PROGRESSIVE SPINE & ORTHOPAEDICS

PERSONAL INFORMATION :

LAST NAME: _____ FIRST NAME: _____

PHONE #:_____ CELL PHONE#:_____

ADDRESS:_____

TOWN/CITY :_____ ZIP CODE:_____

EMERGENCY CONTACT:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

MARITAL STATUS : _____ MALE/FEMALE: _____

E-MAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____

NAME OF PHARMACY: _____ PHARMACY PHONE #:_____

EMPLOYMENT STATUS:_____

EMPLOYER'S ADDRESS:_____

EMPLOYER'S PHONE NUMBER:_____

HOW DID YOU HEAR ABOUT US?

_____

INSURANCE INFORMATION :

NAME OF INSURANCE:_____

INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

SECONDARY INSURANCE:_____

INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

WORKER'S COMPENSATION/ MOTOR VEHICLE ACCIDENT:

NAME OF INSURANCE:_____

CLAIM NUMBER:_____

DATE OF ACCIDENT:_____

INSURANCE ADDRESS:_____

ADJUSTOR/ NURSE CASE MANAGER'S NAME:_____

PHONE NUMBER:_____ EXT: _____

ATTORNEY'S INFORMATION:

ATTORNEY'S NAME:-_____

ADDRESS:_____

PHONE NUMBER:_____

MEDICAL HISTORY/ PERSONAL INFORMATION:

PLEASE CIRCLE ANY KNOWN MEDICAL CONDITION:

HYPERTENSION	LIVER DISEASE
HEART DISEASE	DIABETES
ASTHMA	ANEMIA
GERD	OTHER:_____

ARE YOU CURRENTLY TAKING ANY MEDICATION?_____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES?_____

PLEASE LIST ANY PRIOR SURGERY:_____

DO YOU SMOKE?_____ DO YOU DRINK ALCOHOL?_____

DO YOU USE ANY RECREATIONAL DRUGS?_____

HOW MANY CHILDREN DO YOU HAVE ?_____

ARE YOU RIGHT HANDED OR LEFT HANDED?_____

DESCRIPTION OF INJURY/ACCIDENT:

WHAT BODY PART DID YOU HURT?_____

WHEN DID THE PAIN START TO OCCUR?_____

BRIEF DESCRIPTION OF THE INJURY: _____

_____

_____

ARE YOU EXPERIENCING PAIN IN EITHER OF YOUR ARMS?_____

ARE YOU EXPERIENCING PAIN IN EITHER OF YOUR LEGS?_____

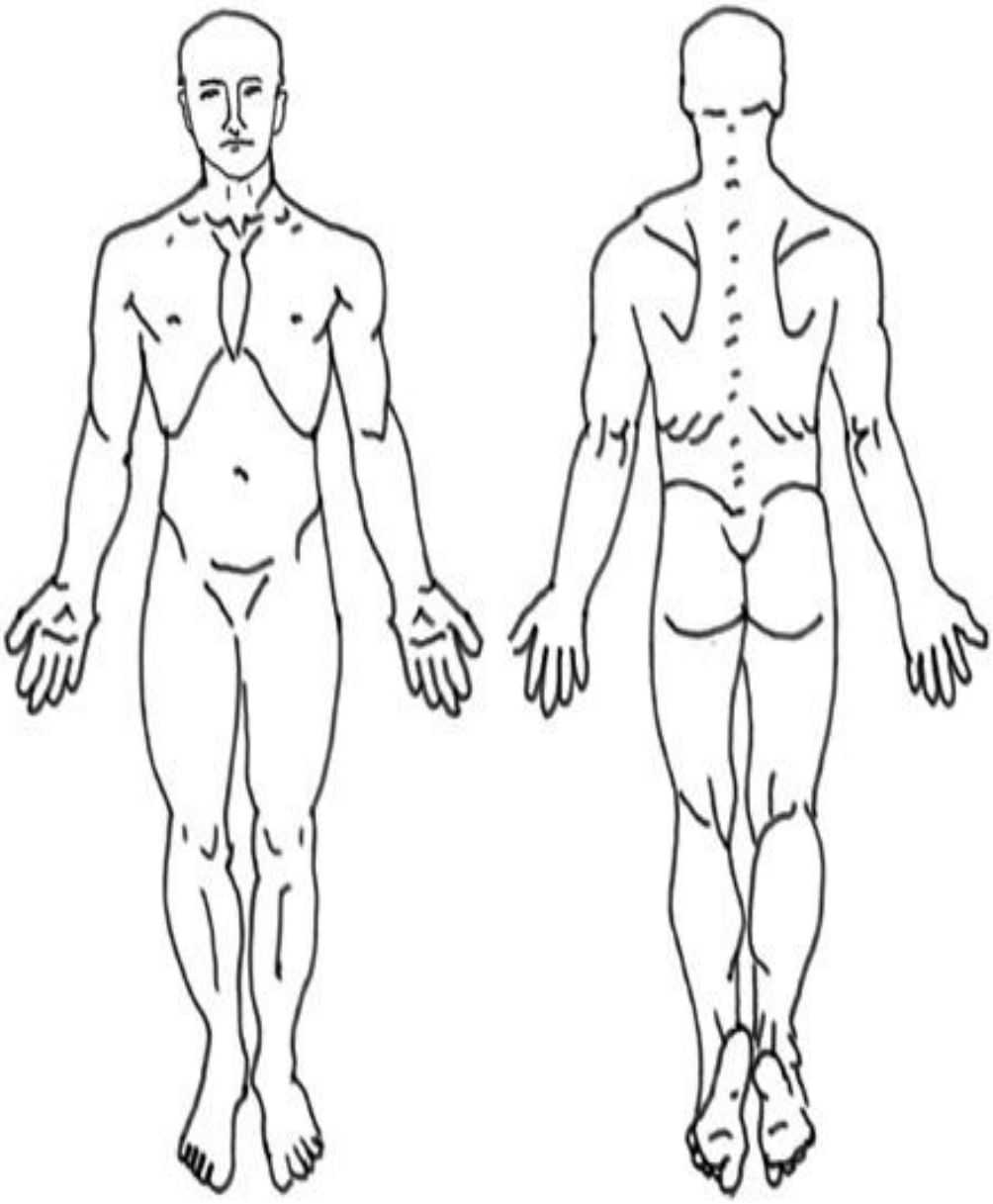
PLEASE CIRCLE:

WHAT MAKES YOUR PAIN WORSE?	SITTING	STANDING	WALKING	LAYING
WHAT MAKES YOUR PAIN BETTER?	SITTING	STANDING	WALKING	LAYING

ON A ONE TO TEN SCALE HOW WOULD YOU RATE YOUR PAIN ON AN EVERY DAY BASIS?_____

Mark the area(s) on your body where you feel the described sensations. Use the appropriate symbols for areas of radiation (include all affected areas).

NUMBNESS/PINS & NEEDLES ++++ PAIN >>>>



One Time Authorization Form

PATIENT'S NAME:_____ DATE _____

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named facility all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I, and not the insurance company, am responsible for the payment of all services.

INITIAL: ____ SIGNATURE:_____ DATE:_____

Responsibility for copay amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physician's visit. Further, I understand that if my copay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received, once insurance has paid, will be due upon receipt.

INITIAL: ____ SIGNATURE:_____ DATE:_____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits, including Medicare, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of as third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

INITIAL: ____ SIGNATURE:_____ DATE:_____

Acknowledgement of Receipt of Privacy Notice.- I acknowledge receiving today a copy of the provider's notice of privacy policies- I consent to the provider's use of protected health information as described in the notice for treatment, payment, of health care operations- I understand that I must provide a separate authorization before any other disclosures may be made.

INITIAL: ____ SIGNATURE:_____ DATE:_____

Reminder / notification: We may call you to remind you of your appointment or notify you of test results. I agree, if I have an answering machine, to allow the doctor or staff members to identify themselves, as well as myself and to notify me of my appointment or tell me that test results are back. We will not leave test results on your answering machine.

INITIAL: ____ SIGNATURE:_____ DATE:_____

Request for restrictions: I request that my protected health information be disclosed to the following persons or facility:

(please list): _____

SIGNATURE:_____ DATE:_____