

Spine & Sports Medicine Associates
A Division of Comprehensive Orthopedics and Sports, PC
Advanced Care for Pain Relief, Spinal Rehabilitation & Sports Injuries

www.spinesportsct.com

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62 Buckland St., Suite 301 • Manchester, Connecticut 06040 • Tel: (860) 533-1111 • Fax: (860) 812-0231

CONFIDENTIAL PATIENT INFORMATION

TODAY'S DATE: ___/___/___

NAME: _____ SS#: _____ - _____ - _____ DOB: ___/___/___ AGE: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ - _____ WORK PHONE: (____) _____ - _____ CELL PHONE: (____) _____ - _____

EMAIL: _____ OCCUPATION: _____ MARITAL STATUS: S M W D

EMPLOYER: _____ EMPLOYER ADDRESS: _____

LIST PRESENT COMPLAINTS OR INJURIES:

WHEN AND HOW DID YOUR CONDITION START? _____

DID YOU SEE ANY OTHER DOCTORS FOR THIS CONDITION OR RECEIVE CARE AT A HOSPITAL? IF YES,
WHEN AND WHERE? _____

PRIMARY PHYSICIAN OR FAMILY DOCTOR'S NAME: _____

DATE OF LAST EXAMINATION: _____

INSURANCE INFORMATION

THIS PORTION MUST BE FILLED OUT IN ALL CASES:

PRIMARY HEALTH INSURANCE COMPANY: _____

INSURED: _____ ID#: _____

SECONDARY HEALTH INSURANCE COMPANY: _____

INSURED: _____ ID#: _____

AUTOMOBILE INSURANCE (CAR ACCIDENTS ONLY) _____

POLICY#: _____

WORKERS COMPENSATION INSURANCE CARRIER: _____

CLAIM #: _____ CLAIM REP/CASE MANAGER: _____

TRAUMA • SPINE AND SPORTS REHABILITATION • PHYSIOTHERAPY • CHIROPRACTIC

FINANCIAL RESPONSIBILITY STATEMENT

I UNDERSTAND AND AGREE THAT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT "COMPREHENSIVE ORTHOPEDIC & SPORTS PHYSICAL THERAPY PC" WILL PREPARE NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO "COMPREHENSIVE ORTHOPEDIC & SPORTS PHYSICAL THERAPY PC" WILL BE CREDITED TO MY ACCOUNTS UPON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME BY "COMPREHENSIVE ORTHOPEDIC & SPORTS PHYSICAL THERAPY PC" ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, AGAINST THE DOCTOR'S RECOMMENDATION, MY ACCOUNT BALANCES WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE _____

DATE: ____ / ____ / ____ SOCIAL SECURITY #: _____

OTHER RESPONSIBLE PARTY _____ SS#: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. If you are involved in any legal action or third party suit, this will also allow your attorney access to your records.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

I have received a copy of the offices' Notice of Privacy Practices

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Major Complaint Information

What is your chief complaint? _____

When did this symptom(s) begin? _____

What makes it worse? _____

What makes it better? _____

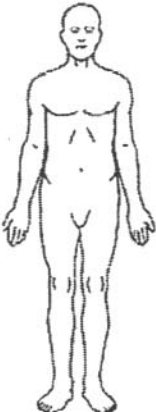
Is the pain worse in the AM or PM? _____ Does the pain radiate? _____

Have you seen another doctor for this? _____ Doctor's Name _____

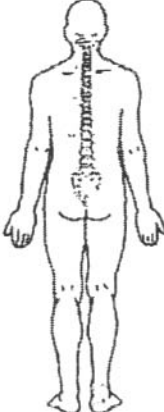
Date Consulted _____ Diagnosis _____

Using the symbols provided in the Pain Index box, mark the areas on the illustrations below where you are experiencing pain.

RIGHT



LEFT



RIGHT


Pain Index

D Dull Nagging Ache

B Burning

S Sharp / Stabbing

N Numbness / Tingling



For example: The image to the left illustrates a burning pain in the neck, a dull ache in the lower back, and a sharp pain in the left thigh.

What is the pain interfering with that's most important in your life? _____

Check those activities below during which you experience difficulty or pain:

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Lying on back | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing for long periods |
| <input type="checkbox"/> Lying on side | <input type="checkbox"/> Dressing self | <input type="checkbox"/> Reaching | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Pushing | <input type="checkbox"/> Stooping | <input type="checkbox"/> Walking | <input type="checkbox"/> Other _____ |

Additional Complaints

Please check all additional complaints that you have at this time

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Loss of concentration | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Allergies (Please list) |
| <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Neck motion restricted | <input type="checkbox"/> Irritability | <input type="checkbox"/> Cold Feet | _____ |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Upper back pain/stiffness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Jaw pain | _____ |
| <input type="checkbox"/> Heavy feeling head | <input type="checkbox"/> Middle back pain/stiffness | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other (Please list) |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lower back pain/stiffness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Left/Right Shoulder pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Convulsions | _____ |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Left/Right Arm pain | <input type="checkbox"/> Excess perspiration | <input type="checkbox"/> Vision problems | (Please specify location) |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Left/Right Leg pain | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Anemia | <input type="checkbox"/> Swelling _____ |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Pins & Needles in Arms/Legs | <input type="checkbox"/> Nausea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cuts _____ |
| <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bruising _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Numbness _____ |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Constipation | | |

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No If so, please list: _____

Have you ever had Motor vehicle injury Sports injury Work injury Slip and fall injury

If yes, please explain: _____

Is there any additional information you would like the doctor to know about before beginning care? _____

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____, the undersigned patient or legal representative, hereby authorize the above-mentioned healthcare facility to provide any and all medical records as described below to Comprehensive Orthopedics and Sports, PC, DBA Spine & Sports Medicine Associates.

The type of information to be disclosed is as follows:

- History and Physical
- Operative Reports
- Discharge Summary
- Laboratory Reports
- Progress Notes
- Other _____

Method of disclosure:

- FAX MAIL VERBAL
- PICK-UP REVIEW

This authorization is valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Patient Relations in writing, but if I do it will not have any effect on actions that have already taken place prior to the receipt of the revocation request.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my treatment or continued treatment with Comprehensive Orthopedic & Sports Physical Therapy is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.

 Signature of Patient or Legal Rep. Today's Date Patient's Date of Birth

If signed by the legal representative indicate your relationship to the patient below and provide appropriate documentation to verify your authority:

- PARENT GUARDIAN CONSERVATOR EXECUTOR OF ESTATE POWER OF ATTORNEY OTHER