PATIENT REGISTRATION *(Please Print)*

PATIENT INFORMATION

PATIENT NAME ______________________________

BIRTHDATE ______________ (MM / DD / YY) AGE ________ SOC. SEC. # ______________________ ☐ MALE ☐ FEMALE

RESPONSIBLE PARTY (if other than patient) ______________ Name ______________ Date of Birth ______________ Relationship

MAILING ADDRESS ______________________ Street APT # ________

______________ City ________ State ________ Zip - ________ +4 ______________ Social Security Number

HOME PHONE ( ) ______ - ________ WORK PHONE ( ) ______ - ________ EMPLOYER ______________

REFERRED BY ______________________ PRIMARY CARE DR ______________________

MARITAL STATUS: ☐ SINGLE 1 ☐ MARRIED 2 ☐ WIDOWED 4 ☐ DIVORCED 5 ☐ SEPARATED 6 ☐ OTHER 3

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________ PLAN COPAY $ ________

______________ Subscriber Name ☐ MALE ☐ FEMALE BIRTHDATE ______________

______________ Social Security Number ______________ Relationship to Patient

______________ Subscribers Employer ______________ Insurance Company Address

SUBSCRIBER ID # ______________ GROUP ID # ______________

SECONDARY INSURANCE ______________________ PLAN COPAY $ ________

______________ Subscriber Name ☐ MALE ☐ FEMALE BIRTHDATE ______________

______________ Social Security Number ______________ Relationship to Patient

______________ Subscribers Employer ______________ Insurance Company Address

SUBSCRIBER ID # ______________ GROUP ID # ______________

(WORKER'S COMPENSATION ONLY)

DATE OF INJURY: ______________ CLAIM # ______________

EMPLOYER AT TIME OF INJ ______________ ADJUSTOR NAME ______________

INSURANCE ______________ CLAIM MAILING ADDRESS ______________

INS. PHONE ________ INS FAX ________ CITY/STATE/ZIP ______________

ATTORNEY'S NAME ______________ ADJ.. PHONE ________ ADJ. FAX ________

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY NOTIFY ______________ Name ( ) ________ Home Phone

______________ Relationship to Patient ( ) ________ Work Phone

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the healthcare provider as well as release of any information by provider or insurance company required for this account. Release of information to include: (1) alcohol and / or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) Treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release PrimeCare from all legal responsibility or liability that may arise from disclosure of my record as provided by this paragraph.

Payment: I am financially responsible for any balance due. I agree to make payment arrangements; pay $5 or 1% interest per month (whichever is greater) on unpaid balances over 30 days and all the reasonable expenses such as attorney fees and court costs should account be referred for collections.

SIGNED ______________ **DATE** ________

I'VE VERIFIED THAT MY PATIENT DEMOGRAPHICS ARE THE SAME.

SIGNED ______________ **DATE** ________

SPINE AND SPORTS MEDICAL GROUP/SURGERY CENTER
429 LLEWELLYN AVE, CAMPBELL, CA 95008
PHONE (408) 364-1616 • FAX (408) 378-6775

HIPPA Privacy Rule – Written Acknowledgement of Privacy Practices Receipt

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____________________________, understand that as part of my health care, the Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

______________________________________ ___________________________

Patient's Signature Date

FOR CENTER USE ONLY
[ ] Consent received by ______________________________ on _________________________.
[ ] Consent refused by patient, and treatment refused as permitted.

Spine & Sports Medical Group
Advanced Pain Rehabilitation Medical Group
Sherman Tran MD & Felicia Radu MD

Agreement for Opioid Maintenance Therapy for Noncancer/Cancer Pain

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. You should use one physician to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.

Pharmacy :_________________________________ Phone number:___________________

3. You should inform your physician of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
4. You will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is not to be used without the explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on weekends; and also Thursday and Friday.
6. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original bottles.
7. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your physician immediately. If your medications are lost, misplaced or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications.
8. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is against the law.
9. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
10. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.
11. You should not use any illicit substances, such as cocaine, marijuana, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable, or complete termination of the doctor /patient relationship.
12. The use of alcohol and opioid medications is contraindicated.
13. You agree and understand that your physician reserves the right to perform random or unannounced urine drug testing. If requested to provide urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your opioid medications when applicable, or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for your benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
14. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).
15. Physical dependence and/or tolerance can occur with the use of opioid medications.

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may haave4 to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

16. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
17. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.
18. You agree to a family conference or a conference with a close friend or significant other, if the physician feels it is necessary.

I have read and agreed to the above terms. I understand that this agreement is necessary so that my physician can provide quality pain management using opioid therapy to decrease my pain and increase my function. Furthermore, my physician might not continue to treat me should I violate this agreement.

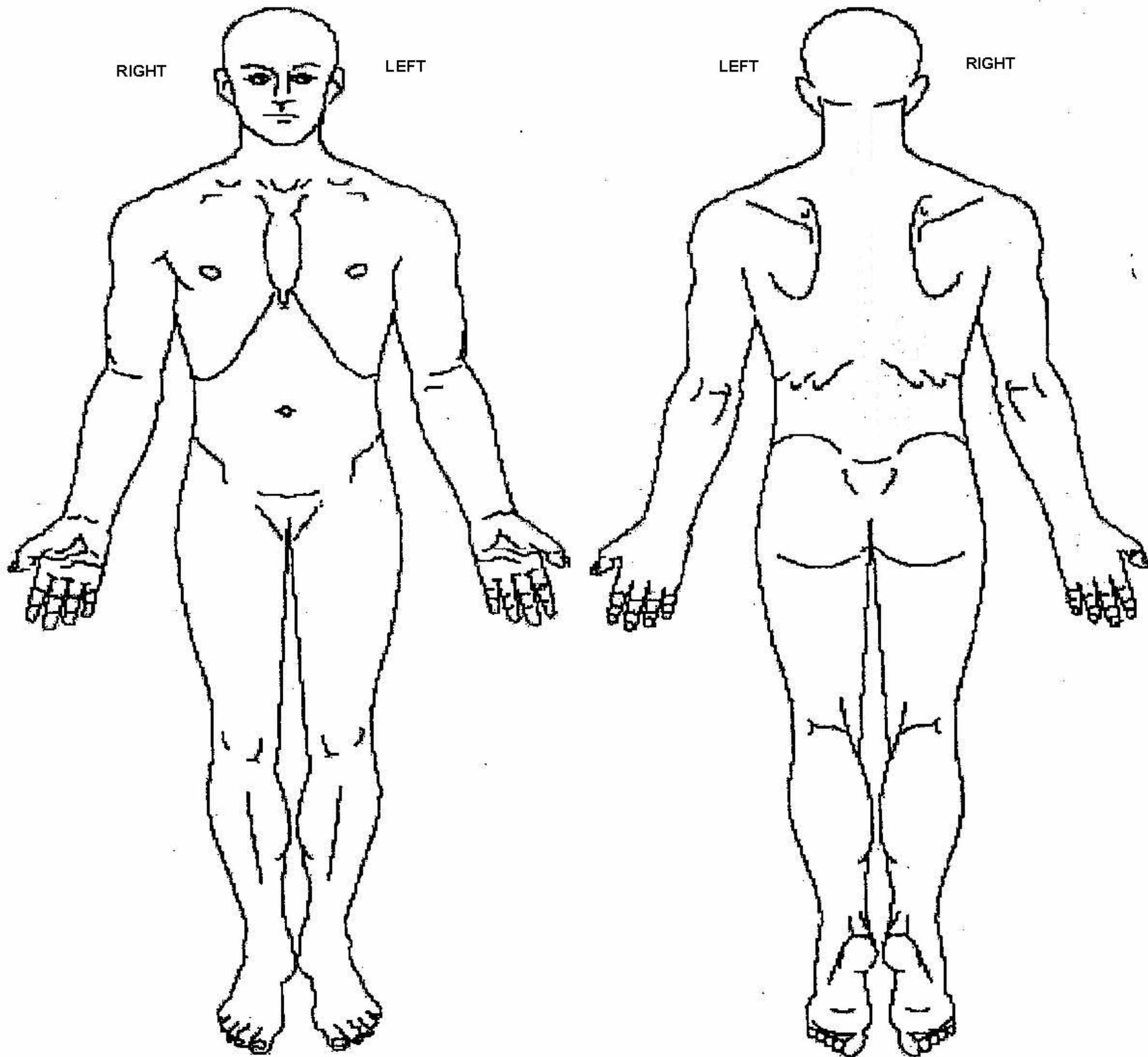
Patients Signature ____ Date ______________ Witnessed by: _________________________

PAIN DIAGRAM

Name: ____ **Date**: _________________

Draw the location of your pain on the body outlines below. Use the following keys

Ache	Burning	Numbness	Pins & needles	Stabbing	Other
/////	**BBBBB**	**XXXXX**	+++++	**ZZZZZ**	**OOOOO**



Circle Your Level of Pain (0 – 10)										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain										Intolerable

HEALTH QUESTIONNAIRE

NAME: ____ **Date of Birth :** __________ **Age:** ______

Height: _______ **Weight:** _______ **Right Handed** ____ **Left Handed** ___ **Ambidextrous** ___

Date of Injury: ____________**Describe what happened?**____

____

____

____

____

What is your employment? ________________________**Describe your duties:**_______________________

____

____

Company name: _____________________________________ Years of employment? ________________
Are you still working? Yes ___ No ____ If no, date last worked? ________________
Are you working full time? _______ If not, how many hours/day? ______________
Regular duty? Yes____ No ____ If no, describe your Modified duty and restrictions? ____________________
____

What activities increase your pain?
Standing____ Walking _____ Sitting _____ Lifting _____
Bending _____ Lying ______ Reaching ___
Others _______________________________

What activities reduce your pain?
Lying _____ Sitting _____ Standing ____Walking ____
Ice ___ Heat ___ Massage ____
Others _______________________________

Have you had? Xrays _____ MRI ______ EMG_______
Others _____________________

What treatments have you had for this injury?
PT: ____ # times ____ Is it effective? ___ **Chiropractor:** ___ # times ____Is it effective? ___
Acupunctures: ___ # times ____ Is it effective? ___

Injections _____ What kind? ____

Surgery _____ What kind?____

Others ____

 Continued on next page

HEALTH QUESTIONNAIRE (Continued)

NAME: ____

1. PAST MEDICAL HISTORY: Have you ever had (circle No or Yes)

Diabetes .... No Yes
Stroke... No Yes
Cancer.. No Yes
High Blood Pressure .... No Yes
Heart Problems .... No Yes
Myocardial infarction........................... No Yes
Rheumatic Fever .... No Yes
Tuberculosis... No Yes
Hepatitis (A B C, please specify) .... No Yes
Anemia.. No Yes

Have you had, or do you have presently, any other serious illness or chronic medical condition that we should be aware of ? No Yes

If yes, describe ____

Have you ever been hospitalized or been under medical care for any period? No Yes

If yes, for what reason? ____

Injuries:

Have you had any broken bones? .... No Yes If yes, briefly describe ______________________________

Have you had any head concussions or injuries?................. No Yes If yes, briefly describe ______________________________

Have you had any auto accidents?....................................... No Yes If yes, briefly describe ______________________________

2. PAST PSYCHOLOGICAL HISTORY:

Have you ever had psychiatric care? .... No Yes If yes, briefly describe ______________________________

Have you ever been given a psychiatric diagnosis? .... No Yes If yes, briefly describe ______________________________

Have you ever been advised to undergo psychiatric care but not followed through? No Yes If yes, briefly describe

____

3. PAST SURGICAL HISTORY: Have you had any surgery? No Yes **If yes, list all procedures and dates of surgeries**

1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________
4. ______________________________ Date: _________
5. ______________________________ Date: _________
6. ______________________________ Date: _________

4. SOCIAL HISTORY:

Circle one: Single Married Divorced Widowed

Are you living with your husband/wife? .... No Yes

Do you have dependents at home? .... No Yes

Do you drink alcoholic beverages? No Yes Amount and frequency: per day________ per week_______ per month ________

Do you smoke cigarettes? No Yes How many packs a day? ______ Ever smoked?______ How long?_______ Last smoked________

Is there any history of illegal drug abuse? No Yes Is there any history of prescription drug abuse? No Yes

Are you currently working? Yes Full Time Part Time

No On disability Unemployed Retired Medically retired

5. FAMILY HISTORY:

❒ If you are adopted and have no knowledge of your family history, please check this box and proceed to the Section #6.

BIOLOGICAL FAMILY HISTORY	IF LIVING Age:	Health:	IF DECEASED Age (at death) and cause	
Father				
Mother				
Brother/Sister				
Son/Daughter				

HAS ANY BLOOD RELATIVE EVER HAD:		
Arthritis	No ❒	Yes ❒
Bleeding Tendency	No ❒	Yes ❒
Cancer	No ❒	Yes ❒
Diabetes	No ❒	Yes ❒
Epilepsy/Convulsions	No ❒	Yes ❒
Gout	No ❒	Yes ❒
Heart Trouble	No ❒	Yes ❒
High blood pressure	No ❒	Yes ❒
Osteoporosis	No ❒	Yes ❒
Psych problems	No ❒	Yes ❒
Stroke	No ❒	Yes ❒
Tuberculosis	No ❒	Yes ❒

Continued on next page

6. GENERAL MEDICATIONS:

Drugs recently taken, within the past six months, have you taken (circle No or Yes or Don't Know):

Cortisone	No	Yes	Don't know
Anticoagulants	No	Yes	Don't know
Tranquilizers	No	Yes	Don't know
Hypotensives (high blood pressure medications)	No	Yes	Don't know

List ALL GENERAL (i.e. NOT for your current spine condition) MEDICATIONS you are ***currently*** taking

1. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
2. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
3. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
4. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
5. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
6. ________________________ Dose (mg): __________ Frequency (how many times a day): __________

7. MEDICATIONS FOR YOUR SPINAL CONDITION

List ALL PAIN/ANTI-INFLAMMATORIES, etc. you are ***currently*** taking for your spinal condition

1. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
2. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
3. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
4. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
5. ________________________ Dose (mg): __________ Frequency (how many times a day): __________
6. ________________________ Dose (mg): __________ Frequency (how many times a day): __________

8. ALLERGIES AND SENSITIVITIES:

Is there a history of any reaction or sickness following injection or oral administration of:

				Describe Reaction
Penicillin or other antibiotics (please specify)	No	Yes	Don't know	____________
Morphine, codeine, Demerol or other narcotics (please specify)	No	Yes	Don't know	____________
Novocain or other anesthetics (please specify)	No	Yes	Don't know	____________
Aspirin, Empirin or other pain remedies (please specify)	No	Yes	Don't know	____________
Sulfa drugs	No	Yes	Don't know	____________
Tetanus antitoxin or other serums (please specify)	No	Yes	Don't know	____________
Any other drug or medication (please specify)	No	Yes	Don't know	____________
Any x-ray contrast material (dye, etc.)	No	Yes	Don't know	____________
Seasonal/environmental allergies (e.g. hay fever, perfumes, etc.)	No	Yes	Don't know	____________
Any foods, such as eggs, milk, or chocolate (please specify)	No	Yes	Don't know	____________

REVIEW OF SYSTEMS:

Do you have, or have you had, any of the following:

9. General:

Recent weight gain	No	Yes
Have you been in good general health	No	Yes

10. Skin:

Acne	No	Yes
Dry skin/itching	No	Yes
Eczema	No	Yes
Rash	No	Yes

11. Head-Eyes-Ears-Nose-Throat:

Blurry vision/double vision (please specify)	No	Yes
Cataracts	No	Yes
Contact lenses/glasses (please specify)	No	Yes
Dizziness	No	Yes
Ear problems (drainage, earache, etc.)	No	Yes
Eye problems (drainage, infection, etc.)	No	Yes
Hearing loss	No	Yes
Loss of balance	No	Yes
Neck stiffness	No	Yes

12. Breast:

Discharge	No	Yes
Infection	No	Yes
Mass/lump	No	Yes
Surgery	No	Yes

13. Cardiac:

Angina	No	Yes
Cardiac surgery	No	Yes
Chest pain	No	Yes
Murmur	No	Yes
Palpitations	No	Yes
Shortness of breath	No	Yes
Swelling of extremities (arms/legs)	No	Yes

14. Pulmonary:

Asthma	No	Yes
Frequent cough	No	Yes
Pain with breathing	No	Yes
Wheezing	No	Yes

Continued on Next Page

15. Gastrointestinal:

- Abdominal pain .... No Yes
- Appetite change .... No Yes
- Blood in stool........ No Yes
- Change in bowel habits........ No Yes
- Constipation .... No Yes
- Diarrhea .... No Yes
- Gallbladder problems........ No Yes
- Indigestion/heartburn .... No Yes
- Hemorrhoids or piles .... No Yes
- Nausea/vomiting .... No Yes
- NSAID intolerance .... No Yes
- Rectal bleeding .... No Yes
- Ulcers .... No Yes

16. Urologic:

- Dribbling .... No Yes
- Dysuria (pain or burning with urination) .... No Yes
- Frequency .... No Yes
- Incontinence .... No Yes
- Hematuria (blood in urine) .... No Yes
- History of stones .... No Yes
- Infection .... No Yes
- Nocturia (night time urination) .... No Yes
- Stress incontinence .... No Yes
- Urgency .... No Yes

17. Ob-Gyn:

- # of pregnancies ______ # of miscarriages _________
- Date of last Pap smear _________________________
- Results (negative or positive) __________________
- Frequency of periods, every ______ days
- Any pain with periods .... No Yes
- Menopausal........ No Yes
  (if yes, at what age ______)

18. Musculoskeletal:

- Any other problems other than your reason......
  For your visit today .... No Yes

IF YOU ANSWERED "YES" PLEASE SPECIFY BELOW:

- Arthritis........ No Yes
- Joint pain........ No Yes
- Joint swelling........ No Yes
- Osteopenia .... No Yes
- Rheumatoid arthritis .... No Yes
- Other pains/problems........ No Yes
  Please specify below:.............................

....
....
....
....

19. Neurological:

- Dizziness/fainting spells........ No Yes
- Headaches........ No Yes
- Loss of consciousness........ No Yes
- Memory loss .... No Yes
- Paralysis .... No Yes
- Seizures .... No Yes

20. Vascular:

- Abnormal bleeding or bruising........ No Yes
- Aneurysm .... No Yes
- Are you a Jehovah's Witness .... No Yes
- Phlebitis .... No Yes
- Varicose veins .... No Yes

21. Endocrine:

- Blood transfusion........ No Yes
- Hormone therapy .... No Yes
- Thyroid problems .... No Yes
- Varicose veins .... No Yes

22. Immune System:

- AIDS........ No Yes
- Diabetes .... No Yes
- History of infections........ No Yes
- Immunosuppressive disorders .... No Yes

23. Surgery:

- Anesthetic allergy/problem .... No Yes
- Iodine allergy........ No Yes
- Postoperative infections/complications .... No Yes
- Suture reaction........ No Yes
- Tape allergy........ No Yes
- Severe nausea/vomiting after general
  anesthesia .... No Yes
- Waking-up problem after anesthesia .... No Yes

Any other information we should be aware of:

____

____

____

Thank you for filling out the questionnaire. It will assist us in providing the best care to you.

This form is a courtesy of Jeffrey D. Coe, M.D. 2003 Revised by Sherman N. Tran M.D. 2007