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

---

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

Position of Headrest: ___ Even with top of Head ___ Even with Bottom of Head ___ Middle of Neck

---

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:

____

____

____

PRIVACY 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, etc. 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:___________________________________