Office Use Only

Completed by: _____

SWEETWATER SPINE CLINIC

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: ☐M / ☐F

Address: _____
Street or PO Box City State Zip Code

Home Phone: _____ MobilePhone: _____

Email Address: _____

Social Security #: _____ Marital Status: ☐Married ☐Divorced ☐Widowed

Employer: _____ Occupation: _____ Work Phone #: _____

Spouse Name: _____ Employer: _____ Work Phone #: _____

IF PATIENT IS A MINOR OR RESIDES WITH PARENTS, PLEASE COMPLETE THE FOLLOWING

Father's Name: _____ Employer: _____ Wk Phone #: _____

Mother's Name: _____ Employer: _____ Wk Phone #: _____

REASON FOR TODAY'S VISIT

Is this an accident that occurred during school sports? ☐Yes / ☐No If yes: Date of injury: _____

If accident, is there an attorney involved? ☐Yes / ☐No If yes: Date of injury: _____

In case of emergency, please notify: _____ Relation: _____ Phone #: _____

What are you being seen for today? ☐Right / ☐Left _____ Date of injury / Onset of pain: _____

Height: _____ Weight: _____

Who referred you to this practice? _____

REASON FOR TODAY'S VISIT

INSURANCE INFORMATION - PLEASE PROVIDE CARD SO WE MAY SCAN A COPY

Insurance is filed as a courtesy. Co-payments are collected at the time of services.

Primary Insurance: _____ Secondary Insurance: _____

Please specify if you are the Primary Card Holder, Dependent covered under this insurance plan.

Primary Name (if other than patient): _____ Primary Date of Birth: _____

Primary Address: _____ Relation to Patient: _____

Primary Social Security #: _____

Primary Home Phone #: _____ Mobile Phone #: _____ Work Phone #: _____

MEDICAL HISTORY
Review of Symptoms

Please check any box that applies to your current medical condition.

Constitutional

☐ Fatigue
☐ Recent Illness
☐ Fever
☐ Weight Loss

Ear / Nose / Throat / Neck

☐ Headache
☐ Neck Swelling
☐ Oral Pain

Cardiovascular

☐ Arrhythmia
☐ Palpitations
☐ Chest Pain / Pressure
☐ Shortness of Breath
☐ Edema
☐ Exercise Intolerance
☐ Fatigue
☐ Near Syncope / Dizziness

Respiratory

☐ Cough
☐ Shortness of Breath
☐ Wheezing

Gastrointestinal

☐ Gastroesophageal Reflux
☐ Nausea
☐ Vomiting
☐ Abdominal Pain
☐ Constipation
☐ Diarrhea

Musculoskeletal

☐ Stiffness
☐ Swelling
☐ Generalized Joint Pain
☐ Muscle Weakness
☐ Back Pain

Neurological

☐ Dizziness
☐ Paresis
☐ Seizure
☐ Speech Difficulties
☐ Vertigo
☐ Weakness

Psychiatric

☐ Depression
☐ Disturbances of Consciousness
☐ Disturbances of Memory

Endocrine

☐ Frequent Urination
☐ Hot/Cold Intolerance
☐ Flushing

Hematological / Lymphatic

☐ Abnormal Bleeding / Bruising

MEDICAL HISTORY

Please mark the box beside any significant medical problems you have:

☐ Asthma	☐ Diabetes	☐ Heart Problems	☐ Emphysema
☐ Thyroid Disease	☐ Liver Disease	☐ Degenerative Arthritis	☐ Rheumatoid Arthritis
☐ Cancer	☐ Anemia	☐ Yellow Jaundice / Hepatitis	☐ High Cholesterol or Triglycerides
☐ Gout	☐ Alcoholism	☐ Reaction to Anesthetics	☐ Stomach Ulcers, Reflux, Gastritis
☐ High Blood Pressure	☐ Fibromyalgia	☐ Fibrositis	☐ History of Blood Clots / Phlebitis
☐ Other _____	☐ Other _____	☐ Other _____	☐ Other _____

Please explain any of the above marked boxes. Include month and year if possible. List the treating physician for each.

_____

_____

_____

_____

Please list all major SURGERIES requiring anathesia.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list the MEDICATIONS you are taking AND the dosage of each. (Prescription and over-the-counter).

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you have any ALLERGIES TO MEDICATIONS? ☐Yes / ☐No If yes, Please list medication and reaction below.

_____

_____

_____

Do you smoke? ☐Yes / ☐No Packs per day? _____

Do you drink alcohol? ☐Yes / ☐No How often? _____

Do you use illegal (street) drugs? ☐Yes / ☐No What? _____

PLEASE LIST YOUR FAMILY PHYSICIAN OR INTERNIST: _____

For Physician use only
Date Reviewed:

1. _____
2. _____

SWEETWATER SPINE CLINIC

OFFICE NOTICES

Referrals: If your insurance requires a referral from your primary care physician, it is your responsibility to obtain one before you can be seen. If you do not get one, your appointment will be rescheduled. There are no exceptions.

Financial Policy: All co-pays, deductible amounts, and non-covered services for office visits are due at the time of service. If you have any questions please call our office at 325-235-9355.

Insurance: Please bring your current insurance card and picture ID. We will make a copy of both your insurance card and picture ID. We will file your insurance for you. All charges will be the patient's responsibility. Any unpaid insurance claims after 60 days will be billed to the patient. Regardless of insurance, payment remains your personal responsibility.

Minors: All minors under the age of 18 must be accompanied by a parent or guardian who is legally allowed to give medical consent.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Release of Information

I hereby authorize my physician at Sweetwater Spine Clinic to release any information obtained in the course of my examination that my insurance company may request. I authorize any holder of medical information about me to release to the insurance, Medicare, or any other health plan or its agents, any information needed to determine these benefits or the benefits payable to related services. Please consider this signature as authorization to release my confidential medical records with written release on the basis of a telephone request. I understand that it is possible for someone to misrepresent themselves by telephone and that my right to privacy may be compromised.

I give permission for Sweetwater Spine Clinic to discuss any and all medical treatment to the following person. I understand I may revoke this authorization at any time.

Name: _____ Relationship: _____

Assignment of Insurance Benefits

I hereby authorize assignment of my medical and/or surgical benefits to include major medical benefits that I am entitled, private insurance, Medicare, and any other health plans to my physician at Sweetwater Spine Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Acknowledgment

I acknowledge that I have read and agree with all the above information:

_____ _____

Signature of Patient (or Parent / Legal Guardian if under 18 years of age) Date