OKLAHOMA SPINE SPORTS & REHABILITATION

a division of Neuroscience Specialists

4120 West Memorial Road, Suite 118 Oklahoma City, Oklahoma 73120

405.748.4700 Fax: 405.748.5638

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Please Read!

Very important regarding your upcoming appointment

Attached is your appointment card and your paperwork for your future appointment with our office. Please complete the **entire packet completely (all pages)** before your appointment! If this packet is not completed, you will need to arrive early to have it completed before your appointment time. **If the paperwork is not complete by your appointment time, your appointment could be rescheduled.**

REQUIRED: We will need a **complete** medication list with all medications including the dosage and directions. If you have a list, we can copy that in the office for you, but if you do not have a list, you need to copy the details off of your bottles onto our forms. **If we do not have this information at your appointment time, your appointment could be rescheduled.**

You will get a reminder phone call two days in advance to confirm your appointment. Please confirm your appointment with the automated system by pressing 1. The automated system will ask you to arrive 30 minutes early, but if this paperwork is completed, you only have to arrive 10 minutes early.

Bring the packet with you to your appointment completed!
(Do not mail back in because this might not arrive in time for your appointment)

If you have any further questions, please call our office at (405) 748-4700!

Thanks

Neuroscience Specialists, PC
4120 W. Memorial Rd Ste 118
Oklahoma City, Ok 73120
www.ossrokc.org

OKLAHOMA SPINE SPORTS & REHABILITATION
PATIENT REGISTRATION INFORMATION

_____ _____ _____
Last Name First Name MI

_____ _____ _____ _____
Address City State Zip

Home Phone: _____ SSN: _____-_____-_____

Cell Phone: _____ Marital Status: S ☐ M ☐ D ☐ W ☐

Email: _____ Sex: M ☐ F ☐

Date of Birth: _____

Primary Care Physician: _____ Phone: _____

Fax: _____

Referring Physician: _____ Phone: _____

Fax: _____

Emergency Contact: _____ _____ _____
Name Address Phone

Race
- ☐ African American
- ☐ Caucasian
- ☐ Native American
- ☐ Hispanic
- ☐ Other _____

Language
- ☐ English
- ☐ Spanish
- ☐ Other _____

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

PLEASE FILL OUT ENTIRE FORM COMPLETELY!

OKLAHOMA SPINE SPORTS & REHABILITATION
PATIENT INSURANCE INFORMATION

Patient: _____ Date of Birth: _____

I authorize my insurance benefits to be paid directly to Neuroscience Specialists, PC for medical and/or procedure benefits otherwise payable to me. I understand I am financially responsible to the physician any co-pay, deductible, co-insurance, as well as for services not authorized and/or not covered by the insurance company. I authorize Neuroscience Specialists, PC or my insurance company to release any information needed to process my claims.
I give permission to you and any agent of Neuroscience Specialists, PC to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes.

Are you the policyholder on your insurance(s)? YES NO

If not, please provide the following:

Insurance: _____ (Indicate which one) PRIMARY SECONDARY

POLICYHOLDER INFORMATION

Name: _____ DOB: _____

SSN: _____ - _____ - _____ Employer: _____

Relationship to patient: □ Self □ Spouse □Parent □ Other _____

MEDICATION REFILL INFORMATION

This signature acknowledges that I have been given a copy of the Medication Refill and Drug Screen Policies of the office of Neuroscience Specialists, PC. (**which are attached to the back of the new patient forms**)

_____ _____
Signature Date

ACKNOWLEDGEMENT OF DISCLOSURE

As a prospective patient of Neuroscience Specialists, we are pleased to inform you of the following: in compliance with the Code of Federal Regulations Title 42, Volume 3, Section 489.3 defines a physician-owned hospital as any participating hospital (as defined in section 489.24) in which a physician, or their immediate family member, has an ownership or investment interest. Your physicians at Oklahoma Spine Sports and Rehabilitation, a division of Neuroscience Specialists, PC, have no ownership in a hospital; however, these physicians are invested in and have partial ownership in the following entities: Oklahoma Diagnostic Imaging (ODI). A list of physician owners is available upon request. The physicians of Neuroscience Specialists, PC, make referrals to providers based only on the needs of the patient and the medical standard of care in order to provide quality healthcare to their patients. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use healthcare facilities other than the ones listed above. You will not be treated differently by your physician if you choose to use different facilities. If desired, your physician can provide information about alternative providers.

_____ _____
Signature Date

NEUROSCIENCE SPECIALISTS, PC
OKLAHOMA SPINE SPORTS & REHABILITATION

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient: _____ Date of Birth: _____

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S./C/Section 1320d, et. Seq., and regulations promulgated there under, as amended from time to time (collectively referred to as HIPAA). This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing. By signing this form, you are authorizing and waiving physician-patient privilege to (a) permit any physician or employee (present or past) of Neuroscience Specialists, PC, to give testimony relation to your physical condition or treatment as a patient of Neuroscience Specialists, PC, by informal interview, by deposition, by answers to written interrogatives, or at trial in a lawsuit in which you are involved in either as a party or as a witness actually or potentially, and (b) permit Neuroscience Specialists, PC, or its employees to furnish (including by mail, facsimile, or e-mail) the individuals and/or companies which present this release all records and reports relating to your physical condition or treatment at Neuroscience Specialists, PC, or any other treating medical facility, or with any person listed below. In accordance with your rights under and subject to certain restriction imposed by HIPAA, you may inspect or copy your Protected Health Information (PHI) by written request. You have the right to revoke this authorization, in writing, at any time, except to the extent that Neuroscience Specialists, PC, has taken action in reliance on it. A revocation is effective upon receipt by Neuroscience Specialists, PC, of a written request to revoke and a copy of executed authorization form to be revoked at Neuroscience Specialists, PC, 4120 W. Memorial Road Suite 118, Oklahoma City, Oklahoma 73120.

*****This includes anyone that you give permission to have access to records and/or medical information*****
*****including friends and/or family*****

RELATIONSHIP TO PATIENT	NAME Neuroscience Specialists, PC
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge that the data to be released MAY INCLUDE information protected by law. My signature below authorizes the inclusion of information pertaining to not only my Neuroscience Specialists, PC medical records but possibly: Mental Health, Drug, Alcohol, HIV/AIDS, and other communicable diseases as well as Genetic testing. I authorize you to accept a photo static copy of the release and it to have the same force and effect as would the original. Please note that federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 cannot be disclosed without written consent.

_____ _____
Signature Date

PATIENT PRIVACY ACT

This signature acknowledges that I have been offered a copy of the Patient Privacy Act of the office of Neuroscience Specialists, PC. If you would like a copy for your records, let us know and one will be provided to you.

_____ _____
Signature Date

OKLAHOMA SPINE SPORTS & REHABILITATION
PATIENT HISTORY INFORMATION

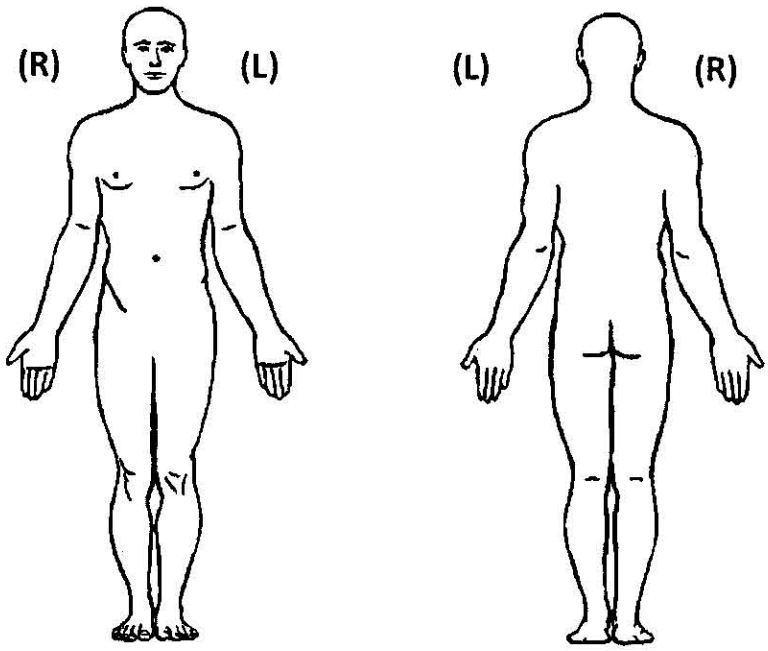
Date: _____ Name: _____ Date of Birth: _____ Age: ____

RIGHT or LEFT handed (**please circle**) Occupation: _____ How Long: _____

Current work status: Full Time Part time Off (last day worked) _____

Indicate your symptoms on the body diagram using the symbols:

/////// Stabbing
xxxxxx Burning
ooooo Aches
===== Tingles
Throbbing



Date symptoms began: _____

Please describe the type of medical problem or symptoms you are being seen for today and the location of your pain:

_____

_____

Indicate CURRENT level of pain on the following scale (**please circle**):

No Pain 1 2 3 4 5 6 7 8 9 10 Intolerable

Are your symptoms (**please circle**): Getting Worse Getting Better Staying the Same

Does your pain radiate from your back to any part of your limbs? (**please circle**) YES NO

OKLAHOMA SPINE SPORTS & REHABILITATION
PATIENT HISTORY INFORMATION

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Please circle all that apply:

Timing of Symptoms	Description of Symptoms	Aggravators of Symptoms
Constant	Aches	Coughing
Occasional	Throbs	Sneezing
Wake you up	Burns	Walking
During Activity	Tingles	Sleeping
	Stabbing	Bending or Stooping
		Other _____

Do you have weakness? YES NO
If yes, where? _____

Do you have numbness? YES NO
If yes, where? _____

Has there been any change in bowel or bladder function? YES NO

What helps your condition? _____

PRIOR TESTING FOR THIS PROBLEM: MRI CT EMG X-RAYS OTHER: _____

Have you had any treatment for your current condition?
Physical Therapy Epidural Steroid Injections Chiropractic Care Other: _____

Do you workout/exercise? YES NO
If yes, please describe: _____

Please circle all that apply:

Heart Problems	YES	NO	Gastritis or Ulcers (explain below)	YES	NO	Seizures	YES	NO
Lung Problems	YES	NO	Liver Disease (such as hepatitis)	YES	NO	Spinal Injury	YES	NO
Kidney Problems	YES	NO	Diabetes or problems with blood sugar	YES	NO	Depression	YES	NO
High Blood Pressure	YES	NO	Any type of cancer (if yes, explain below)	YES	NO	Thyroid disease	YES	NO
Anemia	YES	NO	Stroke	YES	NO	Osteoporosis	YES	NO
Problems with blood (i.e. clotting)	YES	NO	Head Injury	YES	NO	Rheumatoid Arthritis	YES	NO

Please list all surgeries you have had including the year they were performed:

_____
_____
_____
_____

Pharmacy Name: _____ Pharmacy Phone: _____

Please list any medications including **dosing & directions** that you are currently taking including over the counter medications:

_____
_____
_____
_____
_____

OKLAHOMA SPINE SPORTS & REHABILITATION
PATIENT HISTORY INFORMATION

Date: _____ Name: _____ Date of Birth: _____ Age: ____

Medication Allergies: _____

_____

☐ Check here if you do not have any medication allergies

Has anyone in your immediate family had the following:

High Blood Pressure	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Heart Disease	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Cancer	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Diabetes	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Asthma	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Stroke	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Seizures	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Migranes	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling
Other: _____	YES	NO	Who:	Mother	Father	Grandmother	Grandfather	Sibling

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS (CIRCLE ALL THAT APPLY):

Constitutional: FEVER CHILLS WEIGHT GAIN WEIGHT LOSS POOR APPETITE NIGHT SWEATS

Eyes/Ears: VISION PROBLEMS DENTURES HEARING PROBLEMS

Cardiac: CHEST PAIN SKIPPED HEART BEATS LEG PAIN WHILE WALKING SHORTNESS OF BREATH HEART MURMUR EDEMA

Respiratory: COUGH (DRY, PHLEGM, BLOOD) WHEEZING CHEST PAIN WITH DEEP BREATHS

Digestive: INDIGESTION CONSTIPATION BOWEL INCONTINENCE NAUSEA/VOMITTING DIARRHEA

Genitourinary: BLADDER INCONTINENCE URGENCY TO URINATE BURNING WITH URINATION SEXUAL DYSFUNCTION

Musculoskeletal: JOINT PAIN JOINT SWELLING MUSCLE PAIN LIMITED JOINT MOVEMENT

Neurologic: Difficulty with: MEMORY SPEAKING SWALLOWING WEAKNESS NUMBNESS TINGLING DIZZINESS RECENT FALLS

Psychiatric: FATIGUE MOODY DIFFICULTY SLEEPING DEPRESSION

Integumentary: POOR HEALING ULCERS RASH SORES

☐ **CHECK HERE if you currently do not have any of these above symptoms**

OB/GYN (female only): Are you pregnant? YES NO Last Menstrual Period (Month/Year): _____

OKLAHOMA SPINE SPORTS & REHABILITATION
TOBACCO & ALCOHOL USE FORM

Date: _____ Name: _____ Date of Birth: _____ Age: ____

IN ORDER TO COMPLY WITH THE QUALITY REPORTING MEASURES REQUIRED BY GOVERNMENT, WE WILL NEED THIS INFORMATION COMPLETED BEFORE YOU CAN SEE THE DOCTOR.

Tobacco Use

Have you ever used tobacco? YES NO **If you answered yes, complete the rest of this section:**

Smoking Tobacco Use

Tobacco Type	Usage per Day		Years Used	Age Started	Age Stopped
□Cigarette	_____	Cigarettes or Pack	_____	_____	_____
□Cigarillo	_____		_____	_____	_____
□Cigar	_____		_____	_____	_____
□Pipe	_____		_____	_____	_____

Non-Smoking Tobacco Use

Tobacco Type	Usage per Day		Years Used	Age Started	Age Stopped
□Chewing	_____	Units	_____	_____	_____
□Smokeless	_____	Units	_____	_____	_____
□Snuff	_____	Units	_____	_____	_____
□Pipe	_____	Units	_____	_____	_____

Have you tried to quit? ____ / ____ / ____ (mo/day/year)
Longest you've been tobacco free: _____

If you quit using tobacco with a method other than unassisted, please indicate:

☐Acupuncture ☐Over the counter medication
☐Cognitive behavioral therapy ☐Prescription medication
☐Counseling hypnotherapy

Illicit Drug Use

Do you use illicit drugs? YES NO
If yes, what type: _____
How often: _____

Alcohol Intake

Do you drink alcohol? YES NO FORMERLY If formerly, what year did you quit? _____

Type of Alcohol (circle one)		Frequency (circle one)	Amount (circle one)				Last drink (circle one)
Beer	Rum	Daily	1 beer	2 beers	3 glasses	5 drinks	Last month
Beer & Liquor	Scotch	Weekly	1 drink	2 drinks	4 beers	5 glasses	Last night
Beer & Wine	Vodka	Monthly	1 fifth	2 glasses	4 drinks	Greater than 5 glasses	Last week
Gin	Whiskey	Yearly	1 glass	3 beers	4 glasses	6 pack of beer	One year ago
Hard Liquor	Wine	Occasionally	1 pint	3 drinks	5 beers	8 oz.	Today
		Rarely					Two weeks ago
		Socially					Yesterday

NEUROSCIENCE SPECIALISTS, PC

Please answer the questions below

They are required by Medicare and are required for all patients

1. Advance Care Plan

   Do you have an Advance Care Plan with a surrogate decision maker named? YES NO

   _____ Living Will

   _____ Power of Attorney: Name: _____ Relationship: _____

   _____ Other notarized legal document

2. Flu Shot

   Have you had a flu shot for the current flu season? YES NO

   If no, please circle one: ALLERGY TO VACCINE VACCINE NOT AVAILABLE OTHER _____

3. Pneumonia Vaccination

   Have you ever had a Pneumonia Vaccination? YES NO

PATIENT'S NAME: _____ DATE: _____

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MEDICATION POLICY

1. Refill requests may be made Monday through Friday from 8:30 a.m. to 4:30 p.m. Please allow 48 hours for requests to be processed. ALL requests received after 3:00 p.m. will be addressed the next business day.

2. Refills will not be made after office hours, at night, on weekends, or on holidays. The on call physician will not answer calls regarding refills.

3. Please check your bottle for refills. If you have refills, you do not need to call the office. Please call your pharmacy instead.

4. Patients are responsible for their controlled substance medication. New prescriptions will **NOT** be issued for lost, stolen, or misplaced medications. In addition, new prescriptions will **NOT** be issued if you use more medication than the amount prescribed.

5. Please remember to discuss any medication concerns you have with your doctor at your regularly scheduled appointments.

URINE DRUG TESTING PROGRAM POLICY

Effective November 15, 2011, Oklahoma Spine Sports and Rehabilitation implemented a urine drug testing policy which was updated July 1, 2014. All patients are subject to testing as per our office policy. The purpose of this program is to help ensure patient compliance and safety with prescription medication management. Prescription medications are commonly used both short and long term in an effort to reduce pain and improve function.

In addition, any patient who is prescribed a narcotic medication/controlled substance shall be required to sign a "Controlled Substance Treatment Agreement" and comply with the "Oklahoma Spine Sports and Rehabilitation Medication Policy."

If you have any questions about this program, please feel free to speak to your physician during your appointment.