AUTHORIZATION:
I hereby consent to any necessary medical treatment for myself or the minor named below for whom I am legally responsible.

ASSIGNMENT:
I permit payment directly to the Spine Center for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.

MEDICAL RECORDS:
Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Signature:_____ Date:_____

Minor Name:_____

PATIENT REGISTRATION FORM

Last Name _____
First Name _____ MI _____
Address _____
City _____ State _____
Zip Code _____ Sex ____M____F
__Employed __Full-time Student __Part-time Student
Employer/School _____

Home Phone ( ) _____
Work Phone ( ) _____ Ext ____
Date of Birth _____
Social Sec. No. _____
Marital Status ___S___M___D___W
Referred By _____

IN CASE RESPONSIBLE PARTY CANNOT BE REACHED, NOTIFY:

___Spouse___Child___Other_____
Name _____
Address _____
City _____

Home Phone ( ) _____
Work Phone ( ) _____ Ext ____
State _____ Zip Code _____

PATIENT INFORMATION (Complete only if patient is not responsible party)

Last Name _____
First Name _____ M.I. _____
Date of Birth _____
Relationship to responsible party:
___Wife ___Husband ___Child ___Parent ___Other

Marital Status ___S ___M ___D ___W
___Employed ___Full-time Student ___Part-time Student
Social Security No. _____
Sex ___M ___F

Referred By:_____

Patient's Name:_____ DOB_____ Date:_____

HISTORY SHEET FOR NEW PATIENTS OR OLD PATIENTS WITH A NEW PROBLEM

If you would like to have x-rays while you are waiting to see the doctor, please notify the front desk or the doctor's medical assistant immediately.

Medicare and Insurance Companies demand that we update your medical history for a new problem. Therefore, we would appreciate your completing this questionnaire while you wait to see your doctor. We thank you for your cooperation.

1. **Chief complaint** (brief statement): (example: I fell down at work and hurt my left knee).

_____

2. **History:**_____Right-handed _____Left-handed

Age:_____ Please describe the type of work you do (example: machine operator).

Problem area to be examined today: _____

Date of injury:_____ Brief description of injury: _____

_____

_____

Where and when were you **first** seen for **this** problem:_____

_____

If you can remember, please list the doctor(s) name(s) and approximate dates when they saw you for **this** problem: _____

_____

Please list any tests that have been performed for **this** injury:

____x-ray(s) ____MRI ____arthrogram ____urine or wound culture

____EMG ____CAT scan ____ultrasound ____bone scan ____other

Please list any treatments you have undergone for **this** problem:

____physical therapy ____massage ____pain clinic

____chiropractic adjustments ____work hardening ____other_____

Please list medicines or types of medicines you have been given to treat **this** condition:

_____

Have you ever injured **this** area of your body before?

_____yes _____no If yes, please give approximate date: _____

Clinical notes (for Doctor's use only):

_____

_____

_____

_____

_____

_____

_____

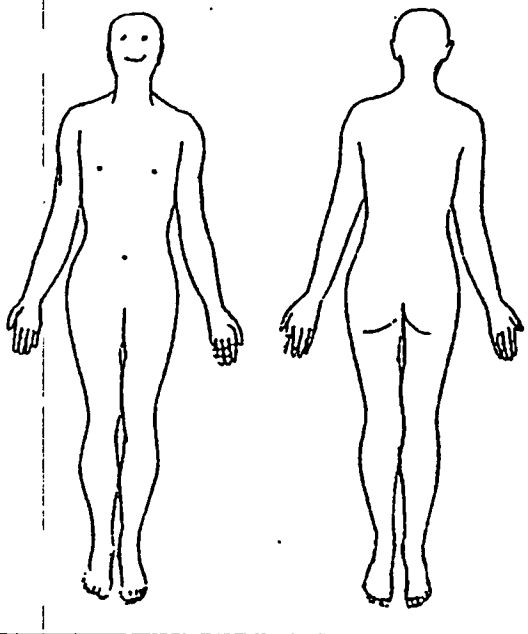
_____

_____

_____

_____

Please mark XXX where you are now having problems



OVER ↓

3. **Work History:**

Employer: _____ Type of work: _____

How long employed by this company? _____

If not presently employed, are you: retired_____, unemployed_____, disabled_____, housewife_____, student_____

4. **Medical and Surgical History**

____Diabetes	____Cancer	____Bone infection(s)	_____Pacemaker
____High blood pressure	____Epilepsy	____Gout	_____Any Metal
____Heart problems	____Bowel problems	____Recent weight loss ____lbs	
____Stomach problems	____Bladder problems	____Other(s)	

Surgical history (list major operations and approximate dates): _____

_____ _____ _____

_____ _____ _____

5. **Drug Allergies** (example: penicillin, iodine, tape, latex): _____

_____

6. **Medications** (list names of medications or types of medications which you are currently taking):

_____

_____

7. **Social History:**

Marital status:_____married _____widow(er) _____single _____divorced

Number of children or dependents living at your home: _____

Tobacco use: _____no _____yes How much do you smoke? _____

For how many years? _____

Do you drink alcoholic beverages? _____no _____yes Type and number per week?

_____

8. **Family History** (list illnesses that run or occur in your family (example: cancer, diabetes, tuberculosis):

_____

9. **Review of Systems** - Are you presently having problems with any of the systems listed below (please check):

_____head	_____throat	_____bowels	_____circulation
_____eyes	_____heart	_____bladder	_____other _____
_____ears	_____lungs	_____female organs	
_____nose	_____stomach	_____skin	

Is there any other information, which you would like the doctor to know? _____

_____

_____

WOMEN'S HEALTH

Osteoporosis Questionnaire: (circle appropriate positive responses)

- Have you ever gone through menopause, had a hysterectomy, or are you on thyroid or cortisone medications?
- Have you broken a bone after 40?
- Do you smoke at this time or have you ever been a moderate to heavy smoker in the past?
- Have you lost 1 inch of height?
- Did/Does your mother have Osteoporosis?

If you answer yes to three or more of these items, please discuss the possibility of osteoporosis screening with your doctor.