Patient Registration

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F	SSN	Preferred Language	Driver's License

Marital Status	Preferred Contact	Ethnicity	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Mail ☐ Home Phone ☐ Day Phone ☐ Cell Phone ☐ Patient Portal	☐ ☐ ☐ Hispanic/Latino ☐ Non-Hispanic	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the Spine & Orthopedic Center
to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize my MemorialCare Medical Foundation affiliated medical group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

_______________________________   _______________________________

Signature of Patient/Responsible Party   Date

_______________________________   _______________________________

Name of Patient/Responsible Party (Please Print)   Relationship to Patient

Patient Registration

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP	
☐ Appendectomy		(Trans-urethral resection of Prostate)	
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.							
☐ Adopted							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

Family History – continued

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient

Occupation		Employer	
Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

For Pediatric Patient

Patient Reside with:					
	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
	Secondary	☐ Mother	☐ Father	☐ Other:	

Mother's Occupation	Father's Occupation
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed	Childcare ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare
Tobacco Exposure: ☐ Yes ☐ No Smokers at home: ☐ Yes ☐ No	Patient is current smoker? ☐ Yes ☐ No

PAIN ASSESSMENT

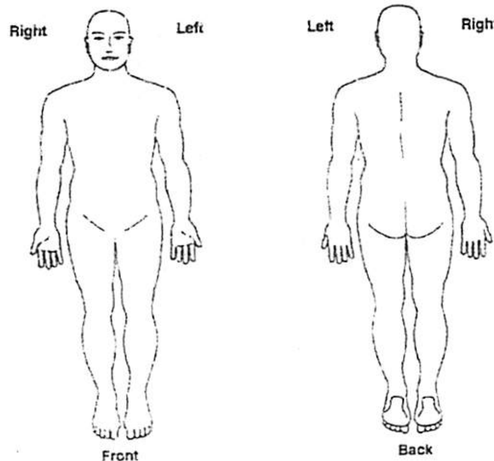
WHERE IS YOUR PAIN? PLEASE CIRCLE ALL THAT APPLY:

SHOULDER	LEFT	RIGHT	BOTH
ARM	LEFT	RIGHT	BOTH
HAND	LEFT	RIGHT	BOTH
WRIST	LEFT	RIGHT	BOTH
ELBOW	LEFT	RIGHT	BOTH
HIP	LEFT	RIGHT	BOTH
LEG	LEFT	RIGHT	BOTH
KNEE	LEFT	RIGHT	BOTH
ANKLE	LEFT	RIGHT	BOTH
FOOT	LEFT	RIGHT	BOTH
NECK	UPPER	LOWER	MID
BACK	UPPER	LOWER	MID

DESCRIBE YOUR PAIN, PLEASE CIRCLE ALL THAT APPLY:

ACHING	SHOOTING	SHARP	PENETRATING
THROBBING	TENDER	NAGGING	BURNING
RADIATING	NUMB	STABBING	EXHAUSTING
MISERABLE	GNAWING	TIRING	UNBEARABLE
OCCASSIONAL	CONTINUOUS		

PLEASE RATE YOUR PAIN ON A SCALE OF 1-10 (10 BEING THE WORST: ____________________
WHAT INCREASES THE PAIN: ____
WHAT DECREASES THE PAIN: ____
PLEASE CIRCLE YOUR POINTS OF PAIN:



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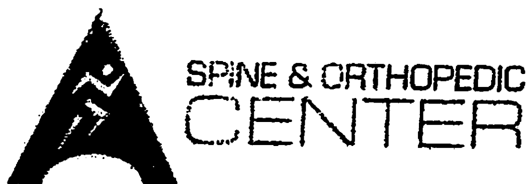

NARCOTICS CONTRACT

Narcotics, tranquillizers and barbiturates are very useful, but have high potential for misuse and are, therefore, closely controlled by local, state and federal government. They are intended to relieve pain to improve function and/or ability to work, not to simply feel good.

Because my physician is prescribing such medication for me, I agree to the following conditions:

1. I will disclose all current doctor relationships and obtain all pain medications such as narcotics or other controlled substances (IE: nerve medications, anxiety medications, sedatives, sleeping pills, or muscle relaxants) only from Spine & Orthopedic Center.
2. I understand these drugs have an abuse potential because they can produce physical and psychological dependance.
3. I will not request or accept controlled substance medications from any other physician or individual will I am receiving such medications from Spine & Orthopedic center, besides being illegal to do so, it may endanger my life.
4. Refills of controlled substance medications require an appointment with my provider at Spine & Orthopedic Center and require a drug screening.
5. Refills will not be made if you run out early, you are responsible for taking your medications in the dose it was prescribed.
6. Refills will not be made if lost or stolen, you are responsible for your medication.

Patient Name: ______________________________ DOB: ____________________

Patient Signature: ______________________________ Date: ____________________

TREATMENT COMPLIANCE CONTRACT

Dr. Sood and the staff at Spine & Orthopedic Center are making a commitment to work with you in your efforts to get better. To help you in this work we agree that we will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment. We will make sure that your treatment is as safe as possible by checking regularly to make sure you are not having any adverse side effects. We will keep track of your prescriptions and test for drug use regularly so you are being monitored well. We will help set treatment goals and monitor your progress in achieving those goals. We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

I, ____(print name), understand and voluntarily agree that: (initial each statement after reviewing)

_________I will refrain from going to the ER and seeking pain medications, except in the event of an acute emergency.

_________ I will advise Spine & Orthopedic Center in advance if any acute situations arise that require other physicians to prescribe pain or controlled medications.

_________ I will cooperate with urine drug screens or family conferences when asked to do so. I understand this may be needed to further evaluate my medical condition and response to these drugs.

_________ I will refrain from using illegal drugs/substances.

_________ I will comply with my recommended treatment plan. ***If you do not agree with your treatment plan, it must be discussed with the treating physician.

_________ I will attend all scheduled appointments (prescription refill, injections, and physical therapy).

_________ I understand that if I violate any of the above information my treatment at Spine & Orthopedic Center may be ended immediately.

_________ I will refrain from being disrespectful to staff.

I have read the contract and I fully understand the consequences of violating any of the information listed.

Patient Signature: ____ Date: ______________________

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FINANCIAL POLICY

Dr. Rajiv Sood & the staff at Spine & Orthopedic Center believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our updated financial policy.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, or credit/debit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit.
2. **INSURANCE** We are participating providers with several insurance plans. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and you, the patient, are ultimately responsible for determining our participation status with your plan, knowing your benefits, and payment. We will verify insurance as a courtesy and will be collecting based off the information available to us. Due to the many different insurance companies and plans, our staff cannot guarantee your eligibility and coverage.
3. **RETURNED CHECKS** will incur a $50.00 service charge.
4. **NO SHOW FEES** Should you need to cancel or change your appointment, we ask that you do so with 24 hour (business days) advanced notice. Failure to do so will result in a $35.00 no show fee or late cancellation fee. No show or late cancellation for a procedure will result in a $75.00 fee. Repeated incidents of no shows/late cancels will be discharged from the practice.
5. **FORMS FEES** Completing forms (insurance, disability, FMLA, etc..) & copying medical records requires office staff and doctors time. We require pre-payment for completing forms, copying medical records, and notary services. The charge is determined by the complexity for the communication.
6. **BALANCE BILLING** Dr. Sood & the staff at Spine & Orthopedic Center understands that billing and collection efforts in the past have not been regular and that this financial policy may be new to many patients. Statements will be going out on a monthly basis going forward. After 3 statements if payment is not made on the account, the account will be at risk of being sent to an outside collections agency. We understand that everyone faces difficult financial times and are will and able to work with our patients on payment arrangements and plans. We will also be happy to offer discounts on accounts paid off in full.

A representative is available in office to answer any questions you may have regarding patient accounts or payment arrangements at 770-473-0038 ext. 101.

**I have read and understand the Financial Policy of Spine & Orthopedic Center, PC and consent to
treatment and agree to all outlined policies.**

Patient Signature: ____

Patient Printed Name: ____

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FINANCIAL RESPONSIBILITY

1. Will you be using medical/health insurance? YES or NO
   If yes, please provide Insurance Company & Policy #:
   ____

2. Have you been in volved in a motor vehicle accident? YES or NO
   If yes, when did the accident occur? ______________________________

3. Do you have an attorney? YES or NO
   If yes, please provide the following information:
   Attorney's Name: ______________________________
   Name of Law Firm: ______________________________
   Address: ______________________________
   Phone #: ______________ Email: ______________

4. Did you sustain an injury at work? YES or NO
   If yes, when dd the accident occur? ______________________________
   Please provide worker's compensation information:
   Worker's Comp Provider: ______________________________
   Case #/Claim #: ______________________________
   Case Manager: ______________________________
   Phone Number: ______________ Email: ______________

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SPINE & ORTHOPEDIC CENTER

HIPPA -- PATIENT CONSENT OF INFORMATION

Spine & Orthopedic Center, in order to comply with the HIPPA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Spine & Orthopedic Center from violating the patient's confidentiality. If there is not a signed consent on file, the physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone.

By completing the consent below, you are allowing Spine & Orthopedic Center to leave a message on an answering machine, voicemail or with a specified person. You may specify what information is left and with whom by noting below. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Spine & Orthopedic Center physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_________ via text message
_________ on a voicemail at home or cell phone
_________ via portal
_________with _________________________________ Relationship: ______________________
_________with _________________________________ Relationship: ______________________

_________ I do not consent to messages being left at home, on my cell or with any other person. I wish to be contacted directly.

Patient's Name: ____ DOB: ________________

Patient's Signature: ____ Date: ________________

HIPPA – Notice of Privacy Practice Acknowledgement

_________ I have been provided with a copy of Spine & Orthopedic Center's privacy practices.

_________ I have declined a copy of Spine & Orthopedic Center's privacy practices.

Patient's Signature: ____ Date: ________________

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