



Date: _____ Physician to be seen: _____

Name (First, MI, Last): _____

DOB: _____ Age: _____ Gender (Circle One): MALE FEMALE

Primary Phone#: _____ Secondary Phone#: _____

Address (Street, City, State, Zip): _____

SSN: _____ Email Address: _____

Emergency Contact Name: _____

Phone#: _____ Relation: _____

Referring Physician: _____ How did you hear about us? _____

Primary Care Physician: _____

Pharmacy: _____ Pharmacy Phone#: _____

Please Circle One: SINGLE MARRIED DIVORCED WIDOWED

Race (Circle): ASIAN AFRICAN/AMERICAN HISPANIC INDIAN LATINO WHITE

OTHER: _____

Ethnicity (Circle One): Hispanic/Latino Non-Hispanic/Latino Refuse to Report

Is this a work related injury? (Circle) YES NO Adjuster Name: _____ Phone#: _____

Insurance (Check which applies): Insurance _____ Self Pay _____

Primary Insurance Company: _____ Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Member ID#: _____ Group #: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Policy Holder: _____ Policy Holder DOB: _____

Member ID#: _____ Group #: _____

Please be advised that DFW CENTER FOR SPINAL DISORDERS does not treat injuries acquired by an accident where a third party entity is held liable for the incident (i.e. homeowner's insurance, auto insurance, etc.). DFW CENTER FOR SPINAL DISORDERS only files claims on personal insurance and worker's compensation and any appointments made under any other circumstances will be cancelled. I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date: _____

PLEASE FILL OUT COMPLETELY

Patient Name: _____

Date of Birth: ____/____/____

Please list any known allergies and types of reactions:

Are you allergic to Latex: Yes No

Past Medical History and current medical condition: None

Please mark any of the following symptoms that you currently or chronically experiencing:

| | | | |
|-------------------------------|-----------------------------------------------|------------------------------|----------------------------------------|
| Y | <u>Constitutional Symptoms</u> _____ Y | <u>Eyes</u> _____ Y | <u>Gastrointestinal</u> _____ Y |
| | <u>Genitourinary</u> | | |
| | Fatigue | Vision loss | Diarrhea |
| | Fever/chills | Wears glasses/contacts | Incontinence |
| reflux | Kidney problems | | Heartburn/ |
| | Recent weight gain Y | <u>Endocrine</u> | Liver problems |
| Menopausal | Recent weight loss | Always thirsty | Nausea/vomiting Y |
| | <u>Neurological</u> | | |
| Y | <u>Ear, Nose, Mouth, & Throat</u> | Appetite increase/decrease | |
| Ulcers | Fainting/blackouts | | |
| | Dentures/bridges/braces | Sensitivity to heat/cold | Y |
| | <u>Hematologic/Lymphatic</u> | Poor coordination | |
| | Hearing loss | Thyroid disease | Anemia |
| Seizures | Mouth lesions | Diabetes | Bleeding problems |
| Stroke/paralysis | Nose bleeds Y | <u>Cardiovascular</u> | DVT/blood clots |
| | Weakness | Ankle Swelling | Easy bruising Y |
| | Ringing in ear | | |
| | <u>Psychiatric</u> | | |
| | Sinus infections | Chest pain/heart attack | Lupus |
| | Anxiety | | |
| Y | <u>Integumentary (skin)</u> | High/low blood pressure | Y |
| <u>Musculoskeletal</u> | Depression | | |
| | Cancer | Irregular heartbeat | Broken bones |
| Substance dependence | Itching Y | <u>Respiratory</u> | Difficulty walking |
| Trouble sleeping | Rash | Asthma | Joint pain |
| | Skin-related problems | Bloody cough | Joint stiffness |
| | | Shortness of breath | Joint swelling |
| | | Sputum in cough | Uses cane/walker/wheelchair |
| | | Waking up short of breath | |

Family Medical History: **No Known History**

Social Lifestyle:

Alcohol Use Y N If yes, amount: _____

Illegal Drug Use Y N If yes, what type: _____

Prescription Drug Abuse Y N If yes, what type: _____

Tobacco Use Y N If yes, amount daily _____ / yrs

Interested in quitting tobacco? Y N

PLEASE FILL OUT COMPLETELY

Patient Name: _____

Date of Birth: ____/____/____

List of Medications and Dosage:
patient

See list provided by

List of Surgeries:
patient

See list provided by

| Procedure | Year |
|------------------|-------------|
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Have you had any past problems with anesthesia? Y N

If yes, please explain:

Height: _____

Weight: _____

Chief Complaint:

Reason for your visit today:

Symptoms:

—

Date of Injury or when symptoms started:

Describe how the injury or problem occurred:

What treatment have you already tried? :

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient (or Guardian) Signature: _____ Date:

Physician Signature: _____ Date:

PLEASE FILL OUT COMPLETELY

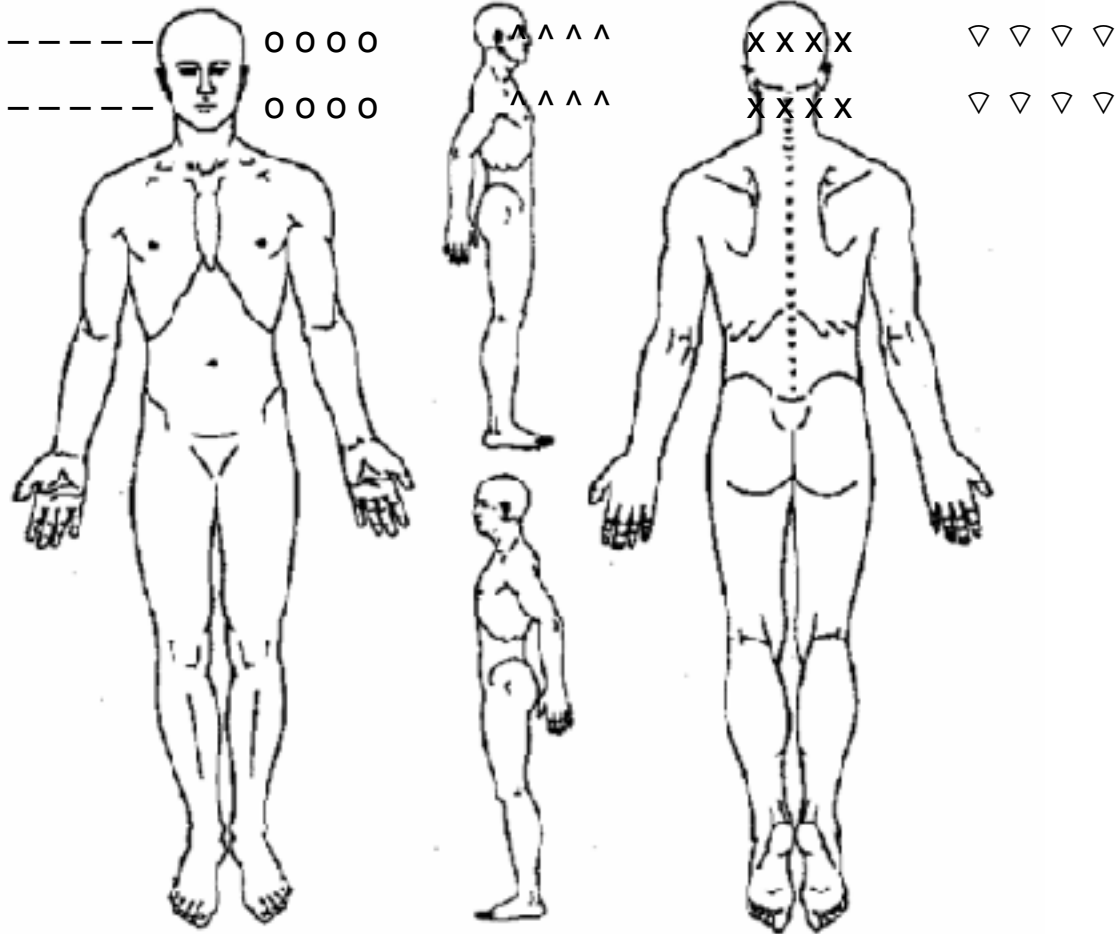
Patient Name: _____

Date of Birth: ____/____/____

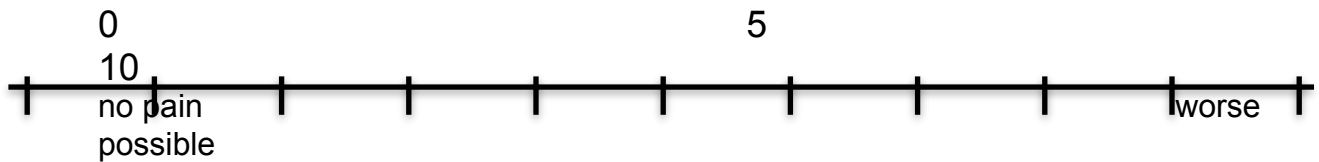
Pain Diagram

Please mark the area of injury or discomfort on the chart below using the appropriate symbols.

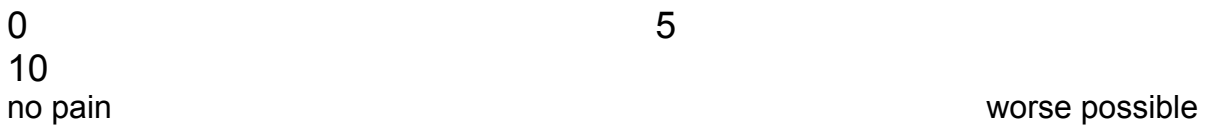
| | | | | |
|----------|----------------|---------|---------|----------|
| Numbness | Pins & Needles | Burning | Aching | Stabbing |
| ----- | o o o o | ^ ^ ^ ^ | x x x x | ▽ ▽ ▽ ▽ |



PLEASE MARK ON THE LINE: How bad is your neck/back pain now?



How bad is your arm/leg pain now?



Patient Name: _____

Date of Birth: ____/____/____

Acknowledge and Acceptance of Privacy Notice and Practice (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practice. I give my consent to release personal information for the purposes of treatment, referrals, research, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing.

I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person (s) permitted to receive my medical records other than listed in the paragraph
one.

No restrictions – may

release information if required to anyone.

Restrictions: List who we may release information to regarding your healthcare:

I wish to be contacted in the following manner (Check all that applies):

Home Phone #: ____/____/____

Cell #: ____/____/____

O.K. to leave message with detailed information.

Leave message with call back number only.

Work Phone #: ____/____/____

O.K. to leave message with detailed information.

Leave message with call back number only.



Patient (or Guardian)

Signature:

_____ **Date:** _____

PLEASE FILL OUT COMPLETELY

Patient Name: _____

Date of Birth: ____/____/____

Office Policies:

Welcome to DFW Center for Spine Disorders. We realize you have a choice for your medical care, and we are pleased you have chosen us to provide your care. Please be advised that our offices house four physicians, an ambulatory surgery center and a physical therapy center. Due to services being rendered in three separate areas, the wait times vary based on the number of patients being treated in that particular area. Please do not be alarmed if someone who comes in after you is called back before you as they may be being seen in a different area. As long as you sign in, our receptionist will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionist of any address changes, phone number changes, or change in insurance **before** you are seen.

Prescription request:

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill request. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day. (NOTE: Dr. Tinley does not refill narcotic prescriptions without seeing you in the office.)

Clinical Questions:

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and cannot be called away from patients to speak to you. Our receptionist will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Patient Forms:

Please be aware that we charge \$25.00 to complete the following paperwork:

AFLAC

FMLA

Disability

We require 4-5 business days to complete any paperwork given.

I have read and fully



understand the above information.

Patient (or Guardian) Signature: _____ **Date:**

PLEASE READ CAREFULLY AND SIGN

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the DFW Center for Spinal Disorders and its representatives (hereinafter, “My Authorized Representatives”) and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Discuss or divulge any of my personal health information or that of my dependents with the health plan

I certify that the health insurance information that I provided to DFW Center for Spinal Disorders is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from DFW Center for Spinal Disorders are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may

have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____. I understand I can revoke this authorization in writing at any time.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient

Date