Date: _____

INLAND NEUROSURGERY AND SPINE

Sacred Heart Doctor's Building

105 W 8th Avenue, Suite 200 Spokane, Washington 99204 Phone: 509.624.9112 Fax: 509.624.1087 Web: www.neuroandspine.com

Name: (Last) _____ (First) _____ (MI) _____ Female ☐

Social Security No. _____ Age:_____ Birth Date: _____ Male ☐

Mailing Address:_____

City: _____State:_____ Zip Code: _____

E-mail Address: _____ OK to contact you by E-mail? ☐

Phone: Home: _____ Cell: _____

Work Number: _____ Employer: _____

Referring Doctor's Full Name: _____

Primary Care Provider's Full Name: _____

Other Medical Provider's Full Names: _____

Pharmacy: Name:_____Phone: _____Location: _____

What are you being seen for today? _____

Location of pain: (Please indicate right or left) _____

How long have you had these symptoms? _____

What helps? _____What makes it worse? _____

What treatments have you had? _____

Is your pain work related? ☐ Yes ☐ No Claim #: _____ Date of Injury:_____

Please mark the severity of your pain on the following line:

On your worst days with **W.** On your average days with **A.** On your best days with **B.**

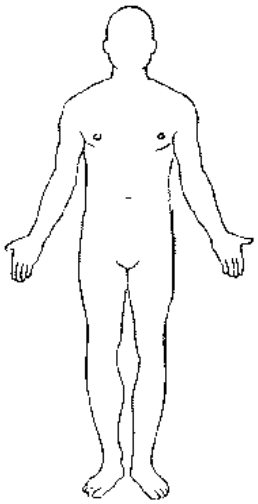
No pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Most severe pain imaginable

PAIN DIAGRAM

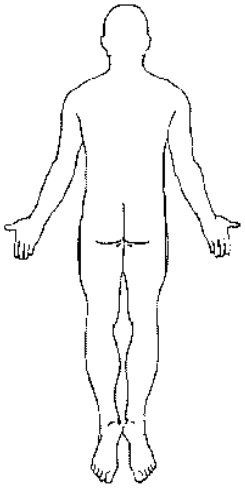
Mark the areas on your body where you feel the described sensations. Please mark all affected areas.

Use the appropriate symbols: Numbness --- Pins/Needles OOO Burning XXX Stabbing /// Aching +++

Front
Right



Left



Back
Right

REVIEW OF SYSTEMS

Do you currently have or have you had in the past 8-12 weeks:

General	Yes	No
Recent fever/chills	☐	☐
Significant weight loss	☐	☐
Skin		
Bruising	☐	☐
Rash	☐	☐
Eyes/Ears/Nose/Throat/Mouth		
Mouth sores	☐	☐
Change/blurring of vision	☐	☐
Double vision	☐	☐
Ear infections	☐	☐
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Vertigo	☐	☐
Nasal congestion	☐	☐
Recent sore throat	☐	☐
Respiratory		
Cough (recent or chronic)	☐	☐
Shortness of breath	☐	☐

Cardiovascular	Yes	No
Calf pain w/ walking	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Irregular heartbeat	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Blood in stools	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Genitourinary		
Painful urination	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Musculoskeletal		
Joint pain or swelling	☐	☐
Muscle pain	☐	☐

Neurological	Yes	No
Confusion	☐	☐
Memory loss	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Headaches	☐	☐
Balance problems	☐	☐
Numbness/tingling	☐	☐
Seizures	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Endocrine		
Excessive thirst	☐	☐
Cold/heat intolerance	☐	☐
Low blood sugar	☐	☐
Hormone replacement	☐	☐
Steroid use	☐	☐
Hematologic		
Excessive bleeding	☐	☐

PAST MEDICAL HISTORY

Check the medical problems you currently have or have had in the past.

☐ Cancer, If so, what type?
☐ Congestive heart failure
☐ Heart disease, Cardiologist:
☐ Hypertension (high blood pressure)
☐ Heart attack
☐ Heart murmur
☐ Diabetes: ☐Insulin ☐ Oral meds ☐ Diet controlled
☐ Hypothyroidism
☐ Depression
☐ Anxiety
☐ Blood clots (DVT/Pulmonary embolus)
☐ Kidney disease
☐ Hepatitis A ☐ B ☐ C ☐
☐ HIV
☐ Ulcers
☐ GERD (gastroesophageal reflux disease)
☐ History of blood transfusion (Reaction?_____)
☐ Rheumatoid arthritis
☐ Seizures/epilepsy
☐ COPD
☐ Asthma, If yes, last hospitalization: _____
☐ Sleep apnea, If yes, do you use a CPAP? _____
☐ Stroke
☐ MRSA (*Methicillin resistant staph aureus)*

Other: _____

_____

ALLERGIES

Please list all allergies, including medications, iodine, contrast, and latex.

None known ☐ -OR - Yes, ☐ Please list them: _____

_____

_____

*Pediatric Patients (Ages 0-16): Are immunizations current? ☐ Yes ☐ No

FAMILY HISTORY Please list family history. If yes, list relative (paternal or maternal), if they are living or age at death.

Problem List	Yes	No	Relative (paternal/maternal)	Living	Deceased	Age at death
Blood clotting disorders	☐	☐	_____	☐	☐	_____
Cancer, what type? _____	☐	☐	_____	☐	☐	_____
Diabetes	☐	☐	_____	☐	☐	_____
Heart disease	☐	☐	_____	☐	☐	_____
Heart attack	☐	☐	_____	☐	☐	_____
Hypertension (High blood pressure)	☐	☐	_____	☐	☐	_____
Stroke	☐	☐	_____	☐	☐	_____
Other _____			_____	☐	☐	_____
_____			_____	☐	☐	_____

SOCIAL HISTORY

Current/history of drug use?	☐ Yes	☐ No	If yes, describe: _____
Do you drink alcohol?	☐ Yes	☐ No	If yes, ☐ Occasional ☐ Moderate ☐ Heavy
Smoke currently?	☐ Yes	☐ No	If yes, _____ packs/day for ____ years
Quit smoking?	☐ Yes	☐ No	If yes, how long ago did you quit? _____
Do you use smokeless tobacco or chew?	☐ Yes	☐ No	☐ Previously
Are you married?	☐ Yes	☐ No	If yes, what is your spouse's name? _____
Employed:	☐ Yes	☐ No	☐Full-time ☐ Part-time ☐ Disabled ☐ Retired Occupation: _____
Do you have children?	☐ Yes	☐ No	If yes, number of children: _____
Student:	☐ Yes	☐ No	*Pediatric patients (Ages 0-16) Grade level: _____ Name of school/daycare attending: _____

MEDICATIONS List ALL medications, including over-the-counter products, minerals, vitamins, herbal, and dietary supplements. For pain medications, please include the date started and if it provided relief.

Drug name	Dose/How often	Drug name	Dose/How often

PAST SURGICAL HISTORY Please list all surgeries you have had, including the date. Circle Right or Left, if applicable.

PRIOR JOINT SURGERIES					Date	OTHER SURGERIES			Date
Hip:	☐ No	☐ Yes	R	L	_____	Heart surgery/Heart stents	☐ No	☐ Yes	_____
Knee:	☐ No	☐ Yes	R	L	_____	Appendectomy	☐ No	☐ Yes	_____
Shoulder:	☐ No	☐ Yes	R	L	_____	Tonsillectomy	☐ No	☐ Yes	_____
Neck:	☐ No	☐ Yes			_____	Gallbladder	☐ No	☐ Yes	_____
Back:	☐ No	☐ Yes			_____	Hysterectomy	☐ No	☐ Yes	_____
Other surgeries not listed, type & date:						_____			_____
_____					_____	_____			_____
_____					_____	_____			_____

Problems with anesthesia? Yes ☐ No ☐

DIAGNOSTIC STUDIES Which of the following diagnostic tests have been done on your back/neck? Please indicate date.

	Yes	No	Date	*(MD Use Only)*
Regular Spine X-ray	☐	☐	_____	_____
CT Scan	☐	☐	_____	_____
Myelogram	☐	☐	_____	_____
MRI Scan	☐	☐	_____	_____
Discogram	☐	☐	_____	_____
Bone Scan	☐	☐	_____	_____
EMG	☐	☐	_____	_____
Nerve Blocks	☐	☐	_____	_____
Facet Blocks	☐	☐	_____	_____

Are you claustrophobic? Yes ☐ No ☐ Do you have any metal in your body? Yes ☐ No ☐

CONSERVATIVE CARE What types of conservative care have you tried? (Physical therapy, chiropractic, massage therapy)

What type?	Where?	How long (date range, # of visits)	Did you get relief?

Language:			
Ethnicity:	☐ Hispanic/Latino	☐ Not Hispanic/Latino	☐ Refuse to Report
Race:	☐ American Indian/Alaska Native	☐ Asian	☐ Black/African American
☐ White	☐ More than 1 Race	☐ Pacific Islander	☐ Refuse to Report

Weight: _____ Height: _____ Dominant hand: ☐ Right ☐ Left

[Office use only: BP: _____/_____ P: _____ RR: _____]

Nearest friend/relative to contact in case of an emergency, ***NOT*** living with you:

Name: (Last) _____ (First) _____ (MI) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Relationship to Patient: _____

Patient/Guardian's Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION

Patient Name: _____ Social Security Number: _____

Guarantor Name: _____ Social Security Number: _____

Guarantor Date of Birth: _____ Telephone Number: _____

Guarantor Address: _____

Is injury work related? Yes _____ No _____ If Yes, Claim #: _____
Date of Injury: _____ Employer: _____
Is your claim open? Yes _____ No _____

If Self-Insured Worker's Compensation (please provide the following):

Insurance Company: _____ Claim Manager: _____
Billing Address: _____ Phone Number: _____
_____

Is injury auto accident related? Yes _____ No _____ If yes, Insurance Carrier: _____
Billing Address: _____ Adjustor Name: _____
_____
Phone Number: _____ Date of Accident: _____
Claim Number: _____ Is your claim open? Yes _____ No _____

Primary Health Insurance: _____ Policy #_____ Group # _____
Subscriber Name:_____ Relationship to Patient: _____
Subscriber DOB: _____ Subscriber Phone Number: _____

Secondary Health Insurance (if applicable): _____ Policy #_____ Group # _____
Subscriber Name:_____ Relationship to Patient: _____
Subscriber DOB: _____ Subscriber Phone Number: _____

Is your insurance company an HMO or Medicare Replacement/Advantage Plan? Yes _____ No _____

Who is your primary care physician? (First, Last Name): _____
Phone Number: _____

- **PLEASE BRING And PRESENT INSURANCE CARDS AT THE TIME OF YOUR VISIT.**
- **ALL CO-PAYMENTS OR DEPOSITS ARE DUE AT THE TIME OF YOUR VISIT.**
- **If you have no <u>health insurance</u> to bill, as a new patient you will be required to make a deposit of $75.00 at the time of service. For returning patients, you will be required to make a deposit of $50.00 at the time of service, and will be quoted prior to your visit. (Auto PIP/MedPay is not considered health insurance).**

Providence Inland Neurosurgery and Spine relies on the insurance and billing information provided to us by you or your referring provider. After services are provided, Providence will submit our claim to your insurance carrier if applicable. It is the patient's responsibility to contact the financial services department if this obligation cannot be met. If you need assistance with payment, you may wish to contact Providence Financial Counselors at 1-877-215-7833.

ASSIGNMENT: I HAVE READ, COMPLETED, AND FULLY UNDERSTAND THE INFORMATION ABOVE. I HEREBY AUTHORIZE PAYMENT OF MY INSURANCE BENEFITS DIRECTLY TO THE PHYSICIAN AND RELEASE OF ANY INFORMATION REQUIRED.

Signature _____ Date _____