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		**Constitutional Symptoms**	Y		**Eyes**	Y		**Gastrointestinal**	Y		**Genitourinary**
		Fatigue			Vision loss			Diarrhea			Incontinence
		Fever/chills			Wears glasses/contacts			Heartburn/reflux			Kidney problems
		Recent weight gain	Y		**Endocrine**			Liver problems			Menopausal
		Recent weight loss			Always thirsty			Nausea/vomiting	Y		**Neurological**
Y		**Ear, Nose, Mouth, & Throat**			Appetite increase/decrease			Ulcers			Fainting/blackouts
		Dentures/bridges/braces			Sensitivity to heat/cold	Y		**Hematologic/Lymphatic**			Poor coordination
		Hearing loss			Thyroid disease			Anemia			Seizures
		Mouth lesions			Diabetes			Bleeding problems			Stroke/paralysis
		Nose bleeds	Y		**Cardiovascular**			DVT/blood clots			Weakness
		Ringing in ear			Ankle Swelling			Easy bruising	Y		**Psychiatric**
		Sinus infections			Chest pain/heart attack			Lupus			Anxiety
Y		**Integumentary (skin)**			High/low blood pressure	Y		**Musculoskeletal**			Depression
		Cancer			Irregular heartbeat			Broken bones			Substance dependence
		Itching	Y		**Respiratory**			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: ☐ **See list provided by patient**

_____
_____
_____
_____
_____

List of Surgeries: ☐ **See list provided by patient**

Procedure	Year

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: _____

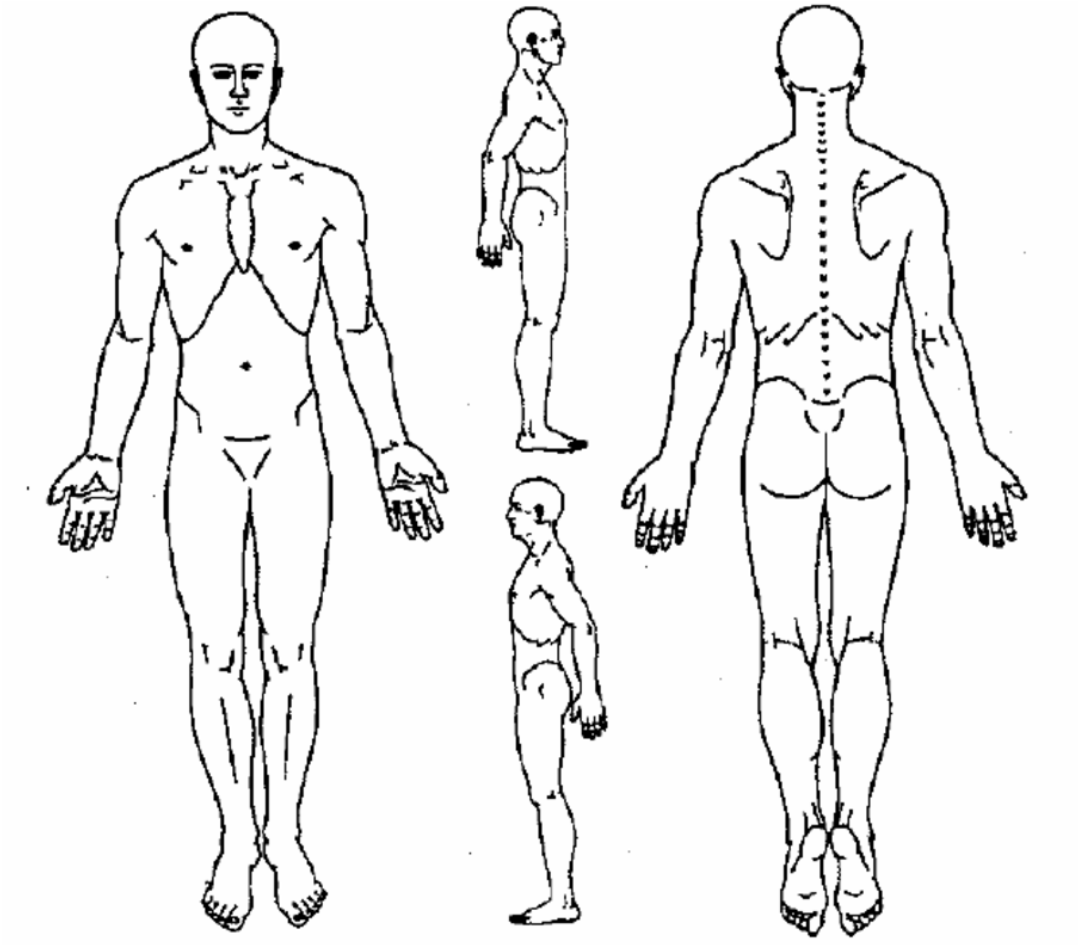
PLEASE FILL OUT COMPLETELY

Patient Name: _____ Date of Birth: ____/____/_____

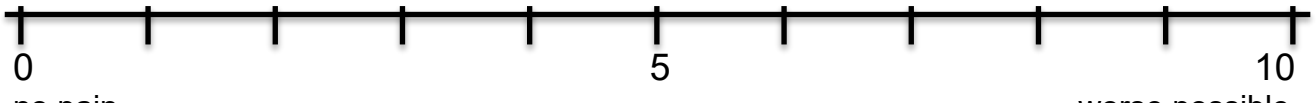
Pain Diagram

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

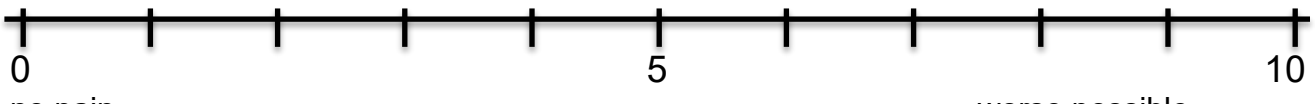
Numbness	Pins & Needles	Burning	Aching	Stabbing
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
– – – – –	o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



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 note that we have multiple providers in our office and 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 by a different provider. 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