PATIENT INFORMATION

Name:	Date of Birth:	Age:	Sex:
Race:	Ethnicity:		Primary Language:
Address: (City, State, Zip)			
Billing Address:	SSN:		
Employment: Full/Part/None	Employer:		
Primary Phone #:	Work Phone #:	Cell Phone #:	
Email Address: (used to set up your patient portal)			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Cell Phone #:
Relationship:	Home Phone #:

INSURANCE INFORMATION

Primary Insurance: Copay:	Secondary Insurance: Copay:
Certificate#/Policy ID:	Certificate #/Policy ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB/Relationship:	Subscriber DOB/Relationship:

REFERRALS

Referring Physician:	How did you hear about us? (Referring doctor, friend, family, self referral, internet, magazine, newspaper, advertisement, other)

PRIMARY CARE

Primary Care Physician:	Last Office Visit:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.
Authorization To Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment.
I certify that the above information is correct as of the date signed.

______________________________ ____________________

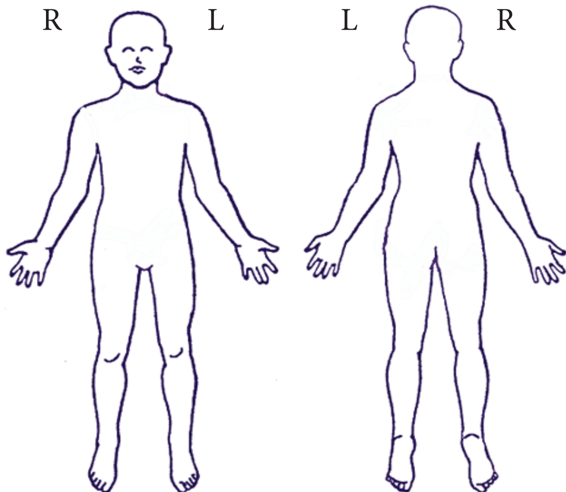
Signature Date

Patient Name: ___________________________________

Referring Provider:___________________________

Location of Pain:____________________________

Circle the area of your pain:



Height:__________ Weight:__________

Onset of Pain:

○ Acute ○ Sudden ○ Gradual

Severity of Pain:

○ Mild ○ Moderate ○ Severe

Intensity of Pain at Best: (circle #)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Intensity of Pain at Worst: (circle #)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Intensity of Pain at Average: (circle #)

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Description of Pain:

○ Aching	○ Burning	○ Cramping
○ Deep	○ Dull	○ Numbness
○ Pins & Needles	○ Pressure	○ Sharp
○ Shooting	○ Stabbing	

Pain Pattern:

○ Episodic ○ Persistent ○ Intermittent

Course of Pain:

○ Gradual Worsening	○ Gradual Improving
○ Rapidly Worsening	○ Rapidly Improving
○ Recurrent	○ Without Change

Duration of Pain:

Years (How Many? __________)
Months (How Many? ________)
Weeks (How Many? _________)

Pain Aggravated by:

○ Nothing	○ Sneezing	○ Coughing
○ Lying Down	○ Bending	○ Twisting
○ Lifting	○ Sitting	○ Standing
○ Walking	○ Bowel Movements	

Pain Relieved by:

○ Nothing	○ Rest	○ Change in Position
○ Exercise	○ Heat	○ Pain Medication
○ Sitting	○ Ice	○ Standing
○ Bending Forward		○ Physical Therapy

Daily Activities Impaired by Pain:

○ None	○ Work	○ Sleeping
○ Eating	○ Using Toilet	○ Intimacy
○ Dressing	○ Bathing	○ Exercise
○ Getting Up From Bed/Chair		

Tried & Failed:

○ Physical Therapy	○ Bracing	○ Heat
○ Chiropractic	○ Massage	○ NSAID's
○ Surgery	○ Opiates	○ Ice
○ Radiofrequency	○ Facet Injections	
○ Epidural Injections	○ Modification of Activity	

Associated Factors:

○ Arthritis	○ Flank Pain	○ Painful Urination
○ Chills	○ Hip Pain	○ Urine Retention
○ Fever	○ Numbness	○ Abdominal Pain
○ Tingling	○ Leg Weakness	○ Arm Weakness
○ Loss of bowel control	○ Loss of bladder control	
○ History of Malignancy	○ Unintentional weightloss	

Assisstive Devices:

○ None	○ Cane	○ Walker	○ Wheeled Walker
○ Corset	○ Brace	○ Wheelchair	

Accident/Injury:

Are you currently involved in litigation regarding your injury? Y / N
Is your pain a work related injury? Y / N
Workman's Compensation involved? Y / N
Date of Accident/injury:______________

Patient Name: ____

Review of Systems: (Please mark all that apply)

Constitutional:
○Fatigue ○Weightloss ○Weight Gain
○Appetite Loss

Head:
○Seasonal Allergies ○Vertigo

Eyes:
○Blurry Vision ○Double Vision
○Vision Loss ○Pain with Light

Respiratory:
○Shortness of Breath ○Sleep Apnea
○Chronic Cough ○Difficulty Sleeping

Cardiovascular:
○Chest Pain ○High Blood Pressure
○ Shortness of Breath when Lying Down
○Rapid Heart Rate○Swelling/Pain Legs
○Heart Stents

Gastrointestinal:
○Abdominal Pain ○Constipation
○Diarrhea ○Black, Tarry Stool
○Nausea ○Vomiting ○Bloody Stool

Musculoskeletal:
○Joint Pain ○Muscle Weakness
○Muscle Spasm ○Leg Cramps
○Muscle Loss ○Back Pain ○Neck Pain
○Restricted Motion

Psychiatric:
○Anxiety ○Depression
○Hallucinations ○Mood Changes
○Panic Attacks ○Anger
○Hearing Voices

Skin:
○Itching ○Rashes ○Open Wound
○Ulcer ○Excessive Sweating
○Bruising

Neurological:
○Headaches ○Numbness ○Strokes
○Trouble Walking ○Seizures
○Leg Weakness ○Buttock Numbness
○Loss of Bowel or Bladder Control

Endocrine:
○Appetite Changes ○Thyroid Problems

Hematologic/Lymph:
○Bruise Easy ○Nose Bleeds
○Blood Clots ○ Bleed Easy

ENT/Ears:
○Hearing Loss

Throat/Neck:
○Ulcer ○Neck Mass ○Swollen Glands

Allergies: Medications

____

____

○Shellfish ○Contrast Dye ○Iodine ○Latex
○Codeine ○Penicillin ○Seasonal Allergies ○Sulfa
○Other:________________

Medications:

Current Prescriptions: (include all Rx's)

Medication   Dose(mg)   Frequency

1.________________________________
2.________________________________
3.________________________________
4.________________________________
5.________________________________
6.________________________________
7.________________________________
8.________________________________
9.________________________________
10._______________________________

Are you taking any blood thinners? Y/N

Previously Tried Pain Medications:

1.__________Reason Discontinued:_______
2.__________Reason Discontinued:_______
3.__________Reason Discontinued:_______

Family History: *Please specify family member including maternal/paternal and alive/deceased

○Diabetes__________ ○Alzheimer's__________
○Migraine__________ ○Heart Disease__________
○Cancer__________ ○Mental Illness__________
○Stroke__________ ○Osteoporosis__________
○High Blood Pressure______________________

Past Medical History:

○Anemia
○Anxiety
○Arthritis
○Asthma
○Atrial Fibrillation
○BPH
○Cancer
○COPD
○Depression
○Diabetes
○Emphysema
○GI Ulcer
○Hepatitis
○ HIV/AIDS
○ Hypertension
○ Kidney Disease
○ Liver Disease
○ Heart Attack
○ Osteoporosis
○ Seizures
○ Shingles
○ Stroke
○ Thyroid Disease
○ Congestive Heart Failure
○ Coronary Artery Disease
○ Other:______________

Patient Name: ___________________________________

Previous Imaging:

- ○X-Ray Date:_______ Location:__________
- ○MRI Date:_______ Location:__________
- ○CT Scan Date:_______ Location:__________
- ○EMG Date:_______ Location:__________
- ○Bone Scan Date:_______ Location:__________

Facility: IHC Revere Health
Other:_____________

Previous Evaluations:

○None ○Urgent Care ○Psychologist
○Neurologist ○Primary Care ○Neurosurgeon
○Emergency Room ○Pain Management
○Rheumatologist ○Orthopedic Surgeon

Previous Procedures:

○None ○Facet Injection
○Radiofrequency ○Epidural Injection
○Kyphoplasty ○SI Joint Injection
○Other:__________ ○Hip Injection

Relief: ○Mild ○Moderate ○Significant
Duration:___Days ___Weeks ___Months

Previous Physical Therapy or Chiropractic Care:

○None ○Yes Please indicate body region ?
____
Mth/Year:___________ Therapy Name/Location:
____

Previous Spine Surgery:

○None ○Yes, Please indicate location below:
____
Date:______________________________
Surgeon:____________________________
Relief: Mild Moderate Significant

Other Joint Surgery Type:_____________
Date:______________________________
Surgeon:____________________________
Relief: Mild Moderate Significant

Social History:

Alcohol Use:
Do you Drink? Y / N If Yes, servings per week:
Beer:_______ Wine:_______ Hard Liquor:_______

Tobacco Use:
○Never Smoked ○Former Smoker
○Current Smoker: Light<10 Heavy>10
Tobacco Type:(Cig, Chew, Vaping):
____

ORT:
Has anyone in your family had a history of:
○Alcohol Abuse ○Illegal Drugs
○Prescription Drug Abuse
Have YOU ever had a history of:
○Alcohol Abuse ○Illegal Drugs
○Prescription Drug Abuse

Please mark your age group:
○0-16 ○17-45 ○46+
Have you had a history of preadolescent sexual abuse?
○Yes ○No
Have you ever been diagnosed with:
○Attention Deficit Disorder(ADD)
○Obsessive Compulsive Disorder(OCD)
○Bipolar Disorder
○Schizophrenia Disorder
○Depression

Surgical History:

○None
○Adenoidectomy
○Appendectomy
○Knee Arthroscopy
○Back Surgery
  ○Cervical
  ○Thoracic
  ○Lumbar
○Brain Surgery
○Carpal Tunnel
  ○L ○R
○Cataract Surgery
○Heart Bypass Surgery
○Coronary Artery Dilation
○Gallbladder Removal
○Hemmorrhoidectomy
○Hernia Repair
○Other:_______________
○Hysterectomy
○Lumpectomy
○Large Bowel Resection
○Mastectomy
○Prostate Surgery
○Plastic Surgery
○Shoulder Surgery
  ○L ○R
○Small Bowel Resection
○Thyroidectomy
○Tonsillectomy
○Hip Replacement
  ○L ○R
○Knee Replacement
  ○L ○R
○Tubal Ligation
○Vasectomy
○Pace Maker

C A R O L I N A
Spine & Pain
C E N T E R S

Patient Consent Form

Please Read and Sign

I, ____, hereby consent to the following:

*Administration and performance of all treatments *Administration of any needed anesthetics

*Performance of such procedures as may be deemed necessare or advisable in the treatment of the patient

*Use of prescribed medication Performance of diagnostic procedures/tests *Taking and utilization of cultures

*Performance of other medically accepted laboratory tests that may be considered medically necssary or adivsable based on the judgment of the attending physician or ther assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Carolina Spine & Pain Centers includes consent at satellite offices under common ownership.

I authorize that Carolina Spine & Pain Centers will use and disclose my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient , such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designee, may be considered medically necessary or advisable.
Payment includes but is not limited to: the authorization of payment directly to CSP Enterprises dba Carolina Spine and Pain Centers of benefits otherwise payable to me. I hereby authorize the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee. I understand that I am financially responsible for charges not covered. I understand that patient records may be stored electronically and made available through computer networks.
Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.
I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood-borne diseases.
Medicare Patients: I authorize to release medical information about me to Social Security Administration or its intermediaries to for my Medicare claims. I assign the benefits for services to Carolina Spine & Pain Centers.

I acknowledge that I have been given the Carolina Spine & Pain Centers Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ __________________

Patient (or Responsible Party) Signature Date

****

I, ______________________ hereby authorize the physicians and staff of Carolina Spine & Pain Centers to give the following people information concerning my test results, health status, appointment times, medications, and procedure information.

☐ Spouse Name: ____

☐ Significant Other Name: ____

☐ Other Name: ____

☐ Carolina Spine & Pain Centers may leave messages on my answering machine

____ __________________

Patient Signature Date

Thank you for choosing us as your pain clinic. Our team of providers is committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon requests.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. __________ **(initial)**
2. Patient Payment: All co-payments and deductibles are to be paid at the time of service. This arrangement is part of you contract with your insurance company. __________**(initial)**
3. Registration: All patients must complete our patient information form, which will be entered into our medical records system to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current insurance care to provide proof of insurance. If you fail to provide us with correct insurance information, or you insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Many insurance companies have a time limit as to when claims can be filed; For example, if a claim is not received within 30 days of the date of service, it can be deemed ineligible for payment and you will be responsible for the balance if you fail to provide us with complete and accurate information. ____________**(initial)**
4. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of you claim is you responsibility whether your insurance company pays or not. Your insurance benefits is a contract between you and your insurance company. ___________**(initial)**
5. Uninsured Patients: We offer a cash pay discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action. ___________**(initial)**
6. Credit and Collection: If your account is more that 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. In the event any amount is referred to a third party debt collection agency, you agree that in addition to any other amount allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc), your will also be responsible for a collection fee of up to 40% of the principle amount owing as allowed by South Carolina. ____________**(initial)**
7. Missed Appointments: Our policy is to charge $30 for missed appointments (no shows) not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment. ____________**(initial)**

Thank you for reviewing our patient financial policy. Please let us know if you have any questions regarding the policy.

By signing below, you acknowledge the terms of the policy and agree to be bound by them.

______________________________________ ______________________

Signature Date