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TEMECULA VALLEY PAIN MEDICAL GROUP, INC. dba

University Spine Institute

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

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

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

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

Home Address: _____

_____

Email address: _____

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

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

_____ _____

Signature of Parent/Guardian*(if patient is a minor)* 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 (*for the benefit of all our patients, we require 24 hours advance notice for cancelled appointments*)	$75.00
Forms 1-3 pages (please allow 5 business days for us to complete)	$45.00
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

- Note- additional fees apply if medical records also requested

PRESCRIPTION REFILLS

For those prescriptions that can be refilled over the phone, please allow five (5) business days for our office to call the refill to the pharmacy. Therefore, please do not wait until your prescription has completely run out prior to calling us for your refill.

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

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

(Any physician that may have medical records that will help treat your condition)
To: _____

_____

_____

_____

Re: Release of Medical Information for _____
Print Patient's First and Last Name

DOB:_____

You are hereby authorized to release to the physician listed below, any and all information you may have concerning my physical, psychological, psychotherapy, alcohol and/or drug abuse records, or other medical condition, including X-Rays, lab work, which you have obtained by way of history, examinations, testing, diagnosis, treatment and prognosis, except for any records noted here: _____

_____

_____

A copy of this authorization is a valid as the original.

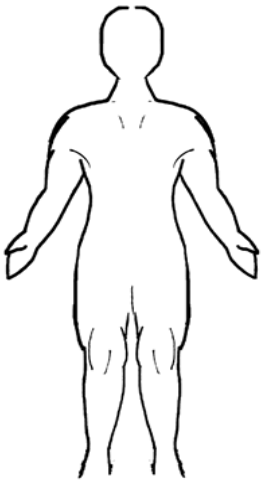
Requesting Physician: Vance Z. Johnson MD / Ben Thomas DO
Temecula Valley Pain Medical Group, Inc., dba
University Spine Institute
27475 Ynez Road #295
Temecula, CA 92591
Phone: (951) 894-5000 Fax: (951) 296-1098

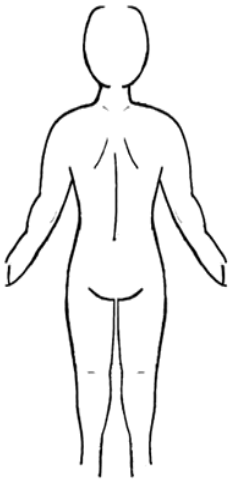
_____ _____
Patient Signature Printed Name

_____/_____/_____
Date

PAIN CHART

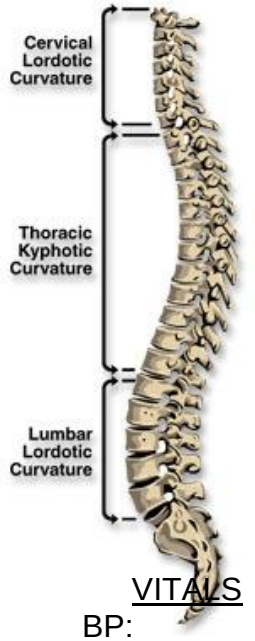
Patient Name: _____ Age_____ Today's date: _____
Current height ___ft. ___inches weight _____lbs. Your weight at age 21 _____lbs.
On the pictures shown below, please **mark "X" on each area that hurts TODAY**. Draw arrows to where any pain radiates. ❑Right handed or ❑Left handed. Primary Physician_____
Referring Physician_____


Front

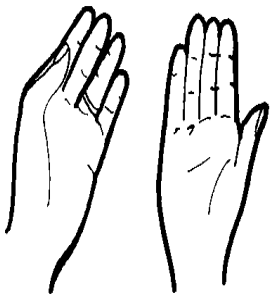

Back


Left side


Right side



VITALS
BP:
P:
T:
RR:
WT:



Circle the number below that best describes your usual pain and another for your worst pain.

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

Doctors area to write Lesegue's- R L SI- R L Occip- R L Facet Reflex Axial Gait
Recommendations: MRI – Lumbar Cervical Thoracic _____ EMG/NCV – Uppers Lowers
Med _____ Fluoroscopy – LESI CESI SI FMBB
Record Review_____ Consultation_____ Physiotherapy_____
Notes:_____
_____
_____Physician Signature: __ _____

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): _____
_____

Please list your current medicines (include vitamins and over the counter remedies):

Medication Name	Dosage	Frequency

Are you allergic to anything? Please list all allergies and your reaction.

Allergic to	Your reaction

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 _____	

Personal History-Have you have ever had?

Illness/Injury	Yes	No
☐COPD ☐ Emphysema ☐Asthma		
High blood pressure		
Heart dz- angina? attack? bad rhythm		
Diabetes- how long?		
Bleeding tendency -		
Thyroid problems		
Stomach disease ☐ Ulcer ☐ Reflux		
Circulation problem		
HIV/Aids		
Arthritis – where? _____		
Cancer – where? _____		
Blood Clot		
Anemia- when?		
Hepatitis- since when?		
Addiction to drugs___ / alcohol___		
Other medical problems?		
List Surgeries		

Please provide details for any "Yes" answers:
_____
_____
_____
_____
_____

What exercise do you do regularly and how frequently? _____
_____
Type of work_____

Are you ❑married_____ yrs ❑divorced
❑ separated ❑ single ❑ widowed
❑ a committed significant other?
_____
Kids?_____
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 / loss lbs____	
Night sweats- how long?	
Persistent fever- how long?	
Sensitivity to- heat / 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

MRI

X-rays

EMG/NCV