SOUTH TEXAS SPINAL CLINIC, P.A.
PATIENT DEMOGRAPHIC SHEET

ACCT # _____ DOCTOR: _____ DATE: _____

PLEASE PRINT

Check Appropriate Block(s)
□ Medicare □ Medicaid □ Group Health Plan □ Workman's Comp □Other

PATIENTS NAME (Last name, first, middle intl)	PATIENT BIRTHDAY -(mm,dd,yy) / AGE	SOCIAL SECURITY #

PATIENTS ADDRESS: CITY : STATE : ZIP: HOME PHONE #:

CELL #	SEX: □ MALE □ FEMALE	DRIVER LICENSE # & STATE	MARITAL STATUS: □ Married □ Single □ Divorced □Widowed

PATIENT'S PRESENT EMPLOYER ADDRESS: CITY / STATE ZIP: WORK PHONE #:

SPOUSE'S / GUARDIAN NAME ADDRESS: CITY / STATE ZIP: HOME PHONE #

SPOUSE'S / GUARDIAN EMPLOYER ADDRESS: CITY / STATE ZIP: WORK PHONE#:

SPOUSE'S / GUARDIAN DATE OF BIRTH:

NAME OF POLICY HOLDER (IF DIFFERENT FROM ABOVE)		DATE OF BIRTH:	SOCIAL SECURITY #
POLICY NAME & ID#	POLICY GROUP #	EMPLOYER:	RELATIONSHIP TO PATIENT:

MAY WE DISCUSS CLINICAL & FINANCIAL INFORMATION WITH YOUR SPOUSE? YES NO

MAY WE LEAVE A MESSAGE AT YOUR HOME, ANSWERING MACHINE OR THIRD PARTY? YES NO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU: Relationship Phone #:
Name ( )

EMERGENCY CONTACT: Address: Phone #:
Name ( )

REFERRED BY: Address: Phone #:
( )

REPRESENTING ATTORNEY (If Applicable)

IS PATIENT'S CONDITION RELATED TO EMPLOYMENT? DATE OF ACCIDENT
(Current or previous) □ Yes □ No _____/_____/_____
AUTO ACCIDENT? □ Yes □ No _____/_____/_____
OTHER ACCIDENT? □ Yes □ No _____/_____/_____

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my Insurance Carrier to pay directly to the South Texas Spinal Clinic, P.A. all benefits otherwise payable to me for Medical and/or Surgical services. I understand I am financially responsible for any non-covered services, deductibles or co-payments.

SIGNATURE_____ DATE _____

MEDICAL RELEASE OF INFORMATION: I hereby authorize South Texas Spinal Clinic, P.A. to release any Medical Information required to process my claim.

SIGNATURE _____ DATE _____

I WILL BE PAYING TODAY BY
(Check one if self pay)
CASH _____ CHECK _____ CREDIT CARD _____

SOUTH TEXAS SPINAL CLINIC
PATIENT HISTORY FORM

ACCT #:_____ DATE:_____

Patient's Legal Name: _____
Last Name *First Name* *M.I.*

Age:_____ Date of Birth:_____ Education Level: (Highest level attained) _____

Primary Care / Family Physician: _____

Referring Physician: _____

□ Initial Office Visit □ Second Opinion □ IME
□ Workers Compensation □ Consultation □ Other _____

REASON FOR VISIT: My area of pain or complaint(s) is/are:

What part of your body is experiencing the GREATEST pain? _____

Location of pain: _____ Rate the pain from 0=none to 10= unbearable: _____
Location of pain: _____ Rate the pain from 0=none to 10=unbearable: _____
Location of pain: _____ Rate the pain from 0=none to 10=unbearable: _____

□ **sudden** since _____
□ **gradually** since _____
□ **following** an injury on _____

□ no prior low back pain
□ a history of low back pain for _____ years

□ no prior neck pain
□ a history of neck back pain for _____ years

_____

_____

_____

MID TO LOW BACK:
Pain quality: □ aching □ sharp □ burning □ cramping □ stabbing
Pain location: □ middle of low back □ to L R □ across buttock / back

NECK:
Pain quality: □ aching □ sharp □ burning □ cramping □ stabbing
Pain location: □ middle of low back □ to L R □ across buttock / back

Dominant hand □ Left □ Right

PATIENT HISTORY FORM

ACCT #: _____ DATE: _____

PAST MEDICAL HISTORY:

ALLERGIES:
List all medications you are allergic to and the reaction you have:_____
_____
_____
_____

MEDICATIONS:
List all medication you are now taking and what they are for: _____
_____
_____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and when they happened:
□ NONE □ Lumbar _____ □ Cervical _____ □ Thoracic _____

Check all OTHER surgeries: □ NONE □ appendectomy □ cardiac surgery □ tonsil / adenoidectomy
□ wisdom teeth removal □ gall bladder surgery □ other orthopedic surgery □ thyroid surgery
□ breast surgery □ hernia repair □ Cesarean section □ Other _____

OTHER INJURIES: _____
_____

REVIEW OF SYSTEMS: CHECK ANY ITEM THAT APPLIES TO YOU:

Musculoskeletal / Joints:	□ Muscular disease	□ Arthritis			
Neurological:	□ Headaches	□ Migraines	□ Seizures / Epilepsy	□ Strokes	
Metabolic:	□ Diabetes	□ Thyroid problems			
Bleeding Disorders:	□ Anemia	□ Blood Clots	□ Bleeding Problems		
Urinary:	□ Blood in Urine	□ Frequent Urination	□ Trouble Starting Urination		
	□ Trouble Stopping Urination	□ Pain with Urination	□ Prostate Disease		
	□ Kidney Disease				
Respiratory:	□ Asthma	□ Bronchitis	□ COPD	□ Emphysema	
	□ Pneumonia	□ Tuberculosis			
Cardiovascular:	□ Chest Pain	□ Mitral Valve Prolapse	□ Irregular Heartbeats		
	□ High Blood Pressure	□ Shortness of Breath			
Reproductive:	□ Infections	□ Herpes	□ Venereal Disease		
Gastrointestinal:	□ Stomach Ulcers	□ Gallbladder Problems	□ Pancreatitis		
	□ Colitis	□ Blood in Stool	□ Hiatal Hernia		
	□ Liver Disease	□ Constipation	□ Loss of Bowel Control		
	□ Hepatitis	□ Jaundice			
Cancer:	□ Lung	□ Breast / Colon / Intestinal	□ Stomach	□ Prostate	□ Skin
	□ Kidney	□ Bone	□ Other Malignancy _____		
Immunological Diseases:	□ HIV Infection / AIDS				
WOMEN ONLY:	□ Endometriosis				
Are you on the Pill?	□ NO □ YES	Are you pregnant now?	□ NO	□ YES due date: _____	

How long ago was your last complete physical? _____ yrs _____months
Where there any abnormal findings? □ NO □ Yes, describe: _____

PATIENT HISTORY FORM

ACCT #: _____ DATE: _____

Other medical history:

Do you smoke NOW?	□ No	□ Yes: Packs per day: _____ for _____ years
Did you smoke in the Past?	□ No	□ Yes: Packs per day: _____ for _____ years
Do you drink alcoholic beverages?	□ No	□ Yes: Drinks per week: _____ for _____ years
Do you have a history of drug abuse?	□ No	□ Yes: Please describe: _____

SOCIAL HISTORY:

Patients Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated

Number of children: _____

Hobbies: _____ Spouse Occupation: _____

FAMILY HISTORY:

Please check any of the problems immediate family have had and indicate the family member:

□ Diabetes	□ High Blood Pressure	□ Neck Pain
□ Heart Disease	□ Low Blood Pressure	□ OTHER _____
□ Vascular Disease	□ Cancer	

OCCUPATIONAL HISTORY:

Occupation: _____

Employer: _____ When did this employer hire you? _____

Presently Working? □ Yes □ No How long off work? _____

ADDITIONAL PATIENT INFORMATION: (Provide additional explanation of any response on this form in the space below and on back of sheet)

I hereby certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

_____	_____	_____
Patient Signature	Date	Verified by Physician/Nurse

[OVER]

INSTRUCTIONS: Use the appropriate symbol(s) below (as many as needed) and rate each.

PAIN SEVERITY SCALE: **MILD – 1 2 3 4 5 6 7 8 9 10 - - INTOLERABLE**

□ **NUMBNESS (SYMBOL: *)**
How would you rate this pain: _____

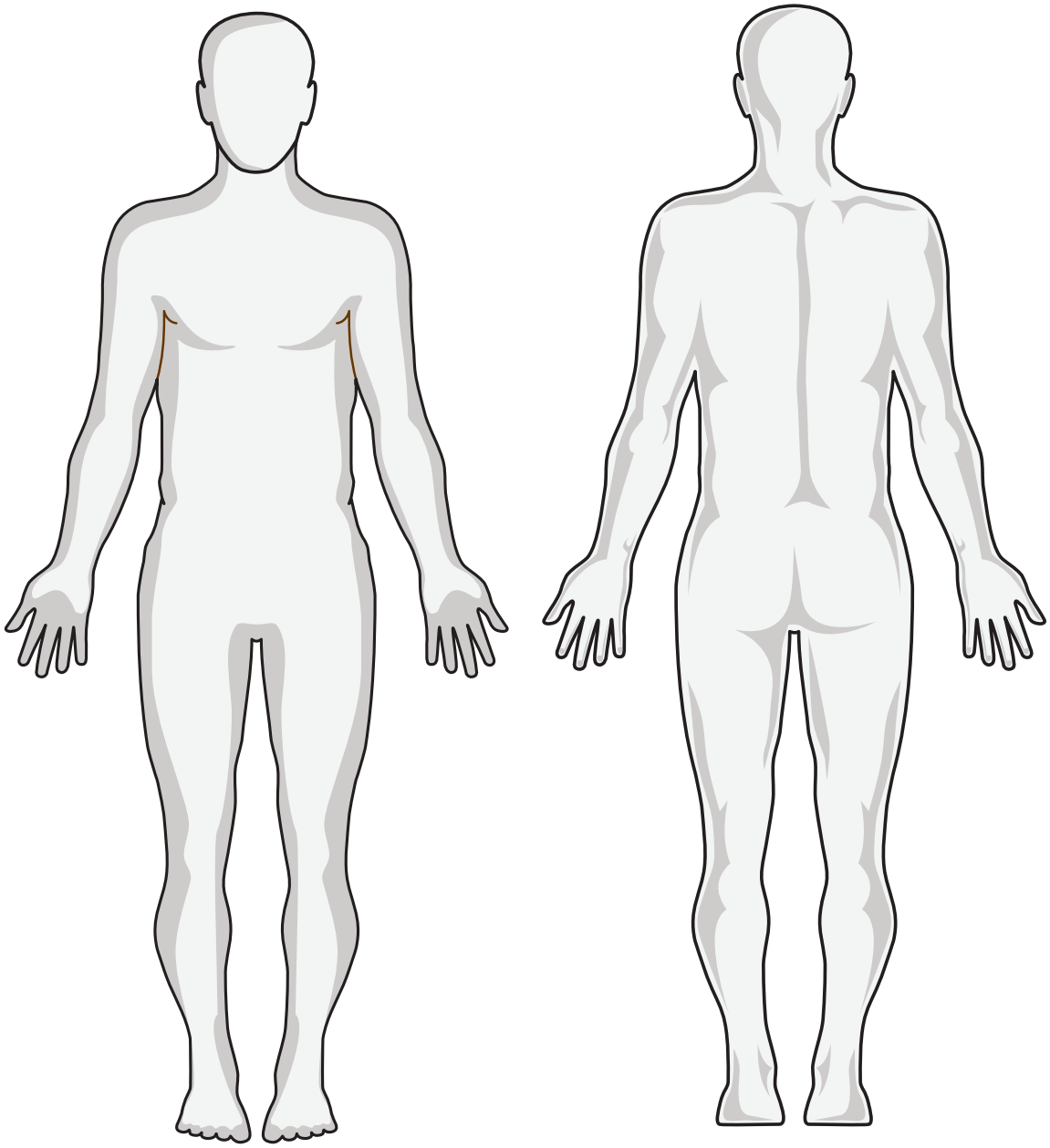
□ **PINS & NEEDLES (SYMBOL: O)**
How would you rate this pain: _____

□ **BURNING (SYMBOL: X)**
How would you rate this pain: _____

□ **STABBING (SYMBOL: /)**
How would you rate this pain: _____

□ **DEEP ACHE OR PAIN (SYMBOL: A)**
How would you rate this pain: _____

How would you rate this pain: _____



SOUTH TEXAS SPINAL CLINIC, P.A.

ACKNOWLEDGEMENT FORM

MR#: _____ PHYSICIAN: _____

PATIENT NAME: _____

DOB: _____ SSN #: _____

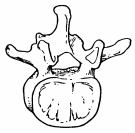
I acknowledge that South Texas Spinal Clinic, P.A. provided me with written copy of the STSC Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
STSC REPRESENTATIVE SIGNATURE DATE

S O U T H T E X A S
SPINAL CLINIC, P.A.



FINANCIAL DISCLOSURE

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Fellow of American Academy of Orthopedic Surgeons

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I _____ understand that the office staff of the South Texas Spinal Clinic, has verified my benefits and to the best of everyone's understanding my insurance carrier covers the procedures performed by the medical staff. As stated by my insurance carrier they are only a verification of benefits and are not a guarantee of payment. If there are any services which are not covered under my plan due to plan provisions within my policy they will be my responsibility. It is also understood that it is ultimately my responsibility to contact my insurance carrier if I have a questions regarding my plan provisions. Due to these provisions I might be liable for a deductible, co-pay and co-insurance depending upon my plan provisions. It is also understood that if there is a change within my insurance carrier, I will notify the South Texas Spinal Clinic office to update my file before my next visit. If I fail to do this I may be responsible for the full fee. When I receive my statement from the South Texas Spinal Clinic billing office I will make arrangements to pay my balance in full within 30 days. If I cannot pay my balance in full I will contact the South Texas Spinal Clinic collections department to make suitable payment arrangements.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Acct # _____

Medical Rec. #_____

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Satellite offices located in: Beeville, Floresville, Kerrville, Laredo, New Braunfels, San Marcos www.spinaldoc.com