SALT LAKE SPINE & SPORTS MEDICINE

Account # _______________ New

Patient Information

Patient's Legal Last Name	**Patient's Legal First Name**	**Patient's Legal Middle Name**

Patient's Mailing Address - Street Apt. P.O. Box	**City**	**State**	**Zip**

Race:	Ethnicity: Not Hispanic or Latin Hispanic or Latin	Primary Language:

Sex: M F	Date of Birth: (MM/DD/YYYY)	Age:	Social Security No.	Home Phone #: Cell Phone #:

Patient's Email Address: (Optional)

Patient's Employer	Patient's Work Number

Emergency Contact	Emergency Contact's Number	Relationship to Patient

Marital Status: Single Married Other Parent	Spouse's Name	Spouse's Contact Number

Full Name of Primary Care Doctor:	Full Name of Referring Doctor:
Preferred Pharmacy	Pharmacy Phone #

Private Pay/No Insurance

Private Insurance Information

(If not filled out completely, we are unable to bill your insurance. Your insurance card does not have all the information we need)

Primary Insurance Carrier			**Secondary Insurance Carrier**		
Primary Insurance Name	Plan Name	Telephone	Secondary Insurance Name	Plan Name	Telephone
Address			Address		

Primary Insurance Carrier		**Secondary Insurance Carrier**	
Policy Holder's Name on Card	Relationship to Patient	**Policy Holder's Name on Card**	Relationship to Patient
Policy Holder's Date of Birth	Policy Holder's Telephone	**Policy Holder's Date of Birth**	Policy Holder's Telephone
Group Number	Policy Number	Group Number	Policy Number
Policy Holder's Employer and Telephone Number		Policy Holder's Employer and Telephone Number	

Auto/Industrial Insurance Information (fill out only if being seen as part of an auto claim)

Insurance Company Name	Date of Injury: (MM/DD/YY)	Industrial? Yes No	Auto? Yes No

Address – Street City State Zip	Adjuster's Name	Adjuster's Telephone

Employer at time of injury:	Employer Address – Street, City, State, Zip	Employer Telephone
Claim Number:	Attorney Name (If you have one):	Attorney Telephone:

Please continue to the next page.

<u>SALT LAKE SPINE & SPORTS MEDICINE</u>

Account # ______________ New

Name ______________________________ **Date** ______________________

Release of Information

The law requires us to make and keep records of each patient's medical treatment. We safeguard those records and their uses and disclose such records and the information they contain only in accordance with state and federal privacy laws.
I authorize this facility to release to my insurance company and all parties involved in my treatment any information concerning the diagnosis, treatment plan, professional opinion, and medical or surgical procedure(s) performed, as well as information contained on this form.
I also authorize any physician, medical practitioner, hospital, or any other medically related facility to release to this facility any and all information regarding my medical history to include: medical, hospital, and other facility records; as well as x-rays, scans, laboratory reports, and any other related testing results.

I have read "<u>Release of Information</u>" disclosure and, as the patient, or the patient's authorized representative for the purpose of signing this document, I accept these terms.

Date ____________________ Signature ____

Financial Responsibility

GENERAL: I understand that I am responsible for the payment of all charges incurred in connection with my treatment at Salt Lake Spine and Sports Medicine and I agree to make full payment for such charges known to not be covered by insurance. These are due in full at the time of service. I certify that the information I have provided is correct. Please note that liens on settlements are not an acceptable payment arrangement with Salt Lake Spine & Sports Medicine.
ASSIGNMENT OF BENEFITS: I hereby assign and transfer to this facility all insurance benefits payable to me by my insurance company(s), as listed on the face of this form, or which may change from time to time, for services and costs incurred in connection with my treatment. I understand that this assignment of benefits shall be exclusively for my insurance company(s) and Salt Lake Spine & Sports Medicine and/or its associated doctors.
MEDICARE/MEDICAIDE/TRICARE CERTIFICATION AND ASSIGNMENT: I certify that the information given by me in applying for payment for Medicare, Medicaid, and Tri-Care benefits or any other government program is correct. I authorize any holder of medical or other information about me to release to the Tri-Care administrator, Social Security Administration or its intermediaries, or other carriers or program administrators, to the State or any other government payer, any information needed to substantiate and process a claim for payment for this or any facility for its charges or those of its associated physicians.
OTHER AGREEMENTS: I understand that I will be responsible for any deductibles, co-insurance, or other amounts not paid by my insurance company(s). Balances remaining after insurance benefits have been paid should be paid within 30 days. I further agree to pay a service charge of $30.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union. I further agree to pay an additional 33% of my balance plus all costs and expenses including attorney's fees that are incurred in the collection of such checks or outstanding balances.

I have read the "<u>Financial Arrangements</u>" disclosure and, as the patient, or the patient's authorized representative for the purpose of signing this document, I accept these terms.

Date ____________________ Signature ____

Account # ____________ New

Salt Lake Spine and Sports Medicine

5770 South 250 East Suite 235
Murray, Utah 84107
801-314-5115

Brent Bowen, M.D.P.C. Richard W. Hurst, M.D.
Stephen M. Clements, M.P.A.S., P.A.-C

No Show and Cancellation Agreement

There is an increasing number of patients who do not come to their scheduled appointments and do not cancel with reasonable notice. This is obviously disruptive of our work and it reduces the number of patients we can assist.

Consequently, we have established a NO Show/Cancellation Policy: *If you are not able to keep a scheduled appointment, we ask that you call and give us at least 24 hour notice.*

If you do not come to your appointment, or do not give us sufficient notice, you will be assessed a $30 charge. This charge must be paid prior to your next visit before your doctor or P.A. will see you.

If you have some extenuating circumstances that make it impossible for you to come to your appointment, or to give us notice of your cancellation, please let the staff know of your situation and we will reconsider assessing the “NO Show” charge.

Patient Name: ______________________________ Date: __________________

_______________________________________ Account: __________________

Patient Signature

Please continue to the next page.

Salt Lake Spine and Sports Medicine
5770 South 250 East, Suite 235
Murray, UT 84107
801-314-5115

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Stephen M. Clements, M.P.A.S., P.A.-C

Authorization to Release Patient Information to Family Members

Patient Name: ______________________________

Account Number: ____________________________

For Doctor: ________________________________

For my benefit and convenience, I hereby authorize the doctor named above, or members of the staff, to release to the following member(s) of my family any medical information regarding my care at the Salt Lake Spine and Sports Medicine. This release of information must be in person with proof of identification.

Authorized Family Member(s):

Name: ______________________________ Date of Birth: __________________

Name: ______________________________ Date of Birth: __________________

Name: ______________________________ Date of Birth: __________________

Name: ______________________________ Date of Birth: __________________

Name: ______________________________ Date of Birth: __________________

I understand that the doctor or his staff will make a good-faith effort to assure themselves that they are releasing such information to individual(s) named above, and I release the doctor and his staff from any claim of negligence or HIPAA violation for doing so.

____________________________________ Date: ______________________

Patient Signature

SALT LAKE SPINE & SPORTS MEDICINE

Account # _____________ New

NEW EVALUATION

Legal Name: ____ **Date:** _____________

Birthdate: ______________________ **Age:** ________________ **Height:** _____________ **Weight:** ______________

Are you: Right-Handed Left-handed

Employment: Full-time Part-time Retired Disability

Job: ____

Describe the *MAIN AREA OF PAIN* for which you are being seen today:

What hurts the most? Head Neck Shoulder Arm Hand

Back Hip Buttock Pelvis Abdomen

Knee Leg Foot

How long have you had your current pain? ____

Ever had this before? No Yes → Describe: ____

How did this pain begin? Gradually (unrelated to any specific precipitating factor, trauma, or injury)

Suddenly → Describe any specific injury, trauma, or activity that caused pain:

____

____

Overall, is your pain: Getting better Getting worse About the same Constant Intermittent

Any prior injury to this area? No Yes → When? ____________ Describe:_______________________________

____

How would you describe your pain? Ache/Throb Sharp/Stab Stiff Burn Numb/Tingling

How intense is your pain currently? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How intense is your pain at its worst? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How intense is your pain at its best? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Is this a work compensation case? Yes No **Any legal action pending regarding this pain?** Yes No

Do you have a known cancer or tumor? No Yes → Describe:____

Have you recently taken corticosteroid medications on a regular basis? Yes No

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What makes your pain feel worse? If one activity is worse than all the others, please check the box:

Standing Sitting Walking →What distance? ____________ Coughing Sneezing Straining
Bending forward Bending Back Stairs Reaching overhead Laying on that side Morning
Evening In bed at night Sexual intercourse Lifting Twisting

What makes your pain feel better?

Standing Still Sitting Down Walking/moving around Lying down Bending forward Bending Back
Rest Heat Ice Stretching Medication Nothing makes it better

Have you had any of these symptoms as part of your current symptoms?

Yes No Weakness
Yes No Fever or chills
Yes No Swelling or fluid on the joint
Yes No Weight loss
Yes No Loss of control of your bladder or bowel
Yes No Rash
Yes No Numbness or tingling
Yes No Difficulty sleeping
Yes No Giveway of your leg, falling down because of pain, locking of your joint
Yes No Constipation / Number of bowel movements per day _______________.

What treatments have you done for your pain? Either mark below, or I haven't done anything for this pain.

MEDICATIONS	**YES**	**NO**	**WHEN**	**What was the result? Is/was it effective?**	**Are you still using it?**
Acetaminophen, Tylenol					
Ibuprofen, Advil					
Aleve, Naproxen					
Daypro, Relafen					
Celebrez, Mobic					
Glucosamine, Chondroitin					
Neurontin, Lyrica					
Amitriptyline (Elavil), Nortriptyline (Pamelor)					
Tramadol, Ultram, Ultracet					
PHYSICAL THERAPY					
Strengthening					
Stretching					
Heat or Ice					
Massage					
Ultrasound					
TENS, Electrical Stimulation					
Traction					
Aerobic Exercise					
Acupuncture					
Manipulation/Chiropractor					
Cane, Walker, or Crutches					
INJECTION(S)					
What was injected?					
TIME OFF WORK					

Please continue to the next page.

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Account # _______________ New

Personal Medical History:

Significant medical conditions:

Diabetes Heart Disease High blood pressure Stomach Ulcers Cancer

Asthma Other: ____

Past surgeries? ____

What are your current medications? (Use back of page if you need more space)

Medication	Dosage	How long have you been taking this?

Do you have any known Drug Allergies? No Yes →Describe: ______________________________

Do you have any metal in your body? No Yes →Describe: ______________________________

Family Medical History

Mother: Diabetes Heart Disease High blood pressure Stomach Ulcers
Cancer Asthma Other: ______________________________

Father: Diabetes Heart Disease High blood pressure Stomach Ulcers
Cancer Asthma Other: ______________________________

Siblings: Diabetes Heart Disease High blood pressure Stomach Ulcers
Cancer Asthma Other: ______________________________

Personal Social History

Marital Status? Single Married Divorced Separated Widowed

Do you have children? No Yes → Ages? ______________________________

Do you smoke cigarettes or chew tobacco? No Yes → How many packs per day? ________________

Do you or have you ever used recreational drugs (cocaine, marijuana, LSD, etc.)? No Yes → Describe: _________

Do you drink alcoholic beverages? No Yes → How much and how often? ____________________

Do have a history of alcohol abuse? No Yes **Have you ever been to Alcoholics Anonymous?** No Yes

What is your highest level of education? ______________________________

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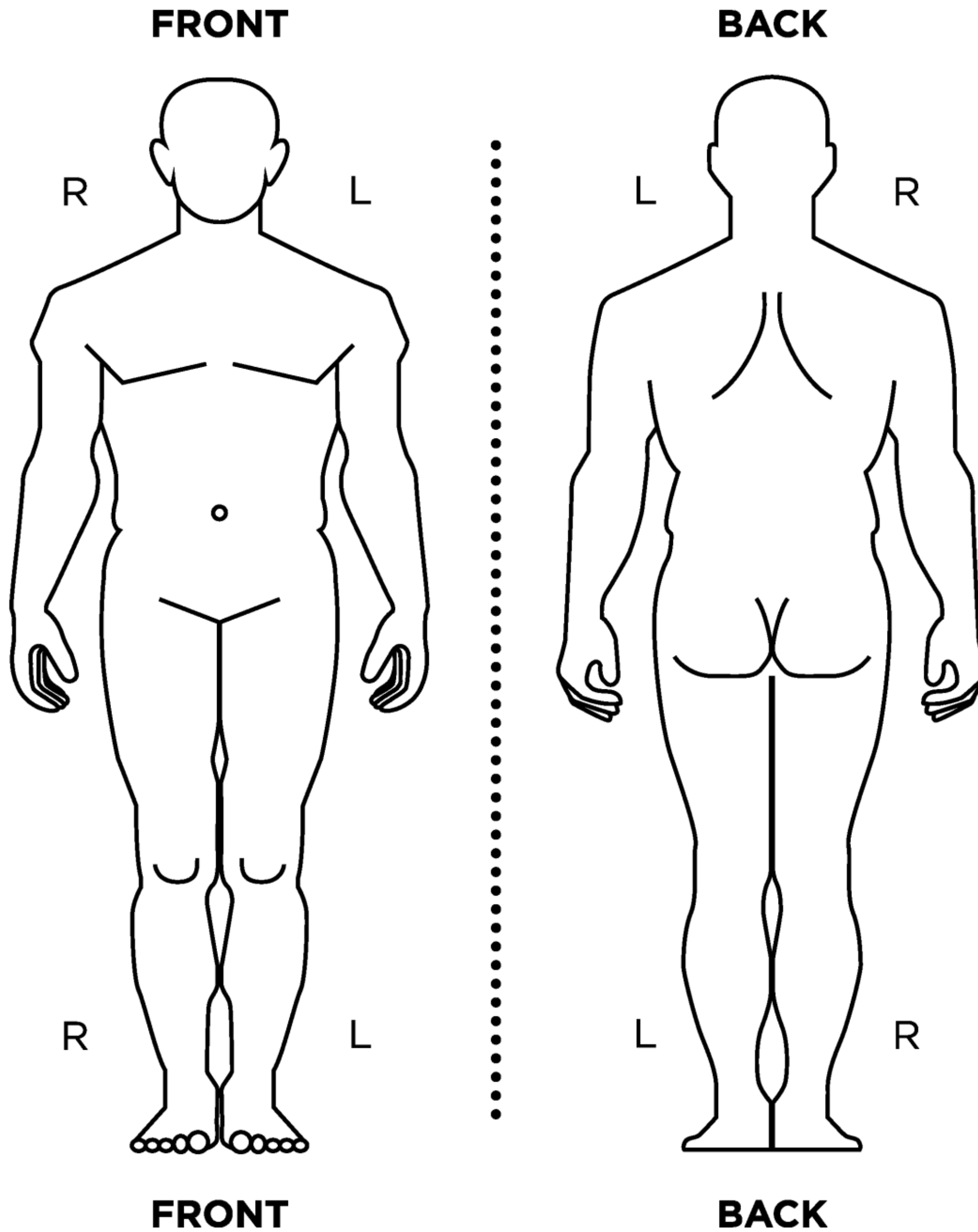
Using these symbols, use the diagram to mark where you feel your pain.

">>>>" for aching pain "XXXX" for burning pain
"////" for stabbing pain "OOOO" for numbness/tingling
"SSSS" for other. Describe other: ____

____



Please submit this completed form by clicking "submit by email."
You may also print them for your own records. Thank you.