Patient Medical History

DISC & SPINE

Patient Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Primary Care Physician: _____ Referred by: _____

CHIEF COMPLAINT: _____ Pain Level (1-10): ____

Was this MVA related? _____ Work-related Injury? _____ Date of Onset: _____

Previous Treatment: ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncture ☐ Medications ☐ Massage Treatment ☐ Epidural ☐ Injections/Other: _____

DRUG ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES

☐ Local Anesthesia ☐ Narcotics ☐ NSAIDs ☐ Penicillin ☐ Latex Other:_____

MEDICATIONS

Please list any medications or supplements that you take REGULARLY including dosage and frequency.

Name of Drug	Dosage	Purpose	Physician

PRIOR SURGERY

Name of Operation	Reason	Date	Location	Physician

PERSONAL ILLNESSES / FAMILY MEDICAL HISTORY

Health Issues	YES	NO	Health Issues	YES	NO
Cancer			Cancer		
Heart disease/heart attack			Heart disease/heart attack		
Stroke			Stroke		
Hypertension (HBP)			Hypertension (HBP)		
High cholesterol			High cholesterol		
Diabetes			Diabetes		
Hepatitis/HIV			Bleeding problems/blood clots		
Bleeding problems/blood clots			Other:		

SOCIAL HISTORY

Occupation: _____ Employer: _____ Still Employed? _____

Do you exercise? ☐ Y ☐ N Frequency: _____

Do you smoke? ☐ Y ☐ N Do you drink? ☐ Y ☐ N Use recreational drugs? ☐ Y ☐ N

Marital Status: _____ Lives with: _____

Patient Medical History

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Patient Name: _____

REVIEW OF SYSTEMS:

Please answer **Yes**, if you experienced any of the following in the ***last few weeks or months***. If you have no recent complaints, please check: ☐ **NONE**

GENERAL

Fatigue	Yes
Decreased appetite	Yes
Fevers	Yes
Weight loss	Yes
Weight gain	Yes
Insomnia	Yes
Do you have a living will	Yes
Do you smoke	Yes
Do you drink alcohol	Yes
Are you in pain 1-10	Yes

EYES, EARS, NOSE and THROAT

Visual changes	Yes
Hearing loss	Yes
Sore throat	Yes
Nasal Congestion	Yes
Runny nose	Yes
Ear Pain	Yes

NECK

Swollen Glands	Yes

RESPIRATORY

Shortness of breath	Yes
Cough	Yes
Wheezing	Yes

CARDIOVASCULAR

Chest pain	Yes
Palpitations	Yes
High blood pressure	Yes
Stroke	Yes

DIABETES

A1C Results	Yes
Blood Sugars	Yes
CGM – Sensor Problems	Yes
CGM – Sensor Readings	Yes
Digestion problems	Yes
Labs	Yes
Lipids	Yes
Loss of consciousness	Yes
Medications	Yes
Meter Problems	Yes
Meter Readings	Yes
Pump Problems	Yes
Pump Settings	Yes
Sores on feet	Yes
Tingling/numbness –Feet	Yes

GASTROINTESTINAL

Abdominal pain	Yes
Constipation	Yes
Bloody stool	Yes
Diarrhea	Yes
Heartburn	Yes
Nausea/Vomiting	Yes

GENITOURINARY

Change in bowel habits	Yes
Painful urination	Yes
Bloody urine	Yes
Increased urination	Yes
Leaking Urine	Yes
Erectile Dysfunction	Yes

GYNECOLOGIC

Irregular Menses	Yes
Abn. Vaginal Discharge	Yes
Pelvic Pain	Yes
Pain with intercourse	Yes
Painful Menses	Yes
Pregnant	Yes

SKIN

Rashes	Yes
Itching	Yes
Mole Changes	Yes

MUSCULOSKELETAL

Joint pain	Yes	Where?
Muscle pain	Yes	Where?
Leg swelling	Yes	Where?

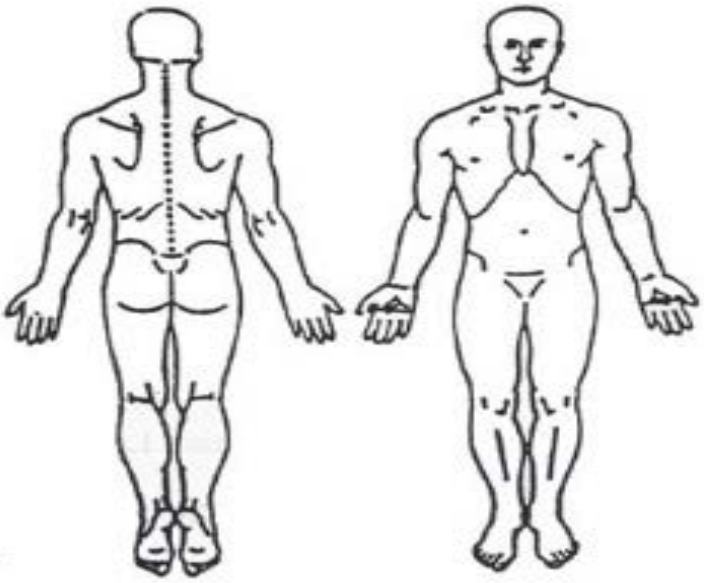
NEUROLOGIC

Headaches	Yes
Dizziness	Yes
Difficulty walking	Yes
Numbness or tingling	Yes

PSYCHIATRIC

Anxiety	Yes
Irritability	Yes
Sexual Problems	Yes
Suicidal Ideation	Yes
Depression	Yes
Concerns about your emotional or physical safety?	Yes

Please mark with an X where you are experiencing pain.



Are you pregnant? [ ] Yes [ ] No

If yes, date of delivery _____

Have you had blood transfusion previously?

[ ] Yes [ ] No

Patient's Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

DISC & SPINE

PATIENT REGISTRATION FORM

RR □ VT □

Patient Name:_____

DATE OF BIRTH: _____ Social Security #: _____ ☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Other (*please specify*): _____

Race/Ethnicity: _____ Primary Language: _____

Mailing Address: _____ Apt/Suite #: _____

City _____ State _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred: ☐ Home ☐ Cell ☐ Work

Email Address: _____

PRIMARY CARE PHYSICIAN: _____ Phone No.: _____

REFERRED BY: _____

EMPLOYMENT:

Employer's Business Name: _____ Occupation: _____

Current Status: ☐ Full-time ☐ Part-time ☐ Seasonal ☐ Retired ☐ Unemployed ☐ Student

RESPONSIBLE PARTY INFORMATION:

Complete if patient is 17 or younger. Any legal guardian/parent presenting a minor patient for medical services is considered financially responsible for services rendered. Any minor patient accompanied by an adult other than their legal guardian/parent must present written and notarized authorization for medical treatment from the legal guardian/parent prior to services being rendered.

Full Name: _____ Social Security #: _____

Relation to patient: _____ Date of Birth: _____

Address (if different from above): _____

Phone Number: _____ Employer: _____

EMERGENCY CONTACT (*if different from above*):

Full Name: _____ Relation to patient: _____

Phone Number: _____ City, State: _____

HOW WILL THE SERVICE BE PAID?

☐ Private Insurance ☐ Worker's Compensation ☐ Self-pay (NO Insurance)

☐ OTHER (need complete documents): _____

Patient Signature: _____

Today's Date: _____

DISC & SPINE

INSURANCE INFORMATION 2

FULL NAME: _____

PRIMARY INSURANCE:

Insurance Company Name: _____ ☐ PPO ☐ HMO ☐ EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

- *If Policyholder/Subscriber for Primary Insurance is different from patient, please answer below.*

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (*if issued through employment*): _____

SECONDARY INSURANCE:

Insurance Company Name: _____ ☐ PPO ☐ HMO ☐ EPO

Address: _____

Subscriber's ID #: _____ Policy or Group #: _____

- *If Policyholder/Subscriber for Secondary Insurance is different from patient, please answer below.*

Name: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Complete Address: _____

Employer (*if issued through employment*): _____

DO YOU HAVE AN ATTORNEY? ☐ YES ☐ NO

If YES, who? _____ Phone Number: _____

Address: _____ Which Law Firm? _____

WORK RELATED INJURIES:

Date of Injury: _____ Claim Number: _____

Worker's Compensation Carrier: _____

Address: _____

Claim Adjuster's Name: _____ Phone Number: _____

FAX: _____ **Do you require an interpreter? Yes No**

Employer at time of Injury: _____

Supervisor's Name: _____ Phone Number: _____

Patient Signature: _____

Today's Date: _____

DISC & SPINE

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Robert A. Rovner, MD, *A Professional Corporation*
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Fellow American Academy of Orthopedic Surgery

Vikram Talwar, MD, *Incorporated*
Diplomate American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient Name: _____ Date of Birth: _____

I understand that as part of my healthcare, Dr. Rovner and Dr. Talwar originate and maintain health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

Please refer to the "Privacy Policy" Brochure, refer to the "Request Restrictions section. This brochure is available in the office upon request.

Please answer the following 3 questions:
I request the following restrictions to use or disclose of my health information:

1) Medical Information can be discussed with:
Patient Only ☐ Yes
Family Member or Friend
(Please list Name/Relationship)
_____
_____
_____
Physician: _____
Attorney: _____
Other: _____

2) Detailed messages regarding test results can be left on answering machine
☐ Yes Phone Number: _____
☐ No

3) Do you authorize our office to send an automated voice message reminder:
☐ Yes Phone Number: _____
☐ No

Signature of Patient or Legal Representative:

_____ _____ _____
Date Witness

Relationship to Patient: _____