Patient Registration

Patient

Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Social Security # _____ Home Phone _____

Cell Phone _____ Marital Status: S☐ M☐ D☐ W☐

May we contact you at work? Yes☐ No☐ Work Phone _____

Employer_____ Bank Name _____

Employer Address _____

May we contact you by e-mail? Yes☐ No☐ E-Mail Address _____

Person to Contact in an Emergency_____ Relationship_____

Phone _____

Spouse / Guardian Information

Name_____

Address_____ City, State, Zip_____

Phone _____ Relationship to patient_____

Primary Insurance Company_____

Name of person responsible for account_____

Policy #_____ Group #_____

Social Security #_____Date of Birth_____

Employer_____

Secondary Insurance Company_____

Name of person responsible for account_____ Policy #_____

Group #_____ Social Security #_____

Referring Physician_____ **Primary Care Physician**_____

Notify Primary Care Physician of procedure? Yes☐ No☐

Notify Referring Physician of procedure? Yes☐ No☐

Address to notify Physician_____ Phone _____

Advanced Directives? Yes☐ No☐ ☐ I would like information on Advance Directives

If you have a signed Advanced Directives, please bring a copy to the Surgery Facility the day of your procedure.

I have been informed of the Notice of Privacy Practices. I understand that I can obtain a copy of the Notice of Privacy Practices upon request.

I authorize use of this form for ALL of my insurance submissions. I authorize release of medical information to all my insurance companies and any physician or hospital involved in my medical care.

Office Use Only
Advance Directives
☐ *Faxed*
☐ *Mailed*
*Initials*_____
*Date*_____

Name (please print) _____

Signature_____ Date _____

Reviewed by _____Date _____

**It is your responsibility to see that our office has a copy of your current insurance card*

PATIENT MEDICAL HISTORY

Name _____ DOB _____ Age _____ Ht _____ Wt _____

ALLERGIES ☐ LATEX ☐ No known drug allergies ☐ Food ☐ Other
List _____

PERSONAL HEALTH HISTORY (Check all that apply)

Cardiologist ☐ Yes ☐ No Name/Phone # _____ Last Visit _____

Heart Problems: ☐ Heart attack ☐ Chest pain ☐ Heart failure ☐ Irregular heart beat
☐ Internal defibrillator ☐ Rheumatic fever ☐ Mitral valve prolapse ☐ Pacemaker ☐ EKG

Comments _____

Lung Problems: ☐ Asthma ☐ Emphysema ☐ TB ☐ Chronic lung disease
☐ Shortness of breath ☐ Sleep Apnea ☐ CPAP ☐ Pneumonia

Comments _____

☐ Diabetes
☐ Stroke
☐ High blood pressure
☐ Cancer
☐ Chemotherapy
☐ Radiation therapy
☐ Circulation problems
☐ Bleeding problems
☐ Stomach problems
☐ Other _____
☐ Bowel problems
☐ Hepatitis
☐ HIV
☐ Chicken pox
☐ Depression
☐ Emotional problems
☐ Thyroid problems
☐ Kidney/bladder problems

Comments: _____

Have you ever been diagnosed with or treated for methicillin-resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant enterococci (VRE) or any other multidrug-resistant organism (MDRO)? ☐ Yes ☐ No

Comments _____

Last Menstrual Period _____ Pregnancy _____ Childbirth _____

Previous surgeries with dates _____

_____

_____

Complications to anesthesia? ☐ Yes ☐ No Explain _____

Other hospitalization with dates _____

Family health history (Check all that apply) ☐ High blood pressure ☐ Stroke ☐ Diabetes
☐ Heart disease ☐ Cancer (site) _____ ☐ Other _____

CURRENT MEDICATIONS – See Medication Reconciliation

Tobacco ☐ Yes ☐ No ☐ Stopped Length of time used:	Alcohol ☐ Yes ☐ No Frequency of use:	History of addiction ☐ Yes ☐ No Explain:

Do you feel safe at home? ☐ Yes ☐ No _____

Primary Care Physician _____ Phone # _____

May we contact your primary care physician (PCP) and/or specialist? ☐ Yes ☐ No

Specialist(s) _____

Pharmacy Name _____ Phone # _____
☐ Unknown (per patient)

Clearance ☐ Yes ☐ No Regarding: _____

Patient Signature _____ Date/Time _____ Reviewed By _____ ☐ per phone Date/Time _____

Updated By _____ ☐ per phone Date/Time _____ Updated By _____ ☐ per phone Date/Time _____

PAIN HISTORY QUESTIONNAIRE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Name *(Last, First, M.I.):* ☐ M ☐ F **DOB/Age**:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed **Occupation:**

Primary Doctor: **Referring Doctor:**

Do you Drink Alcohol? ☐ Yes (Type/Amount) _____ ☐ No **Do You Smoke?** ☐ Yes (Packs per day) _____ ☐ No

Do You Take Blood Thinners? ☐ No ☐ Yes If yes, what type and how? _____

Do You Use Recreational Drugs? ☐ YES ☐ NO ☐ Never If yes, type and amount per week? _____ Ever Been in Rehab/Detox? ☐ Yes ☐ No

Allergies:

PAIN HISTORY

Pain Level today? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Current Pain Problem:
☐ Neck Pain ☐ Arm Pain ☐ Low Back Pain ☐ Leg Pain ☐ Chest Pain ☐ Abdominal Pain ☐ Pelvic Pain
☐ Other _____

Date of Onset of Pain:
☐ Days ago
☐ Months ago
☐ Years ago
☐ Exact Date
_____

How did Pain Start? ☐ Work Accident ☐ Home Accident ☐ Auto Accident ☐ After Surgery ☐ No Specific Reason
☐ Other

Describe How the Pain Started: _____

_____

Since the pain began, is it: ☐ Getting Worse ☐ Getting Better ☐ About the Same

Which Best Describes Your Pain? (Check as many as apply) ☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Aching ☐ Burning ☐ Cramping ☐ Crushing ☐ Stabbing ☐ Sore ☐ Tingling
☐ Other _____

Do you use an assistive device?
☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Crutches ☐ None ☐ Other _____

What Makes the Pain Worse?

What Makes the Pain Better?

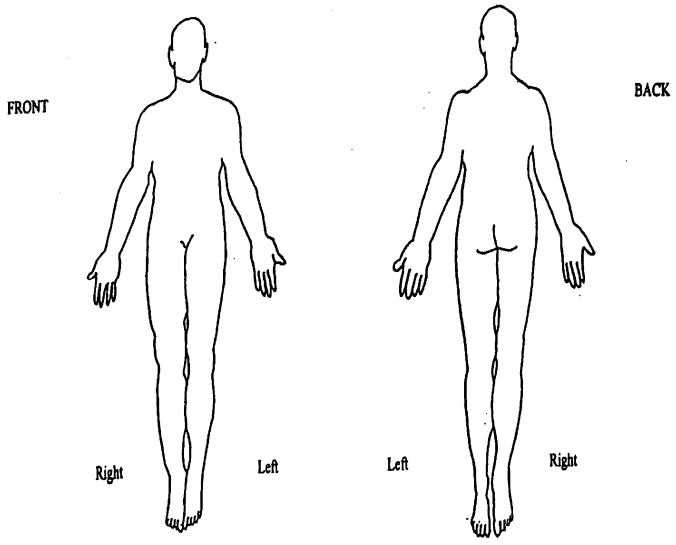
List any medical problems that other doctors have diagnosed:
☐ High Blood Pressure ☐ Diabetes ☐ Ulcers ☐ Heart Problems
☐ Thyroid ☐ Asthma ☐ Kidney Disease ☐ Gout ☐ Rheumatoid
☐ Cancer ☐ Stroke ☐ Bleeding Problems or Bruising Easily
☐ Liver Problems (hepatitis)
☐ Other_____

Previous Treatments for Pain: (Check as Many as Apply)
☐ Physical Therapy ☐ Injections/Nerve Blocks ☐ TENS Unit
☐ Psychological/Counseling ☐ Biofeedback ☐ Chiropractor
☐ Surgery (if yes, detail below) ☐ Other
_____

Have you had any tests for your current problem?
(Check as Many as Apply) ☐ X-rays ☐ MRI ☐ Bone Scan ☐ CT Scan
☐ EMG ☐ Myelogram ☐ Nerve Conduction Test
☐ Other _____

Has the Pain Caused Depression or Emotional Problems?
☐ Yes ☐ No

Mark Areas of Pain On Figure Below:
(If using Acrobat Reader, select Comments and then the Pencil tool to mark areas)



Approximate Height _____ Weight_____

Epidural Injections discussed with Patient? _____ **Date:** _____

Surgical Treatments for Pain: (Date, Surgeon, Results)

Other Past Surgeries (Other than for pain)

MEDICATION LIST

Patient Name _____ Date _____

ALLERGIES _____

☐ **NKDA** _____

☐ **NKA**

LIST BELOW ALL OF YOUR MEDICATIONS INCLUDING OVER-THE-COUNTER, HERBAL MEDS, DIETARY SUPPLEMENTS, VITAMINS, ANTACIDS, PAIN RELIEVERS & RECREATIONAL DRUGS.

MEDICATION NAME (WRITE LEGIBLY)	DOSE	FREQUENCY	INDICATIONS / REASONS

ADDITIONAL HEALTH INFORMATION

RN Signature _____ ***Date*** _____ ***Time*** _____

RENEW SPINAL CARE
Minimally Invasive Spine Surgery...for a new beginning

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize Renew Spinal Care and its office staff, their consulting physicians, associates, physician assistants, nurses and other healthcare personnel, to use and/or disclose any and all of my protected health information to any party deemed reasonable necessary. I understand that this authorization is valid as long as I am a patient of Renew Spinal Care. I understand that the purpose or use of the disclosure I am consenting to will allow Renew Spinal Care's office to use and disclose my protected health information as needed via telephone, email, or the address provided to communicate by me. You have the right to specify the preferred mode of communication.

I expressly acknowledge that this authorization is voluntary. There are no other criteria or limitations that I make regarding this authorization. I understand that Renew Spinal Care office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

I understand that my health care and payment for my healthcare will not be affected if I do not sign this form. I understand that I may see any copy of the information described in this form, if I request it. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.

I acknowledge that I was provided a copy of the Notice of Privacy Practices from Renew Spinal Care and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

I acknowledge that email provided is safe and will only be used by our office and never distributed or shared with other parties. This office has the right to use any email or phone number provided by you to contact you for any and all communications deemed necessary including appointment reminders and other communications from time to time.

PATIENT CONSENT

I hereby voluntarily consent to outpatient care by the physicians for Renew Spinal Care, encompassing routine care, diagnostic procedures, examination and medical treatment including, but not limited to, minor surgical procedures, routine laboratory work, x-rays, ultrasound and administration of medications and injections provided by physicians for Renew Spinal Care. I agree to ask questions to clarify treatment should I not understand the treatment plan.

INSURANCE ASSIGNMENT RELEASE

I certify that I have insurance with the insurance company(ies) disclosed and assign directly to Renew Spinal Care all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions

This authorization is valid as of _____, the date I have signed below and will remain in effect as long as I am a patient of Renew Spinal Care, and its office staff, their consulting physicians, associates, physician assistants, nurses and other healthcare personnel, which in their judgment are advisable during the course of my evaluation, diagnosis and treatment. I have read this complete page and agree to all of its content.

_____ _____
Name of Individual/Legal Representative (Print) Signature of Individual/Legal Representative (Signature)

Witness, if available _____

Please e-mail completed form to: info@renewspinalcare.com