PATIENT INFORMATION FORM

Thank you for choosing Performance Spine & Sports Physicians, P.C.

To help ensure accurate medical records, please complete form in full.

PATIENT INFORMATION

Patient's Name: ______________________ D.O.B.: ____/____/____

Address: ______________________

City: ______________________ State: ________ Zip: ____________

Home Phone: ______________________ Cell Phone: ______________________

Cell Phone Carrier: ☐ AT&T ☐ T-Mobile ☐ Verizon ☐ Other: ______________________

INSURANCE INFORMATION

Primary Insurance Carrier/MVA/WC Company Name: ______________________

Insurance ID, Policy/Claim #: ______________________

Name of Adjuster: ______________________

Adjuster Phone# & Adjuster Email: ______________________

Subscriber Name: ______________________ Subscriber D.O.B.: ____________

Subscriber's Employer: ______________________

Name of Attorney if Applicable: ______________________

Attorney Phone/Fax/Email: ______________________

Address to Send Claims if MVA/WC: ______________________

Secondary/Back-up Health Insurance Co. Name: ______________________

ID # or Policy #: ______________________

PERFORMANCE SPINE & SPORTS PHYSICIANS, P.C.

INITIAL EVALUATION FORM

MEDICAL EVALUATION INFORMATION

Name: ______________________________ Date: ____/____/____

Date of Birth: ____/____/____ Referring Doctor: ______________________________

Family Dr.: ______________________________ Family Doctor Phone #: ______________________________

Pharmacy: ______________________________ Pharmacy Phone #: ______________________________

Date of Accident: ____/____/____ Location: (home, work, auto, etc.) ______________________________

Is this a workers' comp case? ❑ Yes ❑ No Auto? ❑ Yes ❑ No Litigation? ❑ Yes ❑ No

Main Complaint/Reason for Visit: ______________________________

How long have you experienced these symptoms? ______________________________

How did symptoms start? ______________________________

Where (body part) did symptoms start and have they extended to other body parts? (explain) ______________________________

____

What treatments have you tried so far **for your complaint(s)** with results (complete all relevant areas)

Treatment Type **Medications:**	**Other** **Dosage:**	**Results (e.g. helpful/side effects)**

❑ **Physical Therapy** **Appx. Dates/Results:** ______________________________

❑ **TENS/E. Stim** **Appx. Dates/Results:** ______________________________

❑ **Acupuncture** **Appx. Dates/Results:** ______________________________

❑ **Injections** **Type/Appx. Dates/Results:** ______________________________

❑ **Surgery** **Type/Appx. Dates/Results:** ______________________________

❑ **Other** **Type/Appx. Dates/Results:** ______________________________

Psychological **Appx. Dates/Results:**

❑ Biofeedback ______________________________

❑ Cognitive Behavioral Therapy ______________________________

Diagnostic Studies **Appx. Dates/Body Parts/Results:**

❑ X-Ray ______________________________

❑ MRI ______________________________

❑ EMG ______________________________

❑ CT/Bone Scan ______________________________

❑ Other ______________________________

Past Medical History: (please check all that apply to you)

❑ DM ❑ Heart Disease ❑ HTN ❑ Spine Disorder ❑ Arthritis ❑ CTS ❑ Thyroid ❑ Cancer ❑ SZ ❑ COPD ❑ GERD
❑ PUD ❑ GI Bleed ❑ Asthma ❑ Liver Disease ❑ Depression ❑ Anxiety ❑ High Cholesterol ❑ Kidney Disease

❑ Other: ____________________

Please list any medications you are currently taking:

Name	Dosage	Name	Dosage

Please list any medication allergies: ____________________

Are you allergic to any of the following? (check all that apply): ❑ **X-Ray Dye** ❑ **MRI Contrast** ❑ **Iodine**

Do you have any Food Allergies? (please list): ____________________

Family History: ❑ DM ❑ Heart Disease ❑ Spine Disorder ❑ Arthritis ❑ CTS ❑ Thyroid

Social History: ❑ Single ❑ Married Children: ❑ Yes ❑ No

Education (years and degrees): ____________________

Living status: ❑ Alone ❑ With ____________________

Do you have stairs at home? ❑ Yes ❑ No

Hobbies / Sports / Other Activities: ____________________

Do you smoke? ❑ Yes ❑ No If yes, how much/week: ____________________

Do you drink? ❑ Yes ❑ No If yes, how much/week: ____________________

Have you had any problems with substance abuse? ❑ Yes ❑ No If yes, please explain: ____________________

____

Do you have any problems with the following? (check all that apply): ❑ Weight Loss ❑ Weight Gain
❑ Eyes/Ears ❑ Heart ❑ Lungs ❑ Bowel ❑ Headaches/Dizziness ❑ Bladder ❑ Skin ❑ Stroke ❑ Balance/Posture
❑ Depression ❑ Bleeding Disorder ❑ Anemia ❑ Ulcer Disease ❑ Tremors

❑ Other: ____________________

What is your Working Status (circle one)? ❑ Full-Time ❑ Part-Time ❑ Modified Duty ❑ Retired

❑ Disability Short/Long-Term (list reason): ____________________

Please explain the type of work you do/did: ____________________

____

If you are not currently working, what was the last date worked: ____________________

____

PAIN SCALE

What specific part(s) of the body do you need to be seen for? ______________________________

Please check **ALL** that apply for body part(s) you mentioned above:

☐ Right side ☐ Left side ☐ Front/Anterior ☐ Back/Posterior ☐ Other ______________________

On the Pain Numeric Rating Scale below, please check the best answer to questions below using

"0"=NO PAIN; "10"=WORST PAIN IMAGINABLE:

1. How would you rate your pain **RIGHT NOW/TODAY**?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. How would you rate your **USUAL/AVERAGE** Pain during the last week?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

3. How would you rate your **BEST/LEAST** level of pain last week?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. How would you rate your **WORST/HIGHEST** level of pain last week?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please describe your pain by checking **ALL** that apply:

☐ Stabbing ☐ Burning ☐ Aching ☐ Pins & Needles ☐ Numbness ☐ Radiating from one area to another

☐ Other ______________________________

Please describe anything that **Lessens** your pain by checking **ALL** that apply:

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending Forward ☐ Bending Backward

☐ Other ______________________________

Please describe anything that **Worsens** your pain by checking **ALL** that apply:

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending Forward ☐ Bending Backward

☐ Other ______________________________

PERFORMANCE SPINE & SPORTS PHYSICIANS, P.C.

PATIENT RESPONSIBILITY AGREEMENT FORM

PATIENT INFORMATION

LAST NAME: ______________________________ FIRST NAME: ____________________ MIDDLE INITIAL: ______

Sex M / F Emergency Contact: ______________________________ Relationship: ____________________

Phone #: ______________________________

We request that you assist us with the following:

INSURANCE INFORMATION

It is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payment amounts prior to any visit. **Co-payment is due at the time of your visit or your visit may need to be rescheduled.** If you fail to provide timely or accurate insurance information that results in non-payment for services or your insurance denies coverage, you will be responsible for payment. I authorize Performance Spine & Sports to release all medical information to all of my insurance carriers or other third party payers as may be required or requested for the processing of claims.

APPOINTMENTS

We ask that if you must cancel or change an appointment you provide at least 24 hours notification to our office. Missed appointments or arriving late for an appointment is very costly to everyone as we staff based on schedule needs and we can't see other patients who may need or want a visit at that time. Abuse of this policy may result in your discharge from the practice.

DEMOGRAPHIC INFORMATION

It is your responsibility to provide accurate and up-to-date personal information to our office and to notify us of any address or telephone number changes.

FORMS

Please check with our office for our form policy.

PAST-DUE ACCOUNTS

It is your responsibility to keep your account current. Should your account remain unpaid, you will not be able to schedule appointments until arrangements have been made to clear your outstanding balance. If payment arrangements are not made, your account will be turned over to our collection agency.

This is to certify that I understand and consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Performance Spine & Sports Physicians, P.C. to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Performance Spine & Sports Physicians, P.C. for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

______________________________ ____________________

Patient Signature Date

POS Reorder # 1618567