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 LUTHERAN GENERAL - PARKSIDE CENTER
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PATIENT INFORMATION FORM: PLEASE PRINT ALL INFORMATION CLEARLY

Today's Date: ____/____/____

Last Name: _____ First: _____ M: _____ Male Female

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #:(____) _____ Home Cell Other

Date of Birth: ____/____/____ Age: _____ Marital Status: _____

Social Security #: _____ Email Address: _____

Patient's Employer: _____ Employer Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone #: (____) _____

Relationship to Patient: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

Phone #:(____) _____

Pharmacy: _____

REFERRING PHYSICIAN:

Name: _____

Address: _____

Phone #: (____) _____

Phone #: (____) _____

IF YOU ARE NOT THE POLICYHOLDER ON THE INSURANCE, PLEASE COMPLETE THE FOLLOWING SECTION. IF THIS IS NOT COMPLETED, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE CARRIER.

Guarantor Last Name: _____ First: _____ M: _____ Male Female

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #:(____) _____

Date of Birth: ____/____/____ Social Security #: _____

Guarantor Employer: _____ Employer Phone #: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Healthcare Reform Questions

DUE TO RECENT REFORMS MANDATED BY MEDICARE, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

RACE: ___ American Indian or Alaskan Native
 ___ Asian
 ___ Native Hawaiian
 ___ Black or African American

___ White
 ___ Hispanic
 ___ Other Race _____
 ___ Unreported/Refused to Report

ETHNICITY: ___ Hispanic
 ___ Non-Hispanic
 ___ Unreported/Refused to Report

PRIMARY LANGUAGE _____

I hereby authorize the physicians to release any and all information or x-rays acquired in the course of my examination or treatment in this office to my insurance carrier, personal physician, or employer. I hereby authorize benefits to be paid directly to THE SPINE CENTER. I UNDERSTAND THAT PAYMENT OF CHARGES IS NOT CONTINGENT UPON A SETTLEMENT FROM MY INSURANCE CARRIER, AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

Today's Date: ____/____/____

SIGNATURE: _____

(Patient or Guardian of Minor)

PLEASE TURN OVER

MEDICAL HISTORY

Patient Name: _____ Height: _____ Weight: _____ Today's Date: ____/____/____

What problem are you seeing us for today? _____ Date of Onset: ____/____/____

Location of Symptoms: _____ Right Left Both N/A

Is your visit today related to: Workers Compensation? Yes No Date of Injury: ____/____/____

Auto Accident or Personal Injury? Yes No Date of Injury: ____/____/____

Working Now? Yes No Last day on the job? ____/____/____ Retired Disabled

Have you been hospitalized for your pain problem? Yes No Dates: _____

What other types of doctors or health care providers have you seen for this condition? _____

PATIENT QUESTIONNAIRE

How did pain start? (check all that apply) suddenly pulling gradually injured at work lifting auto accident
 twisting hit from behind fall during sport activity bending no apparent cause
 other _____

What activities make the pain worse? exercise (during) bending forward exercise (after) bending backward
 sitting coughing standing sneezing walking physical activity bed rest
 other _____

Is pain constant? Yes No

Does activity affect pain? Yes No If yes, does it make it Worse Better

Does the pain radiate? Yes No If so, where? _____

What reduces pain? exercise lying down pain pills sitting injections standing muscle relaxants
 walking aspirin anti-inflammatory manipulation nothing physical therapy
 other _____

Level of Pain - Pain being 0 (no pain) to 10 (incapacitating pain)

What is your pain level today _____

What is your average pain level from day to day _____

At its worst, what is your pain level _____ What activity/position is the worst _____

At its best, what is your pain level _____ What activity/position is the best _____

What medications are you currently taking for your health? _____

What medications are you currently taking for your spine conditions/pain _____

How long have you had this pain? _____ years _____ months _____ weeks

How long have you had similar pain? _____ years _____ months _____ weeks

Have you had surgery for this problem? Yes No Number of times? _____

Dates: _____

Who was the surgeon? _____

Have you had these diagnostic studies?

	Yes	No	Date		Yes	No	Date
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____	MRI scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Electromyogram	<input type="checkbox"/>	<input type="checkbox"/>	_____	Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____	Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are studies with you	<input type="checkbox"/>	<input type="checkbox"/>					

Have you been hospitalized for your pain problem? Yes No Dates: _____

REVIEW OF SYSTEMS

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes", please describe:

SYMPTOMS

Yes No

Describe all "Yes" responses

Eyes (e.g. blurred vision, double vision, loss of vision)

Ears, Nose, Throat (e.g. sore throat, earache, ringing)

Cardiovascular (e.g. chest pain, palpitations, ankle swelling)

Respiratory (e.g. shortness of breath, cough, snore)

Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)

Genitourinary (e.g. burning, bleeding or difficulty urinating)

Musculoskeletal (e.g. joint, muscle, back or neck pain)

Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)

Neurological (e.g. numbness, tingling, weakness)

Mental Health (e.g. depression, anxiety, memory loss)

Endocrine (e.g. weight gain/loss, excess thirst or urination)

Hematologic (e.g. bruising, bleeding or clotting disorder)

Allergic/Immunologic (e.g. rash, swelling, wheezing)

PLEASE TURN OVER

PAST SURGICAL HISTORY

Patient Name: _____ Today's Date: ____/____/____

Have you been hospitalized for other medical problems? Yes No

Problem: _____	Surgeon: _____	Date: _____
Problem: _____	Surgeon: _____	Date: _____
Problem: _____	Surgeon: _____	Date: _____
Problem: _____	Surgeon: _____	Date: _____
Problem: _____	Surgeon: _____	Date: _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had problems with anesthesia? Yes No If yes, please describe: _____

BLOOD: Have you ever had a blood transfusion? Yes No Do you have a history of blood clotting? Yes No

SLEEP APNEA: Do you have Sleep Apnea? Yes No Snore? Yes No Stop breathing during sleep? Yes No

ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: _____

SOCIAL HISTORY:

Student: Yes No School _____ Grade _____ Sport _____

Tobacco use: Yes No Packs per day: _____ Pipe? Yes No Smokeless Tobacco? Yes No

Quit Years Smoked: _____

Alcohol use: Never Occasional Daily Heavy History of alcoholism? Yes No History of drug use? Yes No

Marital status: Single Married Divorced Widowed

Do you live alone? Yes No If no, who do you live with? _____

Are you pregnant? Yes No Breastfeeding? Yes No Date of last menstrual period? _____

Comments or Clarification: _____

PAST MEDICAL and FAMILY HISTORY

Have you or a family member had problems with any of the following? Please indicate "Yes" with an "x".

DISEASE / CONDITION	Grand						Describe all "Yes" responses
	Self	Child	Mother	Father	Sibling	parent	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina / MI / Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Problem / Rhythm Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke / TIA / Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / COPD / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GERD / Ulcers / Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis / Liver / Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Failure / Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Tract Infections / BPH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding / Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia / Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid / Endocrine Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric / Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____/_____/_____
Patient Signature Date

_____/_____/_____
Guardian Signature Date

Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.
Any Changes

Yes No _____/_____/_____
Signed Date

Yes No _____/_____/_____
Signed Date

Yes No _____/_____/_____
Signed Date

Yes No _____/_____/_____
Signed Date

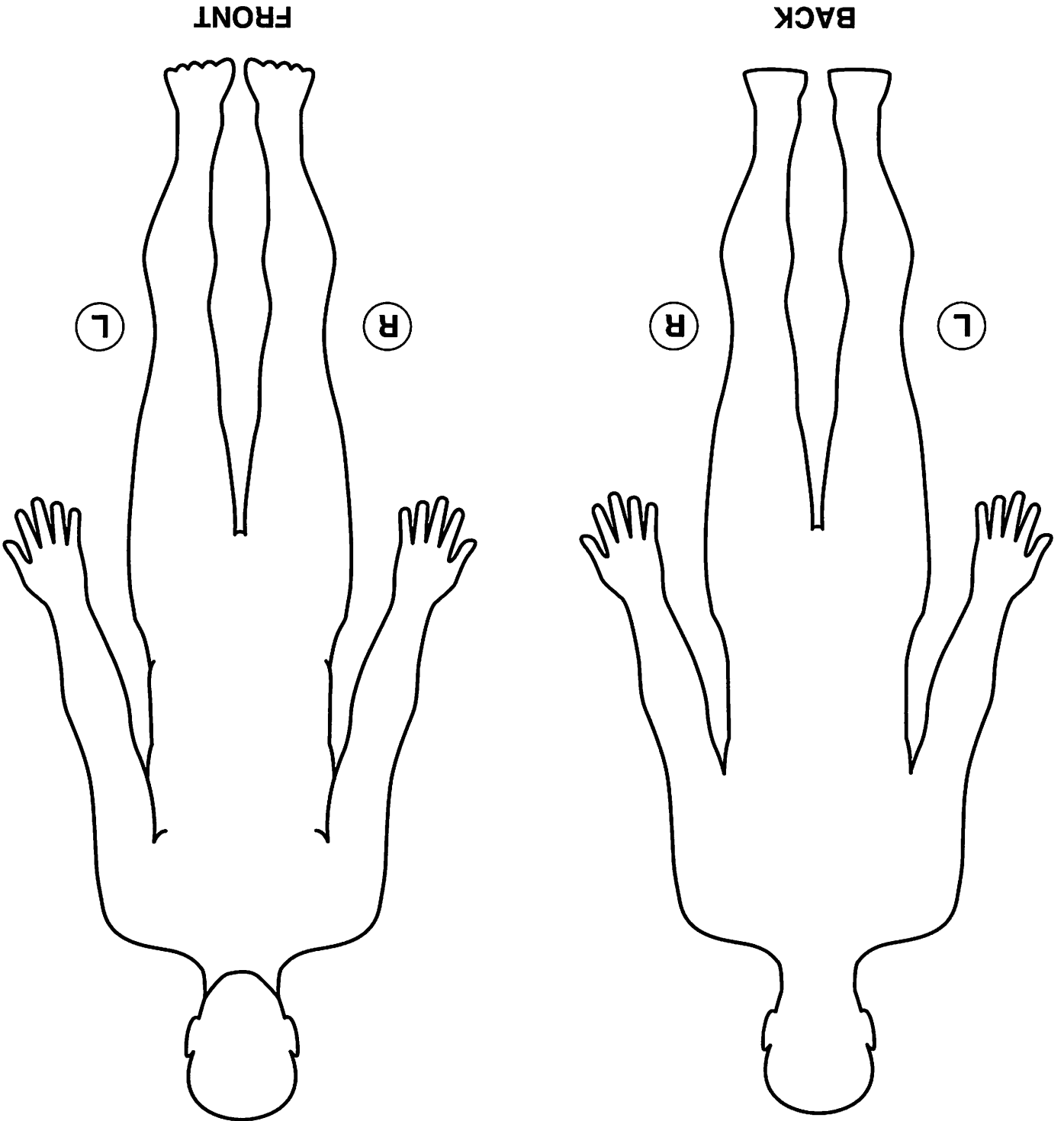
PLEASE TURN OVER

DATE _____

PATIENT NAME _____

NUMBNESS - - - - - PINS & NEEDLES o o o o o o
STABBING // // // // // ACHING + + + + + +
OTHER * * * * *

Please fill out the pain drawing. This will tell us where your pain is now as well as something about your pain.
Mark the areas on your body where you feel pain. Use the following patterns:



THE SPINE CENTER, S.C.
1875 Dempster, Suite 425 – Park Ridge, IL 60068
(847) 698-9330 – Fax: (847) 698-1429

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY# _____

I understand that as part of my healthcare, this organization originates and maintains health 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.
- A means of communication among the many healthcare 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.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

PATIENT:

X _____

Signature of Pt. or Legal Representative

Date

Witness Signature

NOTICE OF PRIVACY PRACTICES

I have received the attached The Spine Center Notice of Privacy Practices.

X _____

Signature of Patient

Date

Print Name

Date of birth of the Patient

Signature of Patient/Legal Guardian/Legal Representative

Relationship to Patient

Witness

Date

This notice became effective 4/14/03 the same date it was published.