health plans to: Back Pain Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. The policy in our office is the parent or guardian requesting treatment for the child is responsible for all fees for services rendered. However, both parents are responsible for payment of Back Pain Center fees.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian Requesting Treatment

\_\_\_\_\_  
Date