Sweetwater
Pain and Spine

NEW PATIENT INFORMATION

Patient Name (Last, First, MI)			Nickname	
SSN	Birthdate	Sex	Marital Status	
Street	City		State	Zip
Email Address			Written Contact Preference (circle): Postal mail Email	
Home/Cell Phone	Work Phone		Text Reminder: YES NO	
Race: (circle): American Indian / Alaska Native / Asian/ Hawaiian / Pacific Islander/ Black or African American/ Hispanic or Latino / White or Caucasian / Refuse to Report			**Ethnicity (circle):** Hispanic or Latino / Not Hispanic or Latino / Refuse to Report	
Have you recently been injured in a Motor Vehicle Accident? YES NO			**If yes:** **Date of Injury**_____ **Name of Attorney**_____	

EMPLOYMENT INFORMATION

Employment Status (circle): Employed / Unemployed / Full-Time Student / Part-Time Student / Other		
Employer Name	Employer Address	Employer Phone

EMERGENCY CONTACT INFORMATION

Name	Relation to Patient
Address (Street, City, State, Zip)	Phone

GUARANTOR/RESPONSIBLE PARTY

Name	Relationship SELF OTHER: (specify)	
DOB	Phone	Address

PRIMARY INSURANCE INFORMATION

Insurance Name	Policy Holder Name	DOB
ID #	Group # Name	Relationship to Policy Holder

SECONDARY INSURANCE INFORMATION

Insurance Name	Policy Holder Name	DOB
ID #	Group # Name	Relationship to Policy Holder

REFERRING PROVIDER/PRIMARY CARE PHYSICIAN

Name of Provider	Phone Number

Informed Consent, Acknowledgements and Authorizations

- **Patient Certification:** I certify that the above information is accurate to the best of my knowledge.
- **Patient Physician Relationship:** I understand that Sweetwater Pain and Spine is staffed by health care professionals who, although all dedicated to helping and caring for patients at Sweetwater Pain and Spine, may be independent contractors with the patient and are not necessarily employees or agents of Sweetwater Pain and Spine. Each patient is under the care and supervision of his/her attending physician and it is the responsibility of all persons involved with patient care to carry out the instructions of such physician. The relationship between the patient and the physician is at the direction of the patient. Should the patient choose to no longer accept the services of their treating physician, it is the responsibility of the patient and/or their family to obtain the services of another physician.
- **Treatment Authorization, Acknowledgment of Risk, and Promise to Cooperate:** I authorize Sweetwater Pain and Spine to evaluate and treat my medical condition. I understand there are no guarantees of expected results. I understand that every treatment has risks that cannot be reasonably avoided. I agree to be a proactive and cooperative and compliant patient in order to optimize treatment and care.
- **Medication History:** I consent to allowing Sweetwater Pain and Spine to access and review my medication history as available via prescription drug monitoring programs in determining treatment decisions and acknowledge that this will become part of my medical records.
- **HIPAA Acknowledgement:** I hereby acknowledge that I have been made aware that Sweetwater Pain and Spine has a Privacy Policy in place in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge that his policy is available for review in the Sweetwater Pain and Spine office as well as its website. I am informed that I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.
- **Financial Responsibility:** I understand and acknowledge that I am personally responsible for the services rendered by Sweetwater Pain and Spine. As a courtesy, my insurance carrier will be billed and, to the extent that applicable insurance benefits exist for treatment received by me from Sweetwater Pain and Spine, said benefits are hereby assigned to be applied to my patient bill. In the event of non-payment by an insurer or any other third-party, I understand I remain responsible for any outstanding balances.
- **Authorization to Verify Information:** I hereby authorize verification of employment history, banking accounts, credit history and any other information deemed necessary in conjunction with accounts owed Sweetwater Pain and Spine.
- **Communications to Patient**: I give Sweetwater Pain and Spine permission to leave a voice message on my preferred phone number voice mail.
- **A photocopy, fax or electronic copy of this form shall be considered as effective and valid as the original.**

_____ ___/___/_____

Patient/Guarantor Signature **Date**

Phone: (775) 870-1480
Fax: (877) 764-6351

Personal Release of Information

This is NOT a professional release intended for attorneys or physicians.

This form is for family members/loved ones to have full access* to your *records and/or billing information

If NO NAME is designated, then information will ONLY be released to you directly.

I,_____give my full permission to Sweetwater Pain and Spine to disclose details of my billing records and discuss my treatment/care either verbally or in written form with:

_____ _____

Name Relation to Patient

_____ _____

Patient Signature Date

Acknowledgment of Receipt of Privacy Notice

Applies to Guarantor of Account or spouse only

I do hereby acknowledge that I have been made aware that Sweetwater Pain and Spine has a Privacy Policy in place in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge that his policy is available for review in the Sweetwater Pain and Spine office as well as its website. I am informed that I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file.

I understand that by law (FPR 45 CPR § 164.524) my records are protected and that disclosure in most instances requires my signed permission.

_____ _____

Print Name **Date**

_____

Signature

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel an appointment. It is therefore requested that if you must cancel an appointment you provide more than a **48 hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot.

With cancellations made less than a 48 hour notice, we are unable to offer that slot to other people. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW.

Office appointments cancelled with less than 48 hours notification or No Show appointments will be subject to the following Cancellation/No Show fees:

$25 fee - Follow up office visits
$50 fee - Procedure appointments (EMG/Injection)

Patients who No Show two (2) or more times in a 12 month period may be dismissed from the practice and denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before or at the time of the patient's next appointment. In other words, you are personally responsible for the fees and this will NOT be billed through your insurance.

In order to be a patient in our clinic you must sign that you have read, understand, and agree to this Cancellation/No Show policy.

_____ _____

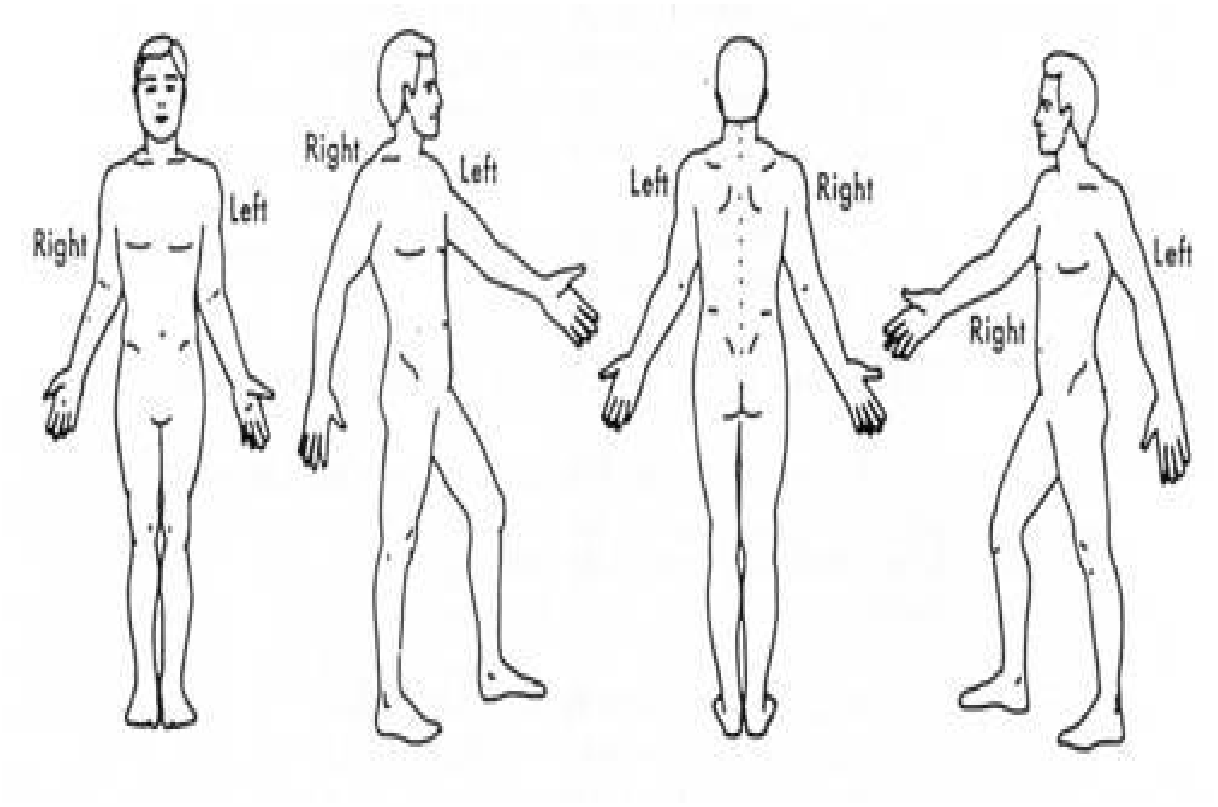
Name (Print) Date

_____

Signature

Patient Name _____DOB_____

Please shade in the area of your pain below:



What number best describes your <u>pain on average</u> in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Have you received an influenza shot? Yes No If yes, when_____

Have you received a pneumonia shot? Yes No If yes, when_____

CHIEF COMPLAINT INFORMATION

Please fill out this form to your best ability so that we may be able to address your pain condition to the best of our ability.

Name: _____

Reason for visit:_____How long ago did your pain start? _____

Where is your pain located? ☐ Head ☐ Neck ☐ Shoulder ☐ Mid Back ☐ Low Back
☐ Arm ☐ Leg ☐ Other: _____

Did it start suddenly or gradually? ☐ Suddenly ☐ Gradually

How would you describe your pain? ☐ Achy ☐ Burning ☐ Cramping
☐ Dull ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Stiff ☐ Throbbing

What makes your pain better? _____

What makes your pain worse? _____

Does your pain radiate?	☐ Yes	☐ No
Do you have numbness/tingling in your limbs?	☐ Yes	☐ No
Do you have weakness in your limbs?	☐ Yes	☐ No
Is your pain constant or does it come and go?	☐ Constant	☐ Comes and goes
Did your pain begin after a trauma?	☐ Yes	☐ No
Does your pain affect your ability to work or go to school?	☐ Yes	☐ No
Does your pain affect your daily activities?	☐ Yes	☐ No
Do you have osteoporosis?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you had cancer?	☐ Yes	☐ No
Have you had surgery for your pain?	☐ Yes	☐ No
Have you ever had similar symptoms/injury before	☐ Yes	☐ No
If yes, describe briefly:		

Have you recently been injured in a Motor Vehicle Accident? YES NO	**If yes:** **Date of Injury**_____ **Name of Attorney**_____

Do you have any of the following? ☐ Fever ☐ Bowel Problems ☐ Bladder Problems

What treatments have you had for your pain? _____

_____

Have you had any of the following diagnostic studies? ☐ X-ray ☐ CT ☐ MRI
☐ EMG (nerve condition studies)

Where were the studies performed? _____

MEDICATION **ALLERGIES**: ☐ No ☐ Yes (If yes, please list below)

Name	Describe reaction:

CURRENT MEDICATIONS

Name	Dosage	How often do you take?

PAST MEDICAL HISTORY

☐ Alcoholism	☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Cancer
☐ Claustrophobia	☐ Dementia	☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Headache	☐ Heart Attack	☐ High Cholesterol	☐ Lung Disease	☐ Organ Transplant
☐ Parkinson's	☐ Shingles	☐ Stroke	☐ Thyroid Disease	☐ Ulcers(GI)
☐ MRSA	☐ HIV / AIDS		☐ Hepatitis (If yes, circle) A B C	

☐ Other Conditions: _____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐ No ☐ Yes

If yes, please list type of surgery and approximate date:

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Autoimmune Disease	☐ Back Problems
☐ Cancer	☐ Dementia	☐ Depression	☐ Diabetes	☐ Epilepsy
☐ Gout	☐ Headache	☐ Heart Attack	☐ Heart Failure	☐ High Cholesterol
☐ Hypertension	☐ Kidney Stones	☐ Lung Disease	☐ Stroke	☐ Thyroid Disease

☐ Other: _____

SOCIAL HISTORY

Marital Status: (Circle one or more)
Single Married Divorced Widowed "Living Together" Separated

Number of Children: _____ Ages: _____

Do you smoke?	☐ No	☐ Yes	How much per day? _____
Previous Smoker?	☐ No	☐ Yes	When stopped? _____
Do you drink alcohol?	☐ No	☐ Yes	How much per day? _____
Coffee, tea, cola beverages?	☐ No	☐ Yes	How much per day? _____
Do you use recreational drugs?	☐ No	☐ Yes	What type? How often? _____
Are you currently employed	☐ No	☐ Yes	If yes, type of job

REVIEW OF SYMPTOMS: Please mark those items which you currently experience

GENERAL

☐ Chills ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weakness
☐ Weight gain ☐ Weight loss ☐ Other:

SKIN

☐ Easy bruising ☐ Itching ☐ Jaundice ☐ Lesions ☐ Rashes

HEAD/EYES/EARS

☐ Dizziness ☐ Head injury ☐ Headaches ☐ Blurry vision ☐ Double vision
☐ Eye pain ☐ Eyeglass use ☐ Light sensitivity ☐ Vision loss ☐ Ear pain
☐ Hearing loss ☐ Ringing in ears ☐ Sound sensitivity

RESPIRATORY

☐ Asthma ☐ Bronchitis ☐ Coughing blood ☐ Shortness of breath ☐ Wheezing

CARDIOVASCULAR

☐ Chest pain ☐ Palpitations ☐ Swelling of legs

GASTROINTESTINAL

☐ Abdominal pain ☐ Bloody/dark stool ☐ Constipation ☐ Diarrhea ☐ Nausea

GENITOURINARY

☐ Blood in Urine ☐ Frequency/Urgency with urination ☐ Incontinence ☐ Pain/burning on urination
☐ Retention ☐ Stones ☐ Discharge ☐ Irregular Menstruation
☐ Menstrual Pain ☐ Sexual problems ☐ Venereal disease

MUSCULOSKELETAL

☐ Arthritis ☐ Joint swelling ☐ Muscle cramps ☐ Trauma

NEUROLOGICAL

☐ Numbness/tingling ☐ Seizures ☐ Unsteady gait ☐ Weakness

PSYCHIATRIC

☐ Anxiety ☐ Depression ☐ Disturbing thoughts ☐ Disorientation ☐ Mood Changes ☐ Stress