THE JOINT AND SPINE INSTITUTE

PATIENT INTAKE FORM

Today's Date: _____

Patient Identity:		
Name:		
Address:		
City:	State:	Zip:
Cell Phone #:	Home Phone #:	
E-mail:		
Demographics:		
Date of Birth:	Sex: M F	
Social Security #:	Height and Weight:	
Marital Status: Spouse Name:	Emergency Contact: Emergency Contact #:	
Employer:	Occupation:	
*Referring Doctor:	*Primary Care Doctor:	
If no referring doctor, did you hear about us through: A Prior Patient: Online Search/Website:		

Name: _____ **Age:** _____

PLEASE FILL OUT THIS FORM **COMPLETELY** TO HELP DEVELOP A PLAN OF CARE.

Medical History**:** (*Diabetes, High Blood Pressure, etc*) _____

Surgical History: _____

Family History: *(Diabetes, High Blood Pressure, etc)*_____

Current Medications: _____

Allergies: _____

DESCRIBE WHERE YOU ARE EXPERIENCING PAIN:

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WAS THIS DUE TO AN INJURY/ACCIDENT? IF SO, DESCRIBE TRAUMA AND PROVIDE DATE:

_____

DESCRIBE PAIN: SHARP DULL
PLEASE CIRCLE: INTERMITTENT CONSTANT
PLEASE CIRCLE: IMPROVING PAIN WORSENING PAIN

RATE YOUR DISCOMFORT ON A SCALE FROM 0 (no pain) to 10 (severe pain):

0 1 2 3 4 5 6 7 8 9 10

WHAT MAKES YOUR PAIN WORSE? _____

WHAT HELPS ALLEVIATE YOUR PAIN? _____

HAVE YOU HAD PREVIOUS TREATMENT OR IMAGING FOR THIS CONDITION?

☐ No Previous Treatment or Imaging of any kind

☐ Physical Therapy/Chiropractor (Name of Therapist and Dates Completed):

_____

☐ Injections (Type of Injection, Name of Doctor, and Dates Completed):

_____

☐ Medications (Name and Dosage):

_____

☐ MRI / CT /X-Ray/ Nerve Tests (Type and Date of Exam and Imaging Center Name):

_____

PLEASE CHECK YES OR NO FOR THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
Fever			High Blood Pressure			Stomach Ulcer		
Weight Loss			Chest Pain			Weakness		
Headache			Leg Cramps			Numbness		
Blurry Vision			Depression			Tingling		
Difficulty Breathing			Alcohol/drugs dependency			Difficulty walking		
Coughing			Painful Urination			Pregnant		

24 Hour Cancellation Policy

In order to promote timely office visits and enhance patient care, if you need to reschedule or cancel your appointment, please do so **at least 24 hours** prior to your appointment time. If an appointment is not cancelled or rescheduled 24 hours in advance, you will be charged a fee of **$50 for office visits and $100 for procedures**.

Financial Policy

Your clear understanding of our financial policy is important to our professional relationship.

Our Financial Policy is as stated:

- All co-pays are due in full at the time of service
- You will be balance billed for outstanding deductible amounts or coinsurance amounts
- We accept cash, checks, or credit cards
- If you are paying by check, we will charge a $20 fee for returned checks
- If your account balance exceeds 120 days, your account may be turned over to collection agency

Insurance

We accept Medicare and most PPO insurances.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. The Joint and Spine Institute will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of benefits. If this occurs, you will be responsible to pay all fees. Please be aware that some, and perhaps all, of the service provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Surgical Facilities

You may be referred to a surgical facility which the physician may have a financial interest in. As a patient, you have freedom of choice, meaning you are free to choose any doctor or organization you wish for obtaining services that may be recommended for you. Your doctor would be happy to discuss alternatives with you. Potential sources of information concerning alternatives can also be obtained from your insurance, the internet, or the county medical association.

HIPAA & Your Privacy Rights

The Joint and Spine Institute strictly adheres to the Health Information Portability and Accountability Act (HIPPA). Passed into law in 1996, HIPPA sets federal standards for the privacy and security of patient information for all healthcare providers, health plans, insurance companies and anyone they do business with. HIPPA also gives you additional rights regarding control and use of your health information. Please ask any staff member to review a complete HIPPA Notice of Privacy.

I have read the above policies and agree to them. I confirm that the information provided in the questionnaire is accurate. I authorize The Joint and Spine Institute to provide me with services, to receive payment of benefits for services provided, and to furnish information to my insurance company or attorney concerning my injury and treatment.

Patient Signature: _____

Printed Name of Patient: _____

Date: _____