Back and Neck Questionnaire

Name ___________    Date__________

Age ______    Primary Care Physician ____________________

- Is your pain sharp, stabbing, dull, tingling, pins and needles, cramping? (Circle all that apply.)
- Rank severity of your pain from 0 to 10 (10 being extremely painful)
- How long have you had this pain?
- Is your pain occasional, frequent, or constant? (Circle one)
- Does your pain radiate to your arms and/or legs? (If so, circle)
- Is your pain worse with bending, twisting, coughing, straining, prolong sitting, prolong standing, prolong walking, lifting? (Circle all that apply)
- Explain if your pain is improved with sitting, medication, massage, walking? (Circle all that apply or write N/A if none apply)
- Do you get cramping in your legs with walking? (Circle one): Yes    No
- Do you have pain in your shoulders or hips? (Circle one): Yes    No
- Is your pain associated with any injury, or has it occurred over time? Please explain:

- What type of treatment have you had up to this point? Physical therapy, chiropractic, massage therapy, medication, acupuncture, epidural injection, or surgery? (Circle all that apply. If you have had any other treatment that's not listed, please list):

Weight:___________    Height:___________
**Medical History:** (Circle Yes or No)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
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<tr>
<td>Heart Trouble</td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Medical Condition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If yes, please explain)

**Previous Hospitalizations/Surgeries/Serious Injuries/Complications? When?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Social History:**

Career/job: ____________________________

Hobbies/Sports: ____________________________

Who lives at home with you?

- **Use of alcohol:**
  - Never: ________
  - Rarely: ________
  - Moderate: ________
  - Daily: ________
  
  If stopped, when? ________ Rehab: ________

- **Use of tobacco:**
  - Never: ________
  - Previously, but quit (Date): ________
  - Daily: ________
  
  # of packs/day: ________

- **Use of drugs:**
  - Never: ________
  - Type/Frequency: ________
  
  Rehab: ________

**Family Medical History:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Diseases</th>
<th>If deceased, cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Mother</td>
<td>________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Siblings</td>
<td>________</td>
<td>____________________________</td>
</tr>
<tr>
<td>Children</td>
<td>________</td>
<td>____________________________</td>
</tr>
</tbody>
</table>
Patient Name:___________________ Date of Birth:_____________

**Review of System:**

Please circle all that applies for today's visit:

- **General:** fever, chills, fatigue, night sweats, weight loss or weight gain.
- **Eyes:** diplopia, blurred vision, eye pain and redness, cataract & glaucoma.
- **ENT:** headache, hearing loss, ear pain, tinnitus, sinusitis, sore throat and hoarseness.
- **GI:** indigestion, heartburn, vomiting and bowel changes.
- **GU:** painful urination, flank pain, urgency, frequency, blood urine.
- **Nuero:** fainting, weakness and loss of coordination.
- **Musculoskeletal:** back/neck pain, muscle weakness and cramps, joint pain, edema, stiffness, and cold extremities.
- **Endocrinology:** heat/cold intolerance, weight changes, excessive thirst, excessive urination.
- **Skin:** rash, eruption, itching, pigment changes.
Please circle area where your pain is and where it radiates to:

Patient Signature: ___________________________  Date: ___________________________

E-mail: ___________________________
Patient Registration Form

Date of Registration: _______________ Family Physician: ______________________________________

DEMOGRAPHIC:
Name of Patient: ______________________ Social Security #: _________________________________
Birthday: _____________________________ Sex: ________________________________
Home Address: ________________________ City: ________________________________
State: _______________________________ Zip Code: ______________________________
Home Phone: __________________________
Work Phone: __________________________
Cell Phone: __________________________

EMPLOYER INFORMATION:
Name: _______________________________ Occupation: ________________________________
Address: ______________________________

INSURANCE INFORMATION:
Insurance: _________________________________________________________________
Policy Holder Name: ______________________ Policy Holder DOB: __________________________

FAMILY CONTACT INFORMATION:
Name of Spouse: ____________________________
Contact Person In Case of Emergency: ____________________________
Phone: ________________________________

Referred By (Name & Address): __________________________________________

I hereby authorize the medical staff to be my attending physicians and to administer to me any examination treatment, and medications he or she deems therapeutic to my complaints. I hereby authorize the release of any information to insurance carriers to process my medical claims and I irrevocably assign to the doctors at Innovative Orthopedic & Spine Surgery all payments for medical services rendered. I understand that I am responsible for payments for services not covered by my insurance company.

Signature of Patient (or responsible party-please mark relation to patient): ______________________________
Medication List:

Patient Name: ________________________________

Date of Birth: ________________________________

(Please make sure to include the dosage and how you're taking them).

1. __________________________________________

2. __________________________________________

3. __________________________________________

4. __________________________________________

5. __________________________________________

6. __________________________________________

7. __________________________________________

8. __________________________________________

9. __________________________________________

10. __________________________________________

11. __________________________________________

12. __________________________________________

13. __________________________________________

14. __________________________________________

15. __________________________________________
Non-Medicare Patients Release and Assignment:

I state the above is true and correct and do here by authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physician. I understand that this office will make reasonable effort to my insurance company(ies), yet, I am ultimately responsible for any balance left uncollected. If after 90 days my insurance has not paid my provider, I will be expected to pay for the outstanding balance. I am also informed that as a courtesy to patients who may be in need of an earlier appointment, our office requires at least 24 hours notification or be responsible for a $50.00 late charge or complete payment for a no show.

Signature: ___________________________ Date: ___________________________

Medicare Patient’s Please Read and Sign:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to my physician for any services furnished me by that physician. I authorize any holder of medical information about me to release the HEALTH CARE FINANCING Administration and its agents any information needed to determine this benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1 500 claim form or elsewhere of other approved claim forms or electronically submitted claims, my signature authorizes, releasing of the information to the insurer or agency shown. In determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature: ___________________________

Date: ___________________________

Members of out-of-network insurance please read and sign:

I understand that Doctor Morteza Farr, Innovative Spine Surgery are not preferred providers for: ___________________________

I agree to pay any and all charges that are accumulated due to my treatment that my insurance does not pay.

Signature: ___________________________ Date: ___________________________
Acknowledgement of Receipt of Notice of Privacy Practices

Name of patient: DOB:

I hereby acknowledge that I received a copy of this medical practice’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________________

Dated: ______________

If not signed by the patient, please indicate relationship: (Check please)

○ Parent of guardian of minor patient
○ Guardian or conservator of an incompetent patient
○ Beneficiary or personal representative of deceased patient
PLEASE READ AND SIGN THIS MESSAGE AS IT EXPLAINS OUR OFFICE POLICIES

Our goal is to provide all our patients with the highest level of care and satisfaction. Please take the time to fill our Patient Data Forms out completely. Any information left blank will result in a less than productive visit.

Insurance information must be completed on our form and a copy of your insurance card is required. If you have insurance, but fail to bring your card with you at the time of the visit, you will have 24 hours to provide us with a copy either in person or by facsimile. If a card is not received within 24 hours, you will receive a statement in the mail.

You are responsible for all co-payments, co-ins, and deductibles at the time of service. Cash, all major credit cards and debit cards are acceptable payment methods also offer Care Credit to arrange payment plan. There is at least a 24 hour requirement for cancellation for appointments and a $50.00 fee will be charged for any missed appointment.

PRESCRIPTION REFILLS: All prescription refills must be faxed to our office by your pharmacy and you must allow 72 hours for processing refills. No REFILL ON ANY PRESCRIPTION OVER WEEKEND OR HOLIDAYS. REQUESTS SUBMITTED OF FRIDAYS WILL NOT BE REFILLED UNTIL THE FOLLOWING MONDAY.

FORMS: It will take no more than 2 weeks for the procession of ANY forms. We will make every attempt to complete them sooner; however, the filling out of forms is a time consuming and extremely labor-intensive process, and we are limited to non-clinical days to complete them. A fee of $20 per page is due and payable at the time forms are submitted.

REQUESTS FOR MEDICAL RECORDS: ALL of our Medical records are stored electronically and must be reviewed by the physician before release. This takes a fair amount of time. Please allow a minimum of 2 weeks for processing. There is a $0.20 per page charge and an administrative fee for processing as allowed by the state of CA. You will be notified in advance of the total charges. Payment is due prior to medical records being released.

Thank you for your cooperation.

Patient's Name: ___________________________ Date: ______________

Responsible Party’s Name: _________________________________________

I have read and agree to the above office policy:

________________________
Signature of person Financially responsible (Relationship to Patient)