PATIENT HEALTH QUESTIONNAIRE (Page 1)

Robert E. Scott, Jr., M.D.

Spine Care • Musculoskeletal & Sports Injuries • Neurodiagnostic Testing • Spinal Interventions

9834 Genesee, Suite 223B
La Jolla, CA 92037
Phone 858-277-7123
Fax 858-277-3470

Please fill out **completely.** Failure to do so may delay payment of your claim. Indicate N/A if not applicable

Patient (Last, First): _____ , _____

Sex: ☐ M ☐ F DOB:_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed

SSN: _____-_____-_____

Patient Contact Information: Home #_____ Cell #_____

Address:_____
Street City State Zip

Employer Information: _____ Occupation: _____

Work #_____ Fax #_____

Employer Address: _____
Street City State Zip

Emergency Contact: _____ Home # _____ Cell # _____

Pharmacy Information: Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____
Street City State Zip

Referred by: _____ ☐ Family ☐ Friend ☐ Insurance

☐ Physician ☐ Other _____

Referring Physician: _____

Phone #_____ Fax #_____

Address: _____
Street City State Zip

Primary Care Physician: _____

Phone #_____ Fax #_____

Address: _____
Street City State Zip

I authorize the release of any medical information necessary to process my insurance claim to the insurance company shown above. I herby authorize payment of medical benefits due me to Dr. Robert E. Scott Jr. I understand that even if a patient carries medical insurance, professional services are rendered and charged to the patient not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to Dr. Robert E. Scott Jr. I accept financial responsibility for all charges incurred and herby promise to pay all charges promptly including those not paid by my insurance. If my account has to be referred to outside collection I will be charged a service charge to over the additional collection costs. If my payment does not clear my bank account I will also pay service charges to cover the bad payment. This is true for all patients except for work comp.

X _____ **Date:** _____

Signature of patient or legal guardian

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Notice and Acknowledgement of Privacy Practices:

Our practice reserves the right to modify the privacy practices outlined in the notice.

I acknowledge that I have received, been offered, or reviewed Robert E. Scott, Jr. M.D Notice of Privacy Practices.

I also, have been made aware that Robert E. Scott, Jr. M.D. is licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov

_____ _____
Patient Signature Date
Or Personal Representative Signature

If personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

If you would like any person (s) to be able to communicate with Dr. Scott or his staff about your care, please include their name below. You may add or subtract any person at any time.
You may discuss my care with the following person(s).

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____, _____ **Date:** _____
Last **First**

PATIENT HEALTH QUESTIONNAIRE (Page 3)

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STATEMENT OF FINANCIAL POLICIES

1. **Patients are responsible for payment in full for all services rendered.** Please notify the receptionist in advance if another person has assumed financial responsibility such as parent or guardian.
2. If you have insurance, there is no way for this office to know if your insurer will pay for today's services. Insurance policies differ considerably in terms of annual deductibles, copay amounts, place of service and many other requirements. **It is the patient responsibility to know the terms of their insurance policy.**
3. We may or may not be contracted with your insurance company. Upon your request, during regular business hours, we will be happy to contact your insurance company to verify eligibility and contract provisions before providing service. **However, it is the patient responsibility to know and understand the terms of their insurance policy.** Your insurer may require treatment authorization for certain procedures. Only if we are contracted with your insurer, and your treatment has been authorized, can we accept your co-payment and bill your insurance company for the balance. **Your co-pay is required at the time of service.**
4. We can not guarantee that surgery centers or other procedure centers we use are contracted with your insurance plan. Please call the procedure center directly or call the customer service number on the back of your insurance card for verification of coverage. **It is the patient responsibility to know the terms of their insurance policy.**

The undersigned requests the services of Robert Scott, MD for evaluation and treatment. To the extent allowed by law, I (we) am financially responsible for these professional services unless I am eligible for Medicare or Medi-Cal benefits. I hereby give consent that in the event my account becomes delinquent Robert Scot,t MD is authorized to release my name, account balance and further information as required to my insurance company, a collection agency or an attorney for collection of my account. I also agree to assign to Robert Scott, MD any right or cause of action I may have against any third person for payment of this account. I understand that accounts are due and payable within 60 days of the date of service. I agree to pay all service charges and accrued interest of 10% annual percentage rate if my account become delinquent, and pay any collection expenses including attorney fees and costs should any action be initiated on that debt.

I authorize payment of medical benefits to Robert Scott, MD for medical services rendered.

_____ _____
Patient or Guardian's Signature Today's Date

_____
Print Name

Eligibility Guarantee

I hereby certify that I am eligible for benefits with _____ (insurance company) through _____ (employer group), _____ (subscriber name),

_____ (policy number) as of _____ (effective date).
I understand that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the persona financially responsible for me) will pay in full all such charges as described in the Statement of Financial Policies above.
_____(Signature)_____ (Date)

Name: _____, _____ Date: _____
Last First

PATIENT HEALTH QUESTIONNAIRE (Page 4)

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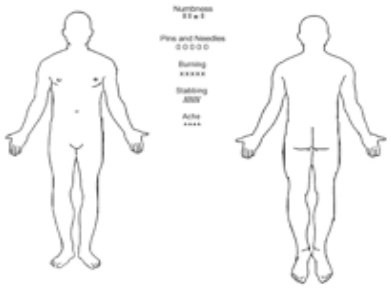
Name:_____ DOB/Age:_____ Date:_____

Please **mark** the painful body regions **on the diagram** shown:



XXX = PAIN 0000 = NUMBNESS ////// = TINGLING

Currently what is your pain level on a scale of 1 to 10? (Please circle below)

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Extreme pain)

IS YOUR **PAIN**?

☐ Stabbing ☐ Radiating ☐ Shooting ☐ Sharp with movement

☐ Constant ☐ Burning ☐ Deep ☐ Numbness ☐ Weakness

☐ Tingling ☐ Other_____

WHAT MAKES YOUR PAIN **WORSE**?

☐ Sitting ☐ Standing ☐ Laying down ☐ Bending Forward/down

☐ Exercising ☐ Usage of painful area ☐ Other_____

WHAT MAKES YOUR PAIN **BETTER**?

☐ Ice/Hot pad ☐ Resting ☐ Sitting ☐ Standing ☐ Laying down

☐ Pain Medications ☐ Injections ☐ Walking/Exercise

☐Other_____

IF YOU HAVE **SPINAL PAIN**, WHAT MAKES IT **WORSE**?

☐ Sitting ☐ Standing ☐ Laying down ☐ Bending Forward/down

☐ Exercising ☐ Usage of painful area ☐ Other_____

IF YOU HAVE **SPINAL PAIN**, WHAT MAKES IT **BETTER**?

☐ Ice/Hot pad ☐ Resting ☐ Sitting ☐ Standing ☐ Laying down

☐ Pain Medications ☐ Injections ☐ Walking/Exercise

☐Other_____

IF YOU HAVE **SPINAL PAIN**, DO YOU EXPERIENCE ANY PAIN, NUMBNESS, TINGLING, OR WEAKNESS IN YOUR LEGS?

☐ Numbness ☐ Pain ☐ Tingling ☐ Weakness ☐ N/A

☐Other_____

IF YOU HAVE **NECK PAIN**, DO YOU EXPERIENCE ANY PAIN, NUMBNESS, TINGLING, OR WEAKNESS IN YOUR ARMS OR HANDS?

☐ Numbness ☐ Pain ☐ Tingling ☐ Weakness ☐ N/A

☐Other_____

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MEDICAL HISTORY/SURGICAL HISTORY

Current Medical conditions/illnesses _____

_____

_____

_____

IMMUNIZATION HISTORY

Please list your immunization history within the past year (Ex: Flu Shot September 2021, etc.):

_____

_____

_____

TREATMENT HISTORY

Number of Physical Therapy Visits: _____

Number of Chiropractic Visits: _____

Number of Acupuncture Visits: _____

List of Other Treatments: _____

List of Imaging Studies (X-Rays/MRI) and Imaging Center: _____

FAMILY HISTORY

Father: _____ Mother: _____

Sibling: _____ Child: _____

Name: _____, _____ Date: _____

REVIEW OF SYSTEMS

Do you, or have you ever had:

Cardiovascular System

Yes No
☐ ☐ Heart disease
☐ ☐ Angina
☐ ☐ Chest Pain
☐ ☐ Heart Attack
☐ ☐ High Blood Pressure
☐ ☐ Do you use a CPAP machine?
☐ ☐ Do you have a heart stent?
☐ ☐ Irregular Heart Beat
Other_____

Respiratory System

Yes No
☐ ☐ Lung disease, TB
☐ ☐ Emphysema
☐ ☐ Asthma
☐ ☐ Wheezing
☐ ☐ Difficulty Breathing
☐ ☐ Documented Sleep Apnea
Other _____

Nervous/Musculoskeletal System

Yes No
☐ ☐ Epilepsy
☐ ☐ Stroke
☐ ☐ Neuropathy
☐ ☐ Chronic Back Pain
☐ ☐ Acute Back Pain
☐ ☐ Neck Pain
☐ ☐ Joint Pain
☐ ☐ Severe Headaches
Other_____

Endocrine/Gastrointestional System

Yes No
☐ ☐ Ulcers
☐ ☐ Diabetes
☐ ☐ Kidney Disease
☐ ☐ Jaundice/Hepatitis
☐ ☐ Thyroid Disease
Other_____

Social Habits/Other

Yes No
☐ ☐ Do you smoke? If so, how much?_____
☐ ☐ Do you drink? If so, how much?_____
☐ ☐ Do you wear: ☐ Hearing Aids ☐ Contact lenses☐ False Eye
☐ ☐ Do you currently have a cold or the flu?
☐ ☐ History of Bleeding tendency
☐ ☐ Drug or Alcohol addiction
☐ ☐ Females: Is there any possibility that you are pregnant at this time?
☐ ☐ Documented latex allergy
Other_____

Name: _____, _____ Date: _____
Last First

Current Medication List

Medication Name (ex. Vicodin)	Dosage (ex.5 mg)	Usage (ex. 1-2 pills twice a day)	Start Date	Updates

☐ See Attached List (Please include patient name and date on list)

Please List any Allergies (or NKA if no known):

_____ _____ _____ _____

_____ _____ _____ _____

Office Use Only:

PMHx:

_____

_____

_____

_____

_____

_____

Ht:_____ Wt:_____ BP: _____ HR:_____ Temp: _____

Name: _____, _____ **Date:** _____

Last **First**