Our Multispecialty Team Welcomes You!

arizonapaintreatmentcenters

MODERN AMBULATORY SURGERY CENTER

Minimally Invasive SPINE
Arizona's Minimally Invasive & Endoscopic Spine Surgery Specialists

McDowell ambulatory surgery center

PACIFIC TOXICOLOGY LABORATORIES

OCA On Call Anesthesia

You may see these names listed on your Explanation of Benefits from your health insurance carrier.
Questions? Contact your assigned account representative.

Who may we thank for referring you to our office? ◯ Medical physician_____

◯ Chiropractor_____ ◯ Family or friend _____◯ Internet ◯ Insurance company

PATIENT INFORMATION (Please complete all fields. If it does not apply or you do not want to provide, please write NA)

Last name_____ First name_____ Middle initial____ Birthdate _____Age_____

Street address_____Apt #_____

City_____State_____ Zip code_____

Home (_____)_____Cell (_____)_____Alt/work (____)_____Email_____

Driver's license_____ SS #_____ Male/Female_____

Marital status: ◯ Single ◯ Divorced ◯ Widowed ◯ Partner ◯ Married. Name of spouse _____

Race_____ Ethnicity_____ Primary Language_____

Employer_____ Occupation_____

Emergency contact _____Relationship_____ Phone (_____)_____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

Address_____ City / State / Zip _____Phone (_____)_____

ARE YOUR SYMPTOMS RELATED TO AN ACCIDENT? ◯ Yes ◯ No ◯ Don't know. Date of accident _____

If yes, what type? ◯ Auto ◯ On the job ◯ Other _____ Date reported_____

Is there an open claim related to this injury? ◯ No ◯ Yes State in which accident occurred_____

APPOINTMENTS
We ask that our patients come to their appointments 15 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT
I authorize the staff at "the Practice" to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION
I authorize "the Practice" and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of "the Practice," which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

_____

Print Name Signature Date

Date: _____ **DOB _____**

Last name_____ First name _____

Who referred you to our practice? _____

Who is your Primary Care Physician? _____

Phone # _____ Last visit _____

List other physicians you have seen regarding your condition (**specifically include any Rheumatologists, Neurologists, Orthopedic Surgeons, Spine Surgeons, or Chiropractic Physicians**) _____

_____

Main pain complaint(s)	**Date started**	**Pain scale (0-10)**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Check whether you have had these treatments			**Approx last treatment**	**Approx relief %**
Chiropractic treatment	**Y**	**N**	_____	_____
Physical therapy	**Y**	**N**	_____	_____
Massage therapy	**Y**	**N**	_____	_____
Psychology for pain	**Y**	**N**	_____	_____

Check whether you have had these injections			**Approx date**	**Relief**	
Epidural Steroid Injection	**Y**	**N**	_____	**Y**	**N**
Facet Joint Injection or facet block	**Y**	**N**	_____	**Y**	**N**
Radiofrequency Ablation	**Y**	**N**	_____	**Y**	**N**
Trigger Point Injection	**Y**	**N**	_____	**Y**	**N**

PLEASE INDICATE IF YOU HAD, OR CURRENTLY HAVE, THE FOLLOWING MEDICAL PROBLEMS:

[ ] Heart	[ ] High Blood Pressure	[ ] Pacemaker/defibrillator
[ ] Bleeding or blood disorder	[ ] Lungs/Shortness of Breath	[ ] Sleep Apnea
[ ] Kidney/Genitourinary	[ ] Bladder/Bowel incontinence	[ ] Stomach/Intestine/Acid reflux
[ ] Nausea/Vomiting	[ ] Diabetes	[ ] Thyroid or another hormone
[ ] Liver	[ ] Hepatitis	[ ] HIV
[ ] Cancer	[ ] Headache	[ ] Stroke/TIA/paralysis
[ ] Seizure	[ ] Fracture	[ ] Osteoporosis
[ ] Joint/Muscle/Rheumatoid/Gout	[ ] Skin Disorder	[ ] Depression/Anxiety/other
[ ] Suicidal ideation/attempt	[ ] Fever recent/current	[ ] Other

If yes to any of the above please explain and provide approximate date: _____

_____

_____

Height_____ Weight _____ BP _____ Pulse _____

Family History

Mother: Alive or Deceased _____ Her medical conditions _____

Father: Alive or Deceased _____ His medical conditions _____

Do you smoke? **Do you drink alcohol?**

List any diagnostic tests you have had for this condition (MRIs, X-Rays, CT Scans, EMGs, etc.)

Date	Test	Body Part	Facility

_____

_____

_____

List all surgeries for brain, spine, joint, muscle and nerve (or any other major surgeries)

_____

_____

_____

Do you have **allergies** to latex, adhesive tape, contrast dye, iodine/shellfish or **medications**?
Please list the allergy and the reaction. _____

Have you had any problems with surgery or anesthesia?
Date/Reaction: _____

Is there anything else in your past medical history that you feel is important to your care here?

_____

Pharmacy Name: _____Phone #_____ Street: _____

Current medications

Name	Strength	Take	Route	Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Mark each box that applies

Male [ ] Female [ ]

Are you under the age of 45? Yes [ ] No [ ]

Is there any family history of substance abuse?

Alcohol	**Yes [ ] No [ ]**
Illegal Drugs	**Yes [ ] No [ ]**
Prescription Drugs	**Yes [ ] No [ ]**

Do you have personal history of substance abuse?

Alcohol	**Yes [ ] No [ ]**
Illegal Drugs	**Yes [ ] No [ ]**
Prescription Drugs	**Yes [ ] No [ ]**

Do you have a history of being sexually abused? **Yes [ ] No [ ]**

Do you have any of the following psychological diagnoses?

ADD, OCD, bipolar, schizophrenia?	**Yes [ ] No [ ]**
Depression?	**Yes [ ] No [ ]**

Signature_____ Date_____

Auto Accident History to be Completed by the Patient

Patient name _____ Accident date _____

Make/Model/Year of **YOUR** vehicle _____

If other vehicle involved, name of **OTHER** driver _____

Make/Model/Year of **OTHER** vehicle _____

Accident type O Rear-end collision O Head-on collision O T-bone collision O Broadside O Non-collision O Other

You were the O Driver O Passenger / O Front seat O Back seat

Was **YOUR** vehicle moving at the time of the accident? O Yes O No

How fast would you estimate the **OTHER** vehicle was traveling? _____

Did you brace for impact? O Yes O No Did your airbag deploy? O Yes O No

Were you wearing your seatbelt? O Yes O No

Did your vehicle have headrests? O Yes O No If yes, what was the position of your headrest?

Top of the headrest was O even with bottom of head O even with top of head O even with middle of head

Was **YOUR** vehicle braking? O Yes O No Was the **OTHER** vehicle braking? O Yes O No

Was any body part struck by the car? O Yes O No Explain_____

Do you recall striking your head at impact? O Yes O No Explain _____

What position was your body in during impact? Looking straight ahead or turned? _____

Which hands were on the steering wheel? _____

What direction did your body move around the car at impact? O side-to-side O front-to-back O back-to-front

Were you evaluated at the scene of the accident? O Yes O No

Were you taken by ambulance to the hospital? O Yes O No If yes, which hospital?_____

Have you received any other medical attention since the date of the accident? O Yes O No

If yes, the name of the clinic _____ Dates _____

Check all symptoms apparent SINCE the accident

O Headache	O Visual disturbance	O Forgetfulness	O Shoulder pain
O Neck pain	O Anxiety/Depression	O Lack of energy	O Elbow pain
O Mid back pain	O Lack of coordination	O Constipation	O Wrist pain
O Low back pain	O Difficulty walking	O Diarrhea	O Ankle pain
O Dizziness	O Difficulty concentrating	O Tingling	
O Sleep disturbance	O Ringing in ears	O Weakness	
O Bruising/cuts/scrapes	O Irritability	O Jaw pain	

Did you have any of your current physical symptoms BEFORE THE ACCIDENT? O Yes O No

If yes, please explain _____

Have you lost time from work as a result of this accident? O Yes O No

If yes, please complete Last day worked _____

If back to work, dates you missed work _____

Type of employment_____

Duties at work that you are unable to perform _____

List your % of work ability since the auto accident_____% *(0% = no capacity/unable to work...100% = full capacity/normal)*

Please list **THREE** activities of daily living that have been affected since the accident and your **% ability** for each

(for example: unable to play with kids 20%, unable to cook 80%, unable to drive 0%)

1)_____ ___% 2) _____ ____% 3)_____ ___%

Notice of Doctor's Lien

PATIENT: _____

DATE OF ACCIDENT: _____

I do hereby authorize “the Practice” to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing said doctor for medical service rendered to me both by reason of this accident and by reason of any other bills that are due the doctor’s office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And, I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for service rendered me and that this agreement is made solely for said doctor’s additional protection and in consideration of the doctor awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor’s office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor’s interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated: _____ _____

Patient’s Signature

Dated: _____ _____

Attorney’s Signature

Please date, sign and return one copy to doctor’s office and keep one copy for your records.

Patient Billing Information

Date_____ **Patient's Name:** _____

Please complete each box. If it does not apply, please write NA.

HEALTH INSURANCE PRIMARY:

Insurance Co_____ Telephone # to verify benefits**:**_____

Name of Insured**:**_____

Insured's Soc. Sec. #_____DOB_____

Group #_____ Policy #_____

Mail claims to:_____

HEALTH INSURANCE SECONDARY:

Insurance Co_____ Telephone # to verify benefits**:**_____

Name of Insured**:**_____

Insured's Soc. Sec. #_____DOB_____

Group #_____ Policy #_____

Mail claims to:_____

Workers' Compensation Insurance Company:

Insurance Co_____ Address:_____

Phone:_____ Case Manager:_____ Date of Injury_____

Claim #:_____ Is Claim still Open?_____

PERSONAL INJURY **Date of Injury: _____**

Auto Insurance Coverage: (Your auto insurance)

Insurance Co:_____ Name of Insured:_____

Address:_____

Insurance Phone:_____ UM/UIM Coverage:_____

Auto Insurance Coverage: (Medpay Claim)

Insurance Co:_____ Name of Insured:_____

Address:_____

Insurance Phone:_____ Adjuster:_____

Medpay Limits: $_____ Is Claim Open? _____ Claim #:_____

Third Party/Liability Insurance Company: (Insurance info for at-fault vehicle)

Insurance Co _____ Name of Insured:_____

Address: _____Adjuster Phone:_____ Adjuster: _____

Is claim still open? _____ Policy/Claim #:_____

Attorney's name:

Attorney's Name:_____ Law Firm: _____

Phone:_____ Contact Person_____ E-Mail_____

Address:_____ Liens to file: County Attorney