SPINE TEAM TEXAS®

PATIENT MEDICAL QUESTIONNAIRE

Today's Date: _____

Please clearly mark the check boxes and fill in the blanks where indicated. Your accurate responses will give us a better understanding of you and your symptoms so that we can provide you with the best care possible. Thank you for your cooperation!

Full Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Hand Preference (Please Circle One): Right / Left / Both

Primary Care Physician: _____ Referring Physician: _____

HISTORY

Please choose priority pain area: ☐ Neck ☐ Low Back Pain ☐ Other: _____

How long have you had this pain? ☐ 0-3 Months ☐ 4-12 Months ☐ 1 Year or More

Does the pain radiate into extremities? (Please Circle Pain Side)

☐ Arms (Left/Right/Both) ☐ Buttocks (Left/Right/Both) ☐ Legs (Left/Right/Both) ☐ Other: _____ (Left/Right/Both)

Do you feel any of the following? If so, please list where on your body.

☐ Weakness: _____ ☐ Tingling: _____

☐ Numbness: _____

Any other symptoms with the pain?

☐ Loss of Bladder Control ☐ Loss of Bowel Control ☐ Headaches ☐ Other: _____

How severe is your pain (mark below)?

☐	☐	☐	☐	☐	☐
0 ABSENT (No Pain)	**1-2 TOLERABLE** (Tolerate Without Medication)	**3-4 BEARABLE** (So Activities Restricted/ Prevented, Requires Medication)	**5-6 NEARLY INTOLERABLE** (Sedentary, Only Able To Watch TV, Read, Etc.)	**7-8 INTOLERABLE** (Can't Read, Watch TV, Use The Phone, Need To Visit ER For Pain Killers)	**9-10 DEVASTATING** (Need Hospitalization For Pain Control)

Did anything specific happen to cause the pain? ☐ Yes ☐ No

If yes, please describe: _____

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PLEASE NOTE: SPINE TEAM TEXAS DOES NOT ACCEPT WORKERS COMP.

Is the injury or pain motor vehicle related? ☐ Yes ☐ No Date of injury? _____

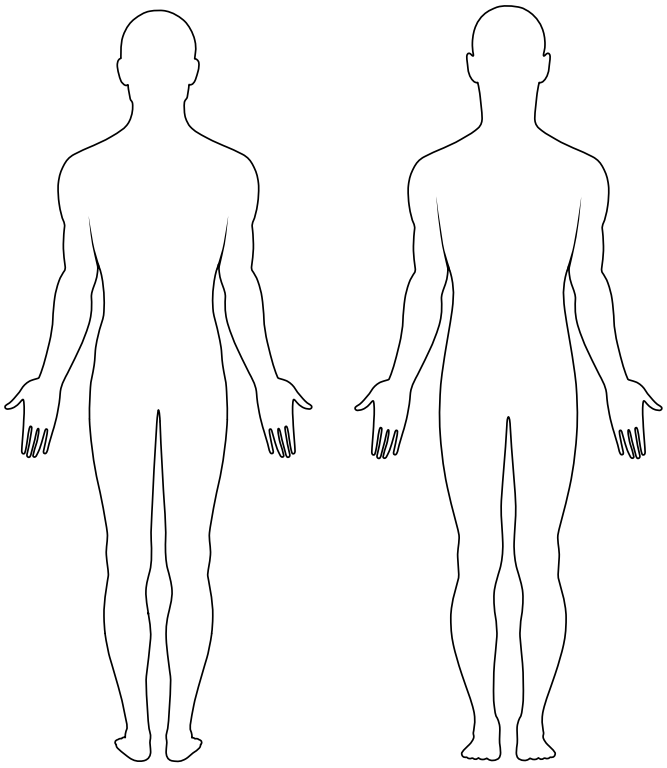
Is there a lawsuit (pending or considered)? ☐ Yes ☐ No

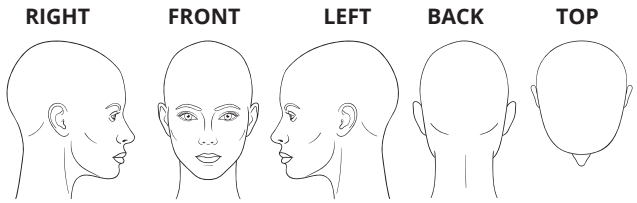
Have you had any of the following treatments for your current condition?

Other Clinicians ☐ Yes ☐ No Name, Date, and Treatment: _____
Physical Therapy ☐ Yes ☐ No # of Sessions: ___ ☐ Better ☐ Worse ☐ No Change
Epidural or Facet Injections ☐ Yes ☐ No # of Injections: ___ ☐ Better ☐ Worse ☐ No Change
Back or Neck Surgery ☐ Yes ☐ No Date and Type: _____
Diagnostic Tests ☐ Yes ☐ No ☐ CT ☐ MRI ☐ EMG ☐ Other: _____

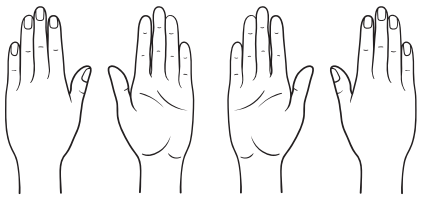
Please mark the location of your symptoms using the key symbols on the figure below:

KEY: Pain= XX Numbness/Tingling= OO Stabbing= // Burning= ++

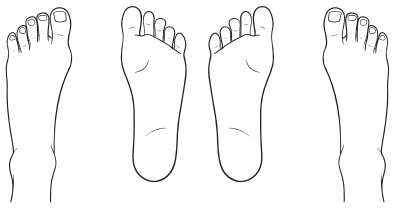




HEAD



LEFT HAND RIGHT HAND



LEFT FOOT RIGHT FOOT

What do you hope we can accomplish today?

_____

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Patient Name: _____ DOB: _____

Illness/Condition:	Please Check All That Apply (Even If Controlled):		
☐ Alcoholism	☐ Gout	☐ Liver Disease/Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Heart Murmur	☐ Lung Disease	☐ Rheumatoid Arthritis
☐ Anxiety	☐ High Blood Pressure	☐ Migraines	☐ Seizure Disorder
☐ Arthritis	☐ High Cholesterol	☐ MRSA	☐ Sleep Apnea
☐ Asthma	☐ History of Addiction	☐ Muscle Disease	☐ Stroke
☐ Bleeding Disorder	☐ History of Substance	☐ Osteoporosis	☐ Thyroid Disorder
☐ Deep Vein Thrombosis	☐ HIV/AIDS	☐ Pneumonia	☐ Tuberculosis
☐ Depression	☐ Hyperthyroidism	☐ Psoriasis	☐ Ulcers
☐ Diabetes ☐ Type 1 ☐ Type 2	☐ Hypothyroidism	☐ Psychiatric Problem	☐ Other (Please Explain): _____ _____
☐ GERD	☐ Kidney Disease	☐ Pulmonary Embolism	

☐ **Patient Cancer History Box:** Please write what kind of cancer you have and when you had it.
_____

PAST SURGICAL HISTORY

Please list any previous surgeries: ☐ No Surgeries ☐ See Attached

_____ Approximate Date: _____
_____ Approximate Date: _____
_____ Approximate Date: _____

MEDICATIONS

Please list all medications you are currently taking. (Include any over the counter medications and supplements. Be sure to list if you are taking any form of blood thinning medication, including aspirin.)

☐ No Medication ☐ Weight Loss Injectable/Weight Loss Oral Medication ☐ See Attached

_____ _____ _____
_____ Dose: _____ Frequency: _____
_____ Dose: _____ Frequency: _____
_____ Dose: _____ Frequency: _____

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Patient Name: _____ DOB: _____

List medications that you have taken in the past and indicate if they were effective (including over the counter medication):

_____ Did the medication help? ☐ Yes ☐ No How long did you take it? _____

_____ Did the medication help? ☐ Yes ☐ No How long did you take it? _____

Medication allergies? ☐ Yes ☐ No

Please list: _____

Allergy Reaction: _____

Do you have any other known allergies to the following?

☐ Latex ☐ Tape OR Adhesive ☐ Shellfish ☐ Iodine

PHARMACY INFORMATION

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Number of Children: _____ Ages: _____

Do you use any of the following? Check and fill in all that apply:

☐ Previous Smoker How much? _____ How long? _____	☐ Non-Tobacco Inhalants How much? _____ How long? _____
☐ Current Smoker How much? _____ How long? _____	☐ Drink Alcohol How many drinks per day? _____
☐ Smokeless Tobacco How much? _____ How long? _____	☐ Recreational Drugs Which type? _____
☐ Vape or E-Cigarettes How much? _____ How long? _____	☐ History of alcohol/drug abuse Explain: _____

Occupation: _____

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REVIEW OF SYSTEMS

Please mark an "X" for Yes or mark "I have none of the symptoms listed above" if you have these symptoms TODAY.

SKIN
- ☐ Rashes
- ☐ Infections
- ☐ I have none of the symptoms listed above

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Swelling
- ☐ I have none of the symptoms listed above

RESPIRATORY
- ☐ Coughing Up Blood
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Sputum Production
- ☐ Recent Infection
- ☐ I have none of the symptoms listed above

MUSCULOSKELETAL
- ☐ Joint Swelling
- ☐ Stiffness
- ☐ Cramping
- ☐ Infection
- ☐ I have none of the symptoms listed above

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Mood Changes
- ☐ I have none of the symptoms listed above

Consent for Treatment

Patient Name: _____ DOB: _____

DISCLOSURE OF INFORMATION:

The undersigned agrees that all records concerning this patient's visit shall remain the property of Spine Team Texas. The undersigned understands that medical records and billing information generated or maintained by Spine Team Texas are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). THE INFORMATION MAY ALSO CONTAIN PSYCHIATRIC RECORDS.** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

SPECIAL CONSENT FOR HIV TESTING:

The undersigned specifically consents to the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease.

❑ Do ❑ Do Not	I (we) authorize Spine Team Texas, PA to obtain my photograph for identification verification.
_____ (Initial)	**ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT POLICY:** I acknowledge the receipt of the payment policy by initialing and signing below. Spine Team Texas, PA is committed to serving you. As part of this commitment, we want you to understand your payment obligations. **Payment is expected at the time services are rendered. If you are unable to pay in full on date of service, payment arrangements must be made.**
_____ (Initial)	**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS:** I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Rights.
_____ (Initial)	**I GIVE PERMISSION** for Spine Team Texas to release any and all of my medical information to my Primary Care/Referring Physician by written or oral communication. I understand these records may contain psychiatric and/or infectious disease information.
_____ (Initial)	**I GIVE PERMISSION** for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. **❑ Yes ❑ No** **If yes, please list names below.** Name: _____ Name: _____ Name: _____
_____ (Initial)	**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

Consent for Treatment

Patient Name: _____ DOB: _____

_____ (Initial)	**I AUTHORIZE** Representatives of Spine Team Texas PA to leave messages for me regarding appointments, prescriptions, or any other information pertinent to my medical care, on any phone number that I have provided. I also understand that I may revoke this agreement by sending a written, certified letter to Spine Team Texas PA, 1545 E. Southlake Blvd. #100 Southlake, Texas 76092, ATTN: Compliance Officer
_____ (Initial)	**I ACKNOWLEDGE AND UNDERSTAND** that Spine Team Texas PA and/or Spine Team Texas ASC LP may not participate with my insurance plan and that any payment due as a result will be discussed with me in detail before services are rendered. I also understand that as a courtesy, Spine Team Texas will review my payment options and evaluate them in detail before any services are rendered.
_____ (Initial)	I acknowledge and understand that Spine Team Texas has a late arrival policy. I understand and acknowledge that if I arrive 15 minutes or more past my scheduled appointment, then I may have to be rescheduled.
_____ (Initial)	**APPOINTMENT POLICY:** I acknowledge and understand that Spine Team Texas has a No Show policy. I understand that if I no show for 3 or more appointments, or cancel with less than 24 hours' notice, I may be dismissed from the practice. I further acknowledge and understand that there is a $50.00 no show fee for EMGs that are no showed or cancelled with less than 24 hours' notice and Spine Team Texas also reserves the right to charge a $35.00 no show fee for office appointments that patients no show or cancel with less than 24 hours' notice. I understand the fees charged for no shows are not covered by my insurance and I will be liable for payment in full.
_____ (Initial)	**MEDICATION HISTORY:** By initialing this paragraph and signing this form, I acknowledge and agree that in the event that I am given a prescription, I am granting permission for Spine Team Texas to obtain my medication history. This may be acquired through direct pharmacy contact.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT SIGNATURE: **X**_____ DATE:_____

PATIENT NAME PRINTED:_____

WITNESS SIGNATURE: **X**_____ DATE:_____

PATIENT IS UNABLE TO CONSENT BECAUSE: _____

RELATIVE / AUTHORIZED AGENT _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

Consent for Treatment

Patient Name: _____ DOB: _____

_____ (Initial)

CONSENT FOR DESTRUCTION OF FILMS

I understand that Spine Team Texas will **not** be responsible for the storage of my x-rays or any other radiological images. By signing this form, I understand and agree that I am responsible for my films and other radiological images that have been performed at a facility other than Spine Team Texas.

I further understand and agree that Spine Team Texas scans my images into their imaging system and retains those images on their scanning system. Spine Team Texas has the right to destroy my actual films if the films have been left at Spine Team Texas for 12 months or longer from today's date.

_____ (Initial)

FINANCIAL GUIDELINES FOR PATIENTS

STT is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. We will assist you when we can, so that you receive all of the insurance benefits to which you are entitled.

To meet the needs of our patients, we participate in many insurance programs. Each insurance company has its own specific rule regarding the level of care and the amount of reimbursement. Insurance plans and benefits vary considerably, and we cannot guarantee what part of our service will or will not be covered by your particular insurance coverage.

We will gladly process your claim for you and when time permits we will also estimate your deductible, co-payment, co-insurance and charges for services rendered. Co-payment, co-insurance and deductibles are a contract responsibility between the patient and their employer and/or insurance carrier. These amounts are non-negotiable. That amount is due at the time of treatment and may be paid by cash, check or credit card. **Our estimates are subject to final approval by your insurance company and what actually takes place in the clinic visit and/or operative/procedure session; therefore, the amount due to our office could change.**

If you are scheduled for procedures or surgery, additional information will be available to you at the time of the scheduling. Please ask if you have any questions about our fees, financial policy or your responsibility.

Please indicate your receipt of this Notice by your signature below.

PATIENT SIGNATURE: **X**_____ DATE:_____

WITNESS SIGNATURE: **X**_____ DATE:_____

SPINE TEAM TEXAS®

NOTICE TO PATIENT OF FINANCIAL INTEREST

As a patient of Spine Team Texas, (the "Practice"), some of your treatment or related procedures may be scheduled at our Texas Health Spine Surgery Centers (the ASC). You are informed by this notice the physicians listed below hold financial interest in the ASC as indicated:

ENTITY	PHYSICIANS
Texas Health Spine Surgery Center Allen, LLC	David Rothbart, MD; Anthony Berg, MD; Amit Darnule, MD; Michael Garcia, MD; David Garrigues, MD; Cortland Miller, MD; Ryan Reeves, MD; Jennifer Donnelly MD; Andrew Carver Wilkins, MD; Anton Zaryanov, DO; Daniel Sanders, MD
Texas Health Spine Surgery Center Alliance, LLC	David Rothbart, MD; Ryan Reeves, MD: Michael Garcia, MD; Amit Darnule, MD; Anthony Berg, MD; Harish Badhey, MD; Jennifer Donnelly, MD; Cortland Miller, MD; Neil Patel, MD; Joseph Platon, DO; Carver Wilkins, MD; David Garrigues, MD; Christina Nguyen, DO; Egle Bavry, MD
THR/STT Rockwall ASC, LLC (d/b/a Texas Health Spine Surgery Center Rockwall, LLC)	David Rothbart, MD; Ryan Reeves, MD; Michael Garcia, MD; Amit Darnule, MD; Anthony Berg, MD; Anton Zaryanov, DO; Richard S. McPherson, DO; Ahmed Embabi, MD
THR/STT Southlake ASC, LLC (d/b/a Texas Health Spine Surgery Center Southlake, LLC)	David Rothbart, MD; Ryan Reeves, MD: Michael Garcia, MD; Amit Darnule, MD; Jennifer Donnelly, MD; Neil Patel, MD; Alexa Royston, DO; Joseph Platon, DO

In addition, you may receive services at Texas Health Harris Methodist Hospital Southlake or Texas Health Presbyterian Hospital Rockwall. You are informed by this Notice that your physician may hold a financial interest in this entity. You have the option, at your discretion, to use an alternative health care facility.

Please indicate your receipt of this Notice by your signature below.

Patient Printed Name	Patient Signature	Date

IMPORTANT INFORMATION FOR PATIENTS

Each facility listed above has entered into a name use agreement with Texas Health Resources (THR).

THR does not supervise any health care professionals at any Texas Health Spine Surgery Center, nor does it provide any patient care services at any Texas Health Spine Surgery Center.

It is important that you also understand that all ASC physicians who provide their services using ASC facilities are employed by Texas Health Back Care and are members of the Texas Health Spine Surgery Center Medical Staff.

Patient Printed Name	Patient Signature	Date

FAMILY AND FRIENDS REFERRAL PROGRAM

Spine Team Texas would like to thank our patients for referring their family and friends to us. Please let us know who referred you so that we can send them a thank you gift.

Today's Date: _____

❒ **Fellow/Former Patient**

Full Name: _____

Mailing Address (if known): _____

❒ **Family/Friend/Neighbor**

Full Name: _____

Mailing Address (if known): _____

Please select the location you are visiting today:

❒ **Southlake** ❒ **Bedford** ❒ **Alliance** ❒ **Rockwall** ❒ **Richardson** ❒ **Allen**

DON'T FORGET!

In addition to the new patient paperwork, please make sure you bring the following with you to your appointment:

- ❑ A picture ID
- ❑ Insurance cards
- ❑ Your co-pay (if required by your insurance)
- ❑ Your referral (if required by your insurance)
- ❑ Any report, film, or disc of radiology relating to your pain and treatment
- ❑ Any medical records relating to your pain and treatment
- ❑ A list of medications you are currently taking or their medication bottles

THANK YOU FOR CHOOSING SPINE TEAM TEXAS!