



PATIENT INFORMATION

Form containing patient information fields: Today's date, Doctor You Are Seeing, Patient's Full Name, Street address, City/State/Zip, Home phone, Email, Social Security #, Sex, Date of Birth, Marital Status, Employer, Work #, Occupation, etc.

PATIENT/GUARDIAN SIGNATURE

DATE

Form containing insurance and payment information: Primary Insurance, Secondary Insurance, Referral Information, Method of Payment.

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TENNESSEE ORTHOPAEDIC CLINICS

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I hereby assign all medical benefits to include major medical benefits to which I am entitled to Tennessee Orthopaedic Clinics, P.C. this will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I further agree to be solely responsible for any balances that my insurance does not pay.

Signature: _____

Date: _____

REFERRAL INFORMATION:

I understand that if a referral is required by my primary physician, I am responsible for obtaining this referral and following the rules/regulations of my insurance provider. I understand that failure to obtain my referral could result in my responsibility for payment of services rendered.

Signature: _____

Date: _____

In the event this account is turned over for collection, patient (or responsible party) agrees to pay for all costs of collections, including court costs and attorney's fees.

Signature: _____

Date: _____

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages and other forms of communications.

Signature: _____

Date: _____



I, _____, give TOC permission to disclose my health information and account information to: Please list all parties we may discuss this information with (spouse, other family members, etc), including yourself if the patient is a minor. **Please give full names.**

Where and how may we contact you?

	Yes	No	
Home	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number

Work	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give phone number

Email	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us your email address

Other/Cell	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please give us another contact number

May we leave a message on your answering machine or voicemail?

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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May we leave a message if there is no answering machine?

At Home?	Yes <input type="checkbox"/>	<input type="checkbox"/>	At Work?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Signature of patient or responsible party

Date



TENNESSEE ORTHOPAEDIC CLINICS

PROOF NOTICE OF PRIVACY POLICIES RECEIVED

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy to the revised notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer.

You will not be penalized for filing a complaint

Contact Information

PLEASE CONTACT THE PRIVACY OFFICER AT THE SITE YOUR SERVICE WERE GIVEN

Effective Date

This Notice is effective April 14, 2003

Please print name

Account#

Signature of patient or responsible party

Date

SPINE NEW PATIENT QUESTIONNAIRE

Rev 10.13.10

Name: _____ Date of Visit: _____

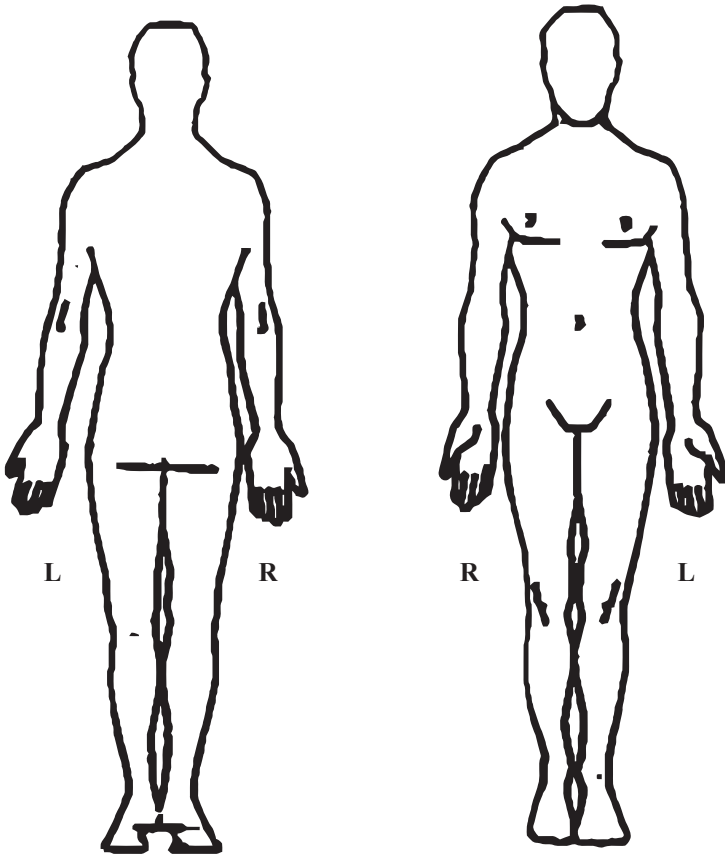
Male Female Temp: _____ Date of Birth: _____

Height: _____ Weight: _____ Age Today: _____

**Please note this is a multi-part questionnaire. When you are done, please take a moment to go over the questionnaire to be sure you have not missed any pages or questions. Thank you for your help.*

1. Pain Drawing: Mark these drawings using the symbol that best describes your pain quality.

Numbness ===== Ache ^^^^ Stabbing ////
Burning x x x x Cramping + + + + Pins & Needles o o o o



2. Which area is most painful?

- Low back and/or legs Neck and/or arms Both are equal

3. If you have BACK pain...

_____ % back pain + _____ % leg pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Back

0 1 2 3 4 5 6 7 8 9 10 Worst
None Pain

Circle one: occasional | intermittent | frequent | constant

Leg

0 1 2 3 4 5 6 7 8 9 10 Worst
None Pain

Circle one: occasional | intermittent | frequent | constant

4. If you have BACK pain...

_____ % neck pain + _____ % arm pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Neck

0 1 2 3 4 5 6 7 8 9 10 Worst
None Pain

Circle one: occasional | intermittent | frequent | constant

Arm

0 1 2 3 4 5 6 7 8 9 10 Worst
None Pain

Circle one: occasional | intermittent | frequent | constant

5. How did you first hear about TOC-Spine?

- Friend/Family Member _____
- Another Patient _____
- Internet
- Physician
- Other _____

6. What is the primary reason of your visit to TOC-Spine?

- Evaluation/Diagnosis/Treatment _____
- Second Opinion
- Education/Information
- Surgical planning

7. How did your current symptoms begin?

- Suddenly Date: _____
- Gradually

Please describe: _____

8. How long ago did your current symptoms begin?

- Less than 2 weeks ago
- 2 to 6 weeks ago
- 6 to 12 weeks ago
- 3 to 6 months ago
- 6 to 12 months ago
- More than 1 year

9. Is this a work-related injury?

- Yes
- No

10. Have you ever filed a Worker’s Compensation claim for your back/neck symptoms in the past?

- Yes
- No

11. Did your pain begin after a car accident?

- Yes
- No (skip to question #12)

If you were injured in a car accident please carefully fill out the questions below.

Date of Action: _____

Briefly describe the details of the accident:

When did you first notice symptoms? _____

When did you first report these to a doctor? _____

Did you suffer any other injuries when you hurt your spine ?

- Yes
- No

If yes, please list: _____

Have you ever been involved in a previous car accident?

- Yes
- No

If yes, please describe: _____

PAST MEDICAL HISTORY

12. Have you received treatment for your back or neck?

- Yes
- No

If yes, what treatments have you had?

- Physical therapy
- Epidural/Caudal Injections
- Chiropractic
- Facet Injections
- Surgery
- Pain Management _____
- Anti-Inflammatories _____

13. Please mark any of the following medical problems you have had:

- Asthma
- Bleeding disorder
- Cancer (Type: _____)
- Depression
- Diabetes (Insulin? Y or N)
- Emphysema/COPD
- Heart attack
- Heart disease
- Hepatitis (Type? _____)
- High blood pressure
- HIV positive
- Kidney/bladder infections
- Kidney stones
- Prostate problems
- Psoriasis
- Rheumatoid arthritis
- Seizure disorder
- Sleep Apnea
- Stroke or TIA
- Thyroid problems
- Ulcers or reflux
- Ulcerative colitis
- Tuberculosis
- Other _____
- NONE

FAMILY HISTORY

14. Please mark conditions in your immediate family:

- Anesthesia difficulties
- Arthritis
- Back Pain
- Bleeding tendencies
- Cancer (Type: _____)
- Diabetes
- Heart Disease
- Stroke
- NONE

15. List all previous hospitalizations that were not for surgery: _____

15. Have you ever had previous BACK or NECK surgery? Yes NONE If yes, how many surgeries? _____

Date of SPINE surgery	Type of surgery	% Improvement	How long did the improvement last?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been involved in a previous car accident?
 No Yes, with no limitations
 Did not work before surgery Yes, with limitations

After your most recent spine surgery, did you return to full function:
 Yes No

16. List all previous surgeries UNRELATED to your spine: NONE

Date of surgery	Type of surgery	Describe Recovery
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS AND ALLERGIES

17. Please list all medications and doses that you are CURRENTLY taking (include herbal supplements): NONE

<u>Medication</u>	<u>Dose/Strength</u>	<u># Pills per Day</u>	<u>Reason</u> Example: diabetes, hypertension
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication Allergies: None Known

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____

Latex Allergy: Yes No

REVIEW OF SYSTEMS

18. Please list all medications and doses that you are CURRENTLY taking (include herbal supplements): NONE

Skin

- rashes
 psoriasis
 bruise easily
 abnormal lumps
 painful breasts

Eyes

- visual loss
 double vision

Ears

- decreased hearing
 ringing in ears

Nose

- sinus problems
 breathing problems

Throat

- sore throat
 hoarseness
 snoring

Cardiovascular

- palpitations
 heart murmur
 chest pain
 irregular heartbeat

Respiratory

- shortness of breath
 wheezing
 cough

Gastrointestinal

- weight loss
 nausea/vomiting
 constipation
 diarrhea
 blood in stool
 loss of bowel control

Musculoskeletal

- fractures/sprains
 osteoporosis
 joint swelling

Genitourinary

- blood in urine
 increased frequency of urination
 painful urination
 loss of bladder control
 kidney stones

Endocrine

- thyroid problems
 excessive thirst/appetite
 diabetes

Neurologic

- headache/migraine
 dizziness
 convulsions/seizures
 loss of consciousness

NONE OF THESE (OR NONE CURRENTLY)

SOCIAL HISTORY

19. Do you currently smoke cigarettes?

- No, I have never smoked
 No, I quit ___ months/ years ago
 Yes ___ packs per day
 Currently Chew Tobacco/ Snuff

20. Do you use alcoholic beverages (beer, wine, liquor)?

- Yes No
If yes, type of alcohol _____
Amount _____

21. Current situation

- Married
 Divorced
 Single
 Living with significant other
 Widowed

22. Do you have children?

- Yes No
If yes, list their ages: -> _____
How many children are living with you? _____

WORK HISTORY

23. What is your occupation? _____

Name of employer: _____

Last date worked: _____

24. Please mark ONE statement that best describes your current employment situation:

- Currently working
 On paid leave
 On unpaid leave
 Unemployed
 Homemaker
 Student
 Retired (not due to health)
 Disabled and/or retired because of my back or neck problems
 Disabled due to a health problem not related to my back or neck
 Other, please specify _____

25. Modified Oswestry Disability Index: This questionnaire has been designed to give your doctor information as to how your pain as affected your ability to manage in everyday life. Please answer every question marking the ONE box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but *please mark only the box that most closely describes your current condition.*

Pain Intensity

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medication provides me with little relief from pain.
- Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

Sitting

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than 1/2 hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want, but it increases my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than 1/2 hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

Social Life

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under 1/2 hour.
- My pain prevents all travel except for visits to the physician/therapist or hospital.

Employment / Homemaking

- My normal homemaking / job activities do not cause pain.
- My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores

I authorize Dr. Bolt and Tennessee Orthopaedic Clinics to release my medical reports to my referring physician and/or attorney if applicable.

REFERRING CARE PHYSICIANS: _____ Phone: _____

Address: _____

REFERRING CARE PHYSICIANS FAX Number: _____

REFERRING CARE PHYSICIANS EMAIL ADDRESS: _____

ATTORNEY'S Name: _____ Phone: _____

Address: _____

ATTORNEY'S FAX Number: _____

Patient's Signature: _____

Please *Print* Name: _____

Patient Email Address (optional) _____