Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address:_____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer_____ Employer Phone Number_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____Date of Birth MM _____/DD _____/YYYY____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature_____ ***Date***_____

Texas Institute of Spine and Neurosurgery

Patient Pharmacy Information:
In order to better serve you, we will send medication requests electronically to your pharmacy. Please provide your pharmacy information to us by completing the requested information below.

Patient Name _____ **Date of Birth** ____/____/____

Pharmacy Name _____

Pharmacy Phone Number (_____) _____ - _____

Address or Location _____

City, State, Zip Code _____

CONSENT TO OBTAIN MEDICATION HISTORY

As a user of an electronic medical record, we would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several resources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and to avoid potentially dangerous drug interactions. By signing this consent form, you give us permission to collect and give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your health record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for you to take the time to discuss everything that you are taking, and for you to tell us about any errors in your medication history.

_____ I **GIVE** permission for Texas Institute of Spine and Neurosurgery to obtain my medication history from my pharmacy, my health insurance and my other healthcare providers.

_____ I **DO NOT** give permission for Texas Institute of Spine and Neurosurgery to obtain my medication history from my pharmacy, my health insurance and my other healthcare providers.

_____ _____

Print Patient Name | Patient's Date of Birth

_____ _____

Signature of Patient or Guardian | Relationship to Patient

Today's Date _____

TEXAS INSTITUTE OF SPINE AND NEUROSURGERY - PATIENT CONTROLLED SUBSTANCE AGREEMENT

Controlled substances are drugs we prescribe to reduce, but not cure your pain. As doctors, we want to provide the best care for your problem; however, because of the concerns we have when we prescribe controlled substances, we feel it is necessary to notify you of our expectations.

When taking controlled substances, it is important to understand that the medications can lose their effectiveness if not taken as prescribed. Side effects may occur, including constipation, drowsiness and sedation. If this occurs, please notify us. It is also important for you to know that, in rare cases, psychological addiction may occur. We do not want psychological addiction to be a problem for our patients; if this occurs, your controlled substance prescription may be stopped. As doctors, we are under strict regulation by the law, and have guidelines we must follow in prescribing all drugs.

Rules of this Controlled Substance contract are for your comfort and to yield maximum benefit:

1. You agree that if you lose your controlled substances or prescriptions for any reason, you will not get a replacement prescription for your controlled substance.
2. You agree that your prescriptions will be given to you on your appointment day only; do not call the clinic for controlled substance medications.
3. You agree to use only one pharmacy to fill your controlled substance prescriptions.
4. You agree to show up for all your appointments here, and provide notification at least 24 hours in advance if you are unable to come to your appointment.
5. You agree that you will take the controlled substance medications exactly as prescribed and will not take more pills in one day than allowed.
6. You agree that you will obtain controlled substances only from this office. If you have an injury or develop a new pain problem between your clinic visits here (i.e. go to the Emergency Room etc.), and receive controlled substance medications you agree to notify us immediately of the medicine, the dosage, and the number of pills given.
7. You agree that you will not sell or share your controlled substances.
8. You agree to notify this office immediately if you become pregnant.
9. You agree that a drug screen may be performed from time to time without notice.
10. You agree that if any of these rules are broken, controlled substance therapy may stop.
11. You agree that if your doctor gives you a referral to see a Pain Specialist, it is your responsibility to make an appointment with that doctor/group. The Pain Specialist will manage your pain medications form that point forward. After the referral has been completed, we will not refill your pain medications in this office.
12. You agree as a part of your treatment plan to see a specialist as referred. This may include Orthopedist, Physical Medicine specialist, and or Psychiatrist. Non-compliance with these referrals can result in your dismissal from this practice.

You have read and understand all the above expectations and agree to be held to the terms in full. If these terms are not upheld, the physician may decide with proper notice to stop treating you completely.

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____

Texas Institute of Spine and Neurosurgery
General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

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

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Financial agreement

Financial acknowledgement for Private Pay Patients or Patients without Insurance
Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

Assignment and Authorization of Benefits for Patients with Insurance
I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to the practice. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

Medicare Lifetime Authorization
I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to the Texas Institute of Spine & Neurosurgery.
Patient Initial: _____

I request this authorization also apply to all other insurance. Patient Initial: _____

Chief Complaint: (Reason for today's visit)

_____

General:

Age: _____
Hand: ☐ Right Handed ☐ Left Handed
Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian
Sex: ☐ Male ☐ Female (☐ Pregnant?)
Other:

_____

_____

What tests or studies have you had?

☐ None
☐ X-Rays ☐ MRI
☐ Physical Therapy ☐ EMG
☐ Injections
☐ Others _____

History of Present Illness:

Location of Pain / Problem:

☐ Head Pain	○ Right	○ Left	○ Both
☐ Neck Pain	○ Right	○ Left	○ Both
☐ Arm	○ Right	○ Left	○ Both
☐ Back Pain	○ Right	○ Left	○ Both
☐ Leg	○ Right	○ Left	○ Both
☐ Hip	○ Right	○ Left	○ Both
☐ Buttock	○ Right	○ Left	○ Both

Please indicate the severity of your pain / problem:

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

No pain Moderate Pain Worst Possible Pain

Please check if any of the following are applicable

☐ Sharp ☐ Throbbing ☐ Burning ☐ Radiating ☐ Dull ☐ Tingling ☐ Numbness ☐ Clicking ☐ Locking
☐ Constant ☐ Intermittent ☐ Less than 3 months ☐ Comes and Goes ☐ Chronic-Started 3 months ago
☐ Lasts for a short period of time ☐ Lasts for a long period of time ☐ Acute onset ☐ Chronic onset
☐ Worse at Night ☐ Better at Night ☐ Worse with Activity ☐ Better with Activity
☐ Better When Treated With Medications ☐ Same or Worse when Treated with Medications
☐ Worse in the Morning ☐ Better in the Morning
☐ Worse Sitting ☐ Worse Standing ☐ Worse at home ☐ Worse at Work ☐ Worse Walking
☐ Dizziness ☐ Headaches ☐ General Aching ☐ Diffuse Pain ☐ Swelling ☐ Weakness ☐ Wakefulness at Night
☐ Sleepy and Lethargic During the Day

Please explain in more detail your history of present illness

_____

Medical History:

☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No	**Bleeding Tendency**
☐ Yes	☐ No	**Hypertension**	☐ Yes	☐ No	**TB infection**
☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No	**Liver disease / hepatitis**
☐ Yes	☐ No	**Rheumatoid Disease**	☐ Yes	☐ No	**Gastritis**
☐ Yes	☐ No	**Heart Disease**	☐ Yes	☐ No	**HIV / AIDS**
☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No	**Hereditary defects**
☐ Yes	☐ No	**Arthritis / gout**	☐ Yes	☐ No	**Asthma**
☐ Yes	☐ No	**Seizures**	Other Condition: _____		

Surgical History:

Please list any surgeries, hospitalizations, trauma you have had. What year? Which hospital?

_____

_____

_____

_____

Medications:

List all medications (prescription, over the counter, herbal, etc.)

Medication	Dose	Frequency	Reason

Allergies / Reactions:

☐ Anesthetic _____ ☐ Latex/rubber/tape _____

☐ Penicillin _____ ☐ Food Allergies _____

☐ Sulfa _____ ☐ Other Drug Allergies _____

☐ Codeine _____ _____

Social History:

Who is going to be looking after you? _____

How many children do you have? _____

Ability to Work: ☐ Not limited ☐ Moderately limited ☐ Severely limited

Retired? ☐ No ☐ Yes (if yes, when did you retire? _____)

Disability Status ☐ Not disabled ☐ Disabled ☐ Applying for disability

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ 1-5 weekly ☐ > 2 daily ☐ Quit (when? _____)

Use of Tobacco: ☐ Never ☐ Occasional (packs/day? _____) ☐ Quit (when? _____)

Use of Drugs: ☐ Never ☐ Occasional ☐ Frequent Type of drug _____

Family History:

☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No	**Bleeding Tendency**
☐ Yes	☐ No	**Hypertension**	☐ Yes	☐ No	**TB infection**
☐ Yes	☐ No	**Cancer**	☐ Yes	☐ No	**Liver disease / hepatitis**
☐ Yes	☐ No	**Rheumatoid Disease**	☐ Yes	☐ No	**Gastritis**
☐ Yes	☐ No	**Heart Disease**	☐ Yes	☐ No	**HIV / AIDS**
☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No	**Hereditary defects**
☐ Yes	☐ No	**Arthritis / gout**	☐ Yes	☐ No	**Asthma**
☐ Yes	☐ No	**Seizures**	Other Condition: _____		

Review of Systems

Please check the box(es) if you currently have any of these symptoms

General ☐ No Symptoms
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Night Sweat
- ☐ Yes ☐ No Weight Loss

Eyes ☐ No Symptoms
- ☐ Yes ☐ No Poor vision
- ☐ Yes ☐ No Blurry vision
- ☐ Yes ☐ No Double vision

Ears, Nose, Mouth and Throat ☐ No Symptoms
- ☐ Yes ☐ No Loss of hearing
- ☐ Yes ☐ No Ringing in ears
- ☐ Yes ☐ No Decreased ability to smell
- ☐ Yes ☐ No Difficulty swallowing
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Slurred speech

Cardiovascular ☐ No Symptoms
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Irregular Heart Beat
- ☐ Yes ☐ No Palpitations

Respiratory ☐ No Symptoms
- ☐ Yes ☐ No Chronic Cough
- ☐ Yes ☐ No Coughing Blood
- ☐ Yes ☐ No Emphysema
- ☐ Yes ☐ No Bronchitis
- ☐ Yes ☐ No Asthma

Genito-Urinary ☐ No Symptoms
- ☐ Yes ☐ No Burning on Urination
- ☐ Yes ☐ No Dark or Discolored Urine
- ☐ Yes ☐ No Difficulty Starting or Ending Stream
- ☐ Yes ☐ No Poor Control of Bladder
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Sexual Dysfunction
- ☐ Yes ☐ No Inability to obtain / maintain erection

Gastro-intestinal ☐ No Symptoms
- ☐ Yes ☐ No Weight loss
- ☐ Yes ☐ No Blood in Stool
- ☐ Yes ☐ No Dark Colored Stool
- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Hernia
- ☐ Yes ☐ No Difficulty Swallowing
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Abdominal Swelling
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Abdominal Mass

*Musculoskeletal ☐ No Symptoms
- ☐ Yes ☐ No Swelling of Limbs
- ☐ Yes ☐ No Masses in Limbs
- ☐ Yes ☐ No Loss of Control of Arms or Legs
- ☐ Yes ☐ No Loss of Muscle Bulk
- ☐ Yes ☐ No Aching Joints
- ☐ Yes ☐ No Neck Pain
- ☐ Yes ☐ No Neck Spasm
- ☐ Yes ☐ No Cramps
- ☐ Yes ☐ No Weakness

*Skin and Breast ☐ No Symptoms
- ☐ Yes ☐ No Dry Skin
- ☐ Yes ☐ No Discharge From Nipples

*Neuro ☐ No Symptoms
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Seizure
- ☐ Yes ☐ No Abnormal Arm or Leg Sensations
- ☐ Yes ☐ No Arm or Leg Weakness
- ☐ Yes ☐ No Poor Coordination
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Tingling
- ☐ Yes ☐ No Loss of Sensation

*Psychiatric / Emotional ☐ No Symptoms
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Disorientation
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Hallucinations

*Endocrine ☐ No Symptoms
- ☐ Yes ☐ No Discharge From Nipples
- ☐ Yes ☐ No Poor Appetite
- ☐ Yes ☐ No Cold Intolerance
- ☐ Yes ☐ No Dry Skin
- ☐ Yes ☐ No Excessive Thirst
- ☐ Yes ☐ No Loss of Body Hair
- ☐ Yes ☐ No Weight Gain of Greater than 20 pounds
- ☐ Yes ☐ No Weight Loss of Greater than 20 pounds
- ☐ Yes ☐ No Easy Fatigue

*Hematology / Lymphatic ☐ No Symptoms
- ☐ Yes ☐ No Bleeding, Clotting or Any Other Blood Disorders

*Allergic / Immunologic ☐ No Symptoms
- ☐ Yes ☐ No Allergic to inhaled pollen, etc.
- ☐ Yes ☐ No Decreased immune system response
- ☐ Yes ☐ No AIDS

Where is your pain now?

Mark the areas on your body where you feel the described sensations. Please use the appropriate symbol(s) to show the type of pain and include all affected areas.

Numbness	Pins and Needles	Burning	Stabbing	Ache
IIIIII	OOOOO	xxxxx	//////	^^^^