THE SPINE CENTER

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LUTHERAN GENERAL - PARKSIDE CENTER
1875 DEMPSTER ST • SUITE 425 • PARK RIDGE, IL 60068
PHONE: (847) 698-9330 • FAX: (847) 698-1429

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: _____

Do you have legal representation? ☐ Yes ☐ No

If Yes: Attorney Name: _____ Phone #: (_____) _____

PRIMARY CARE PHYSICIAN:

Physician Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: (_____) _____

REFERRING PHYSICIAN:

Did a Physician refer you to this office? Yes _____ No _____

Physician Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: (_____) _____

If you were not referred by a physician, please indicate who you were referred by (friend, lawyer, insurance carrier, etc):

Referred By: _____

Pharmacy: _____ 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	☐	☐	_____	MRI scan	☐	☐	_____
CT scan	☐	☐	_____	Myelogram	☐	☐	_____
Electromyogram	☐	☐	_____	Discogram	☐	☐	_____
Bone Scan	☐	☐	_____	Injections	☐	☐	_____
Are studies with you	☐	☐					

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

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

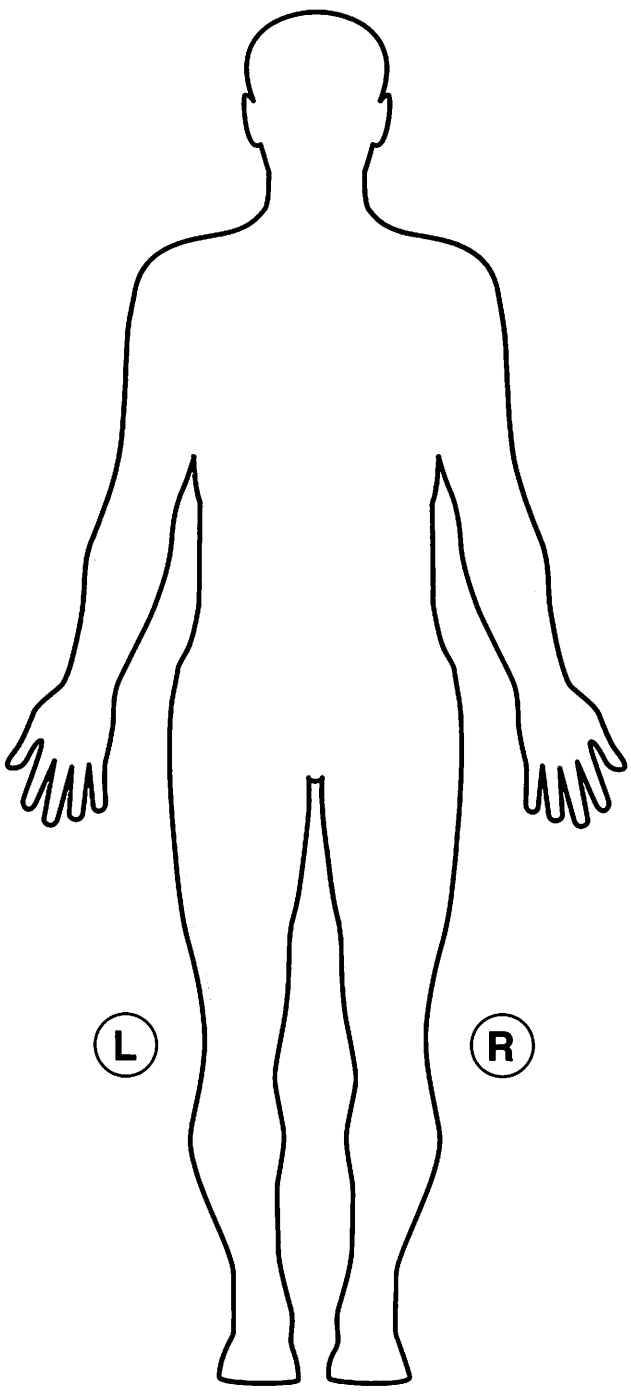
☐ Yes ☐ No _____ ___/___/___
Signed Date

☐ Yes ☐ No _____ ___/___/___
Signed Date

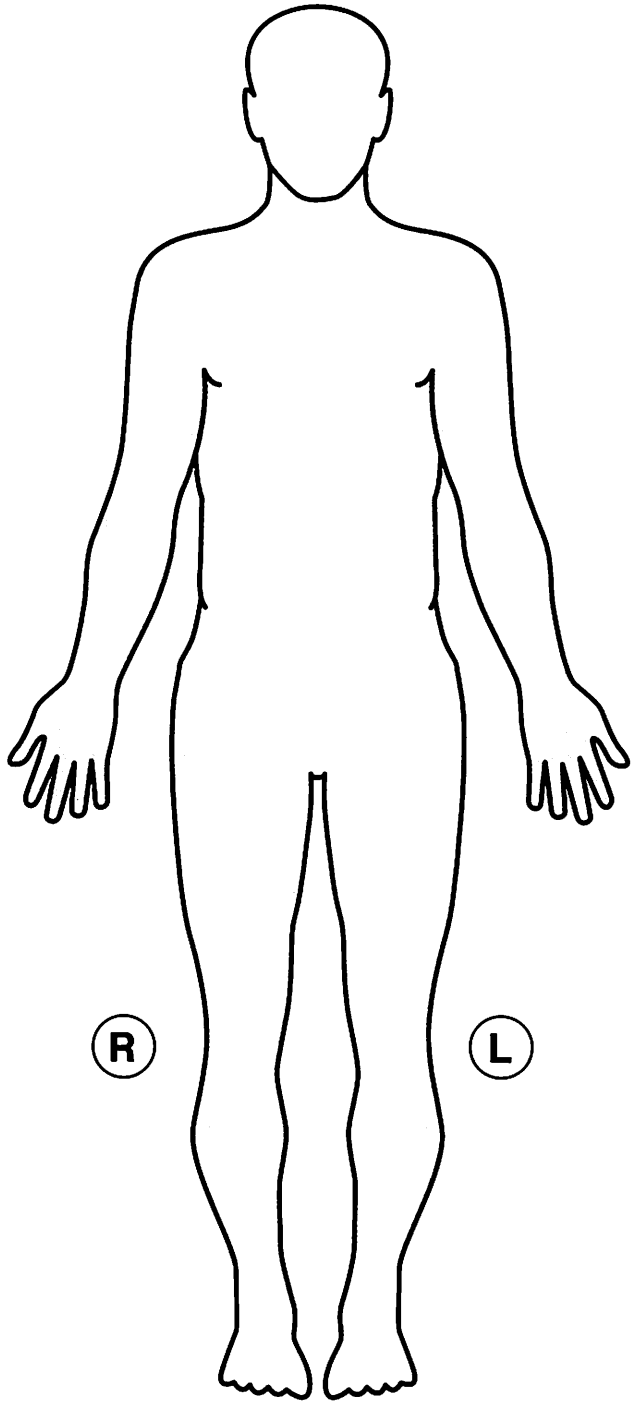
☐ Yes ☐ No _____ ___/___/___
Signed Date

☐ Yes ☐ No _____ ___/___/___
Signed Date

PLEASE TURN OVER



BACK



FRONT

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:

NUMBNESS - - - - - - PINS & NEEDLES o o o o o o BURNING x x x x x x

STABBING / / / / / / ACHING + + + + + + OTHER * * * * * *

PATIENT NAME _____ DATE _____

POS Reorder # 1800305

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 Patient or Legal Representative Date Witness Signature

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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.