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University Spine Institute Inc

TREATMENT ADVISEMENT: The physicians of University Spine Institute are specialists in pain management. The examinations and treatments that you will receive here cannot be construed as a complete physical examination for general health purposes. Only those symptoms directly related to the pain you are experiencing will be assessed and treated at this office. You are advised to seek complete physical examinations for general health purposes from your personal physician.

Patient Name: _____ Birth date: ____/____/____

Age: _____ Social Security No. _____ Sex: Male Female

Race: _____ Ethnicity: _____ Language: _____

Single Married Divorced Widowed Domestic Partner

Home phone: (____) _____ Cell phone (____) _____ Work phone (____) _____

Where do you prefer to receive calls? Home Work Cell

Mailing Address: _____

Email address: _____

If married, spouse's name: _____ Date of Birth: ____/____/____

Do you have an Advance Care Plan or Surrogate Decision Maker? Yes No

Do you have a primary care physician? _____ **Date last seen** _____

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Work Phone: (____) _____ Home Phone (____) _____ Cell (____) _____

Are we seeing you for pain that resulted from an auto or PI case? Yes No

If yes, has a claim been filed with Auto or private Insurance company? Yes No

If yes, have you retained an attorney? Yes No

If yes, have you notified your medical insurance of the accident? Yes No

(If yes, please explain) _____

Are we seeing you for pain that resulted from an employment related injury? Yes No

If yes, have you filed a Workers Compensation claim for this Injury? Yes No

The information I provided above is accurate, to the best of my knowledge.

Patient Signature

Date

Insurance Information: (Please complete this form even though we copy your card.)

Primary Insurance

Insurance Company: _____

Name of Insured: _____

Relationship to Patient: _____

Insurance ID/Subscriber Number: _____

Insured's Birth date: _____

Secondary Insurance (if any):

Insurance Company: _____

Name of Insured: _____

Insurance ID/Subscriber Number: _____

Relationship to Patient: _____

Insured's Birth date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION: Temecula Valley Pain Medical Group, Inc., dba University Spine Institute is authorized to contact my health insurer(s) to confirm my eligibility for certain medical benefits, and is authorized to provide my insurer(s) with details regarding any proposed treatment for me in order to determine if my insurer(s) will cover, or pay for, my treatment. In addition, I hereby authorize University Spine Institute to release any medical or other information concerning my treatment, which may be necessary to process bills and collect payments for the medical services and items I receive here.

ASSIGNMENT OF BENEFITS AUTHORIZATION: I hereby authorize that all insurance benefits for medical services and supplies provided by the physicians at Temecula Valley Pain Medical Group, Inc., dba University Spine Institute to be paid directly to Temecula Valley Pain Medical Group, Inc. / University Spine Institute

INSURANCE

I understand that any medical insurance policies I have, is a contract between me and my insurance company. I am responsible for co-payments, deductibles, co-insurance and any non-covered services. I understand that payment for my portion of all medical services received here are due within 30 days of submission of an invoice by University Spine Institute, and agree to pay all reasonable costs incurred by University Spine Institute to collect such amounts including, interest, cost of collection, and attorney fees. Under certain circumstances, I may also be responsible services deemed not medically necessary by my insurance. I am responsible for services deemed not medically necessary only if University Spine Institute has reason to believe it will be denied and informs me in writing prior to having rendered the services of the likelihood that my insurance will deny the services for medical necessity and I consent to have the services performed. University Spine Institute may not be a participating provider with my insurance company. If University Spine Institute is not a participating provider with my insurance company, I am financially responsible for the balance of fees for the services that are not paid by my insurance company. I hereby assign all benefits, checks or money to which I may be entitled directly as a result of coverage from my insurance plan benefits to University Spine Institute. I understand and agree (the above assignment of benefits notwithstanding) that I am responsible for full and timely payment to University Spine Institute even if the insurance claim is pending

Patient Signature

Date

Printed Name

SCHEDULE OF FEES

The following is a list of fees for missed appointments and services that we are often asked to perform. These are fees that are not insurance billed/reimbursed and would be due from you.

Missed appointments (<i>for the benefit of all our patients, we require 24 hours advance notice for cancelled appointments</i>)	\$75.00
Forms 1-3 pages (please allow 5 business days for us to complete)	\$45.00
• Note- additional fees apply if medical records also requested	
Forms >3 pages	Fee based on Form length & work required
Letters (please allow 5 business days for us to complete)	\$75.00/page
Chart copies to the patient	25¢/page + \$5.00 admin charge
Chart copies to another provider	no charge
Returned checks/charge payments	\$25.00

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

A copy of Temecula Valley Pain Medical Group, Inc., dba University Spine Institute Notice of Privacy Practices has been made available to me. The notice advises me as to how my personal medical information is used at Your Pain Care and how I may assess that information.

Patient/Representative Name (print) _____
Date

Patient/Representative Signature _____
Relationship to Patient

I AUTHORIZE THE FOLLOWING NAMED INDIVIDUAL _____ TO OBTAIN MY PROTECTED HEALTH INFORMATION. I AM AWARE IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY CHANGES TO THE ABOVE INFORMATION.

Patient Signature _____
Printed Name

_____/_____/_____
Date

UNIVERSITY SPINE INSTITUTE
VANCE Z. JOHNSON, MD / BEN THOMAS, DO
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize _____ to
(Name of patient) (Name of person or facility which has information)

release the following health information:

- Unlimited/All records
 Limited to the following medical information: _____

To: _____
The University Spine Institute
(Name and title or facility name to receive health information)

25405 Hancock Ave. Ste 110, Murrieta, CA 92562
(Street address, City, State, Zip code)

951-894-5000
(Phone Number)

951-679-1144
(Fax Number)

For the following purposes: _____

This authorization is in effect until _____.
(Date)

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke it at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

Signature of patient or personal Representative

Relationship if other than patient

Patient's Name (PRINT)

Date

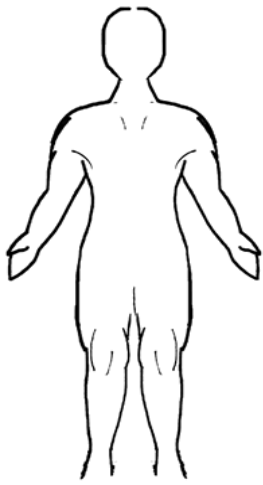
PAIN CHART

Patient Name: _____ Age _____ Today's date: _____

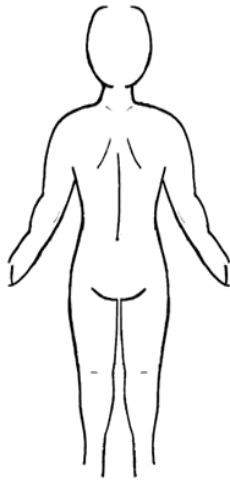
Current height _____ ft. _____ inches weight _____ lbs. Your weight at age 21 _____ lbs.

On the pictures shown below, please **mark "X" on each area that hurts TODAY**. Draw arrows to where any pain radiates. Right handed or Left handed. Primary Physician _____

Referring Physician _____



Front



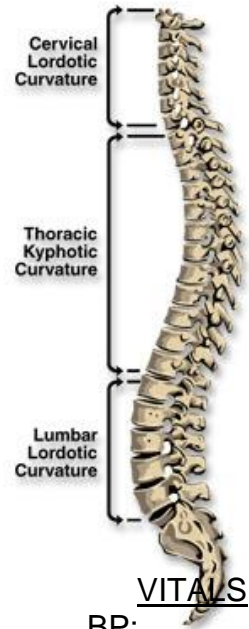
Back



Left side



Right side



VITALS

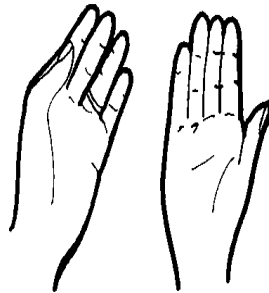
BP: _____

P: _____

T: _____

RR: _____

WT: _____



Circle the number below that best describes your **USUAL** pain:

NO Pain 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst Pain of my life!

Circle the number below that describes your pain **TODAY**:

NO Pain 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst Pain of my life!

When did the pain start? _____ **Circle** any that apply: Numbness Burning Aching Radiating Weakness Shooting Sharp

Circle your responses to the following:

What is the frequency of your pain? Daily Weekly Monthly Random

What is the duration of your pain? Constant Intermittent

What aggravates your pain? Sitting Standing Walking Bending Lifting Reaching Twisting Lying down

What reduces your pain? Medications Sitting Lying down Massage Acupuncture Other _____

Circle the treatments you have tried for this pain: Physical Therapy Medications Chiropractic Bracing Trigger Point Injections Acupuncture Electrical Stimulator Traction Injections into your Spine

HOW LONG HAVE THESE TREATMENTS BEEN TRIED? _____

PAIN MEDICINE CONSULTATION

Name: _____ Date: _____

What is the reason for today's visit? Back pain with Leg pain. Neck pain with arm pain
 Knee pain shoulder pain hip pain other (please list): _____

Personal History- Have you ever had?

Illness/Injury	Yes	No
<input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma		
High blood pressure		
Heart dz- angina? attack? bad rhythm		
Diabetes- how long?		
Bleeding tendency -		
Thyroid problems		
Stomach disease <input type="checkbox"/> Ulcer <input type="checkbox"/> Reflux		
Circulation problem		
HIV/Aids		
Arthritis – where? _____		
Cancer – where? _____		
Blood Clot		
Anemia- when?		
Hepatitis- since when?		
Addiction to drugs ___ / alcohol ___		
Other medical problems?		
Any falls within the last 12 months?		
If yes, how many falls? _____		
Were you injured? _____		
List Surgeries		

Family History- Has any blood relative had any of the following. If yes, indicate relationship.

Illness	Which Relative(s)?
Anemia	
Bleeding Tendency	
Heart disease	
Chronic lung disease	
High blood pressure	
Kidney disease	
Arthritis	
Migraine headaches	
Diabetes	
Thyroid problems	
Cancer type _____	

What exercise regimen are you unable to perform due to your pain? _____

Are you currently employed? _____
 If so, what type of work do you do? _____

Are you married _____ yrs divorced
 separated single widowed
 a committed significant other?

Kids? _____
 Is there a chance you might be pregnant? _____
 Who lives with you? _____

Alcohol- how much? _____
 Smoking- how much? _____
 Caffeine- how much? _____
 Have you used illegal drugs? _____
 When? _____

Place an X by any that apply to you?

Problem	X
General	
Tire easily	
Recent weight gain _____ lbs	
Recent weight loss _____ lbs	
Night sweats- how long?	
Persistent fever- how long?	
Sensitivity to heat	
Sensitivity to cold	
Skin	
Rashes- where? _____	
Eyes	
Eye pain- how long?	
Red eyes- how long?	
Double vision- how long?	
Ears	
Hearing loss	
Ringing in ears	
Nose	
Loss of smell	

Frequent colds- last one? _____	
Nosebleeds- how often? _____	
Mouth	
Sores- where? _____	
Dental problems	
Cardio-Respiratory	
High blood pressure	
Chest pain/discomfort	
Shortness of breath	
Swelling of ankles	
Persistent cough	
Heart palpitations	
Digestive & Urinary	
Decrease in appetite- how long? _____	
Constipation- last stool? _____	
Heartburn- how long? _____	
Nausea- when? _____	
Rectal bleeding- when? _____	
Blood in urine – when? _____	
Diarrhea- how long? _____	
Musculoskeletal	
Muscle weakness	
Joint pain – which? _____	
Swollen joints	
Neck pain	
Back pain	
Hip pain	
Muscle tension- where? _____	
Nervous system	
Headaches	
Fainting– when? _____	
Poor coordination	
Nervousness	
Depression – suicidal? _____	
Memory loss	
Weakness- where? _____	
Sleep Hygiene	
Insomnia	
Sleep apnea	
Excessive sleepiness	
Endocrine	
Thyroid problems	
Adrenal problems	
Cortisone treatments- when? _____	
Diabetes	

Patient Signature

Print Name

Date

