New Patient Registration Form

DATE_____ **PLEASE PRINT**

Full Name _____

Address_____Apt#_____

City_____ State_____ Zip _____

Phone Number _____ Cell _____

Social Security Number_____ DOB_____ Age_____

Sex □ Male □ Female □ Married □ Single □ Divorced □Separated □ Widowed

Is visit related to an accident _____Date of Accident _____

Type of Accident □ Auto □ Home □ Work □ Other

Attorney Name _____ Phone Number _____

Employer Name_____

Employer Address_____

Employer Phone Number_____

Emergency Contact Name _____

Phone Number_____ Relationship_____

Primary Insurance Company _____ ID# _____

Secondary Insurance Company _____ ID# _____

Policy Holders Name _____

Assignment and Release

I certify that I, and/or dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/ Guarantor Signature:

_____Date:_____

PI QUESTIONAIRE

DATE: _____

PATIENT NAME: _____ DATE OF INJURY: _____

AUTO INSURANCE: _____ POLICY #: _____CLAIM #: _____

YOUR VEHICLE TYPE:

___ Car ___ Station Wagon ___Van ___ Pick/Up
Year ____ Make ____ ___ Large Truck ___ Bus ___Other _____

THEIR VEHICLE TYPE:

___ Car ___ Station Wagon ___ Van ___ Pick/Up
Year ____ Make ____ ___ Large Truck ___ Bus ___ Other _____

YOUR POSITION IN THE VEHICLE:

____ Driver ___ Front Passenger
____ Left Rear Passenger ___ Right Rear Passenger

YOUR VEHICLE AT THE TIME OF THE ACCIDENT WAS…

___ Stopped at a Light ___ Making a Right Turn ___ Proceeding Along
___ Stopped in Traffic ___ Making a Left Turn ___ Slowing Down
___ Stopped at an Intersection ___ Parking ___ Accelerating ___ Other _____

SPEED OF YOUR VEHICLE: _____ mph **SPEED OF OTHER VEHICLE:** _____ mph

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DAMAGE TO YOUR VEHICLE: ___ Mild ___ Moderate ___ Totaled
DAMAGE TO THEIR VEHICLE: ___ Mild ___ Moderate ___ Totaled
VISIBILITY AT TIME OF ACCIDENT: ___ Poor ___ Fair ___ Good

ROAD CONDITIONS AT TIME OF ACCIDENT: ___Icy ___ Wet ___ Sandy
___ Dark ___ Clear and Dry
WHO HIT WHAT: ___ Other vehicle hit you ___ You hit other vehicle
POINT OF IMPACT: ___ Head On ___ Left Front ___ Left Rear
___ Rear End ___ Right Front ___ Right Rear

BODY POSITION AT TIME OF ACCIDENT:

Did you see the other vehicle coming? Yes/No
Were you braced for the impact? Yes/No
Did you have your seatbelt on? Yes/No
Did you have your shoulder harness on? Yes/No
Did any Air Bags deploy? Yes/No
Does your car have Headrests Yes/No
Postion of Headrest: ___ Even with top of Head ___ Even with Bottom of Head ___ Middle of Neck

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DURING THE ACCIDENT:

Did your body strike the vehicle? Yes/No Where? _____
Did you Lose Consciousness? Yes/No
Did the police show up? Yes/No
Was a report made? Yes/No
Where did you go after the accident? ___ Home ___ Work ___Hospital ER ___ Private Doctor
How did you get there? ___ Self ___Someone Else ___ Ambulance ___ Police

INSURANCE INFORMATION (continued)

Secondary Insurance: _____
Address: _____
_____
Phone number: (_____) _____
Subscriber's name: _____
Subscriber's SS#: _____
Subscriber's date of birth: _____

Relationship: ___ Patient ___ Spouse
___ Child ___ Dependent

Group Name and #: _____

___ Group Policy ___ Individual Policy ___ HMO
___ PPO/PPC ___ POS

Auto Insurance Name (Only if your injury is auto related):
_____
Address: _____
Phone number: _____
Claim #: _____
Subscriber's relation to patient: _____

WORK RELATED INJURY INFORMATION

Is your injury work related? ___ Yes ___ No

If you answered YES, complete the following:
Date of injury: _____
W/C claim/file #: _____
Employer at time of injury: _____
Contact person: _____
Employer's address: _____
City: _____ State: _____ Zip: _____

Case settled?___ Yes___ No-If Yes, Date: _____
Medical care open? ___ Yes ___ No

Worker's Compensation Carrier: _____
Address:_____
City: _____ State: _____ Zip: _____
Phone:(____)_____Fax:(___)_____

Case Manager's Name: _____
Phone:(___)_____Fax:(___)_____

Adjustor's name: _____
Phone:(___)_____Fax:(___)_____

MEDICAL / SOCIAL HISTORY

1. How did you hear about Cleveland Spine and Pain Management Center? (Please be specific and write the name of the doctor, name of friend, former Pain Center patient, magazine, newspaper, radio, TV station/program or other)

2. If you were referred by a physician you MUST complete the following:

Is this your primary physician? Yes or No

Physician name _____

Specialty: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (____)_____ Fax: (___)_____

What is the diagnosis that you have been given:

3. When did your most recent symptoms begin?

What was the date your pain problem began?

4. What has occurred in the past 6 months to cause you to seek treatment for your condition:

5. Was the problem due to:

- ☐ Disease process
- ☐ Work Injury
- ☐ Auto accident
- ☐ Other accident
- ☐ No apparent reason

Date of injury/accident: _____

6. What is your major problem: (Please check all that apply):

PAIN

☐ Neck	☐ Upper back	☐ Lower back
☐ Shoulder	☐ Hip	☐ Headache
☐ Knee	☐ Extremity	☐ Other_____

7. What activities are you no longer able to do, require assistance in doing, or are becoming more difficult to do because of pain?

- ☐ Self care (grooming, bathing, dressing, feeding,….
- ☐ Home care (grocery, shopping, banking, laundry,..
- ☐ Mobility (sitting, standing, walking, stairs,…)
- ☐ Transfer (bed, toilet, shower, wheelchair, car,…)
- ☐ Household (cleaning, cooking, yard, childcare,…)
- ☐ Vocational activities (work, school, volunteer,…)
- ☐ Avocational activities (leisure, sport, travel,…)
- ☐ Sleep
- ☐ Driving
- ☐ Other _____

8. Do you require the use of an assistive device?

☐ Cane ☐ Walker ☐ Wheelchair
☐ Brace: Type _____

9. Do you have any other medical problems? (check all that apply)

☐ Heart	☐ Lung/breathing
☐ Diabetes	☐ Hernia
☐ High blood pressure	☐ Pacemaker
☐ Ankles swell	☐ Chest pain
☐ Shortness of breath	☐ Dizzy spells
☐ Memory problems	☐ Fall easily

- ☐ Cancer: Type _____
- ☐ Currently under the care of a psychiatrist
  Name: _____
- ☐ Currently under the care of a psychologist
  Name: _____
- ☐ Other _____

10. What is your weight: _____ Height: _____

11. Please list all allergies you have: _____
_____

12. Do you smoke? ☐No ☐Yes ____ # packs/day

13. Do you use alcohol?
☐ Regularly ☐ Occasionally ☐ Never

14. Are you on a special diet? ☐ Yes ☐ No
If Yes, what kind: _____

15. Have you had previous treatment(s) for your current condition (check all that apply):

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Chiropractic
- ☐ TENS
- ☐ Biofeedback
- ☐ Psychological Counseling
- ☐ Psychiatric Treatment
- ☐ Bed Rest
- ☐ Acupuncture
- ☐ Massage
- ☐ Trigger Point Injection
- ☐ Epidural Injections

16. List all surgeries you have had:

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

Date: _____ Type: _____

17. Are you currently involved in any legal activity related to the medical condition for which you are seeking treatment at our Center?

☐ **Yes** ☐ **No**

If Yes, indicate type:

☐ **Workers compensation** ☐ **Liability**

☐ **Malpractice** ☐ **Personal injury**

☐ **Other _____**

18. What are your expectations of our program?

_____

_____

19. Please list any questions you would like answered:

_____

_____

_____

PRICACY STATEMENT:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your protected health information may be used and disclosed by us. It also tells you how you can get access to this information. As a patient, you have the following rights: 1) the right to inspect and copy your information; 2) the right to request corrections to your information; 3) the right to request that your information be restricted; 4) the right to request confidential communications; 5) the right to report of disclosures of your information; and 6) the right to a paper copy of this notice.

We want to assure you that your health information is secure with us. Please sign below to permit us to use, disclose, and share the health information in this application ONLY with personnel in or outside our facility who may be involved in reviewing your application, making your appointments, and authorizing services. Thank you.

Your Signature

_____

Today's Date

_____

WHO SHOULD RECEIVE MEDICAL REPORTS THAT WILL BE GENERATED BY OUR CENTER? (A copy of all RCPC reports will be sent to your referring physician and everyone else you have listed here)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___)_____ Fax:(___)_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___)_____ Fax:(___)_____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___)_____ Fax:(___)_____

NO REPORTS WILL BE SENT UNLESS YOU COMPLETE THIS PART...

I, the undersigned, authorize the above parties to receive copies of medical reports from:

Print name: _____

Your Signature: _____

Today's Date: _____

CURRENT MEDICATIONS

Please list all medications you are taking at this time (prescribed and over the counter). Also, please list herbal products, homeopathic medicines, supplements, vitamins, or artificial sweeteners you are taking.

MEDICATION NAME	DOSAGE (mg)	# PILLS PER DAY	REASON TAKING?

Narcotic Agreement Overview Patient Copy

1. **You should only take your medication as prescribed.**
2. **We must have in your chart a valid phone number with an answering machine or a cell phone with a voice mail to prescribe medications for you. If we should call and find that you do not have a valid contact number, we will not be able to prescribe narcotics for you any longer.**
3. **If you are called in for a pill count, you must come the same day that you are called and have the correct pill count.**
4. **You must always bring your medications with you to the office.**
5. **You must not take other opiates from other providers or individuals besides the ones we prescribe you.**
6. **You must not take xaanax, valium, or soma from individuals. You can only take them if you have a current prescription for them from the primary care physician or psychiatric doctor.**
7. **If you were prescribed an opiate in the past and you do not have a current prescription for it, it should not show on your urine drug screen now.**
8. **If you receive opiate medications for example from the emergency room we must be notified during office hours 9:00am to 5:00 pm Mon-Fri.**
9. **We cannot prescribe pain medications to those who smoke marijuana or use cocaine, drink heavily, methamphetamines, PCP, ect whether they state they use these substances or not.**
10. **If you plan to go out of town, you must notify this office so that we can document your absence and not try to contact you during that time. If we call and you do not respond and then use the excuse you were out of town this will not be considered a valid reason for missing a pill count.**
11. **Patients should not dispose of their medications themselves for example, flushing them down the toilet. Medications will not be replaced by us unless all pills are returned to dispose of them.**
12. **Do not expect narcotic prescriptions for more than a few months due to the risk of addiction, worsening your pain condition or compromising non-addiction pain interventions.**
13. **You may be asked to participate in a self-assessment pain outcome profile to direct and monitor your care progress.**
14. **You agree to perform random drug test at your providers' discretion.**

Patient Name (print): _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Home phone #: _____ Cell phone#: _____

Dear Patient,

We have a commitment to provide all of our patients with high quality outpatient health care. It is a commitment which we take seriously. In return, we expect those whom we serve to be fair and to see that we are paid for services in a timely manner. We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance company, and will be responsible for any charges incurred if the information provided is not correct or updated.

Please understand that your insurance is a contract between you and the insurance carrier, not between the insurance carrier and our office. You are responsible for all fees incurred, irrespective of applicable insurance coverage.

Co-pays:
I understand I am responsible to pay all Co-payment at the time of service.

Deductible
If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely matter.

We contract with some insurance companies, so if we are not contracted with yours, services may not be covered. It is your responsibility to contact your insurance company to determine if services will be covered and how they will be covered. Every plan/policy is unique to each individual and our office will not call your insurance company to find out this information, it is your responsibility.

I acknowledge that I assume full financial responsibility for services rendered to me, if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

Patient_____

_____

Patient Signature/Guardian **Date**

Cleveland Spine and Pain Management Center

4919 WARRENSVILLE CENTER ROAD
WARRENSVILLE, OH 44128
216-581-7246 PHONE
216-475-9969 FAX

RECORDS

I hereby authorize _____ to release to Cleveland Spine and Pain Management Center any information regarding my physical or mental condition; and I release them from any and all consequences thereof.

The following information is requested:

☐ CASE RECORDS _____

☐ MEDICAL RECORDS_____

☐ X-RAY FILMS_____

☐ DIAGNOSTIC TESTS_____

☐ LAB RESULTS_____

☐ OTHER_____

Dated at _____AM/PM this day of _____ 20___.

_____ _____
Witness Signature of Patient

Patient_____

Address_____
_____

SS# _____

DOB:_____