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_____