ANIMAS SPINE

Today's Date: _____/_____/_____ **Physician: O Dr. McLaughlin**

Patient's Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Social Security #: _____-_____-_____ **Date of Birth:** _____/_____/_____ **Age:** _____

Race: □ **American Indian/Alaskan** □ **Asian** □ **Black** □ **Caucasian** □ **Declined** □ **Other Race**

Language: _____ **Ethnicity:** □**Hispanic** □ **Non-Hispanic** □ **Declined**

Marital Status: □**Married** □ **Single** □ **Divorced** □ **Widowed** □ **Other**

Email: _____ **(please provide for billing statements)**

Pharmacy: _____ **Pharmacy phone:** _____

Emergency Contact

In case of emergency contact: _____
Relationship: _____ **Phone:** _____

Insurance Information

Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____ **Tertiary Insurance Carrier:** _____
Please give insurance card (s) and/or Worker's Compensation/MVA declarations page upon arrival to the front desk.

If you do not provide insurance information at the time of your appointment ***YOU*** *will be responsible for payment.*

Is this a Work Comp or Motor Vehicle Accident? □ **Yes** □ **No**

If YES, on what date did the injury occur? _____

Work Comp|MVA Claim Number: _____

Insurance: _____ **Adjustor's Name:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Referring Physician

Referring Physician: _____ **Phone:** _____
Primary Care Physician: _____ **Phone:** _____

ANIMAS SPINE

Welcome to our office! In order to accommodate the many needs of our patients and to provide you with quality medical care, we have adopted the following policies:

1. Please bring your insurance card and ALL insurance information (including worker's compensation / motor vehicle accident claim information if applicable). **IF YOUR INSURANCE PLAN REQUIRES A COPAY, IT MUST BE PAID AT THE TIME OF SERVICE.**

2. For all patients holding private insurance, YOU, the patient, are responsible for calling your insurance carrier regarding benefits. Make sure Patrick N. McLaughlin, M.D. and Brandon Messerli, D.O. are in your network.

3. This office will locate all radiology films performed at the Animas Surgical Hospital. **YOU, the patient, are required to obtain all radiology films/exams performed outside this facility. Failure to do so WILL result in rescheduling your appointment.**

4. As a courtesy, our office will bill your insurance for you. Please inform the office staff if your phone number, address and/or insurance information has changed. This information is vital to office billing procedures. IF information is not current the patient is responsible for all undiscounted pricing.

5. Patients that arrive to their appointments late may not be seen and may need to reschedule their appointment. **Patients will be considered a "NO SHOW" and a $25.00 fee will be charged. This includes first time consults as well as maintenance follow up appointments. As a courtesy, our office will make reminder calls. Please call the office 24 hours in advance if you will NOT be able to attend the scheduled appointment.** We do realize there are emergencies that cause you to cancel your appointment. The office will not be able to reschedule appointments if there are 2 or more cancelled/no show appointments.

6. If prescription refills are needed, please call your pharmacy directly. The pharmacy will forward information to our office. **Please allow 48 hours for prescription refill requests.**

7. Please note, the doctor may not prescribe any narcotics (i.e. Oxycontin, Oxycodone, Percocet, Lortab, Vicodin, Norco and Methadone) during the first, second or third visits. In some cases, narcotics may not be prescribed at all. Please make payment arrangements with your referring physician if there is a current need for narcotic medications.

8. Any patient has the right to choose a provider and facility for their health care services. Thus, we would like to inform you that Animas Surgical Hospital meets the definition of a physician-owned hospital under 42 CFR 489.3 and Dr. David R. Silva, D.O. and Dr. Patrick N. McLaughlin, MD are proud owners of the Animas Surgical Hospital.

9. Due to HIPAA guidelines, it is our policies here that patient to doctor relationships are kept private. **Any outside family/visitors that arrive with the patient will be asked to wait for the patient, unless the patient is a minor.** Disclosed health information will be provided to visitors if the doctor deems it necessary to disclose medical information to associated parties.

Thank you for your attention to these matters. **Initials** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE of HEALTH PRIVACY POLICIES

I understand that Animas Spine is part of an organized healthcare arrangement and that these providers may share my healthcare information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting Animas Spine.

My signature below constitutes my acknowledgement that I have been provided with a copy of this notice of privacy practices.

CORHIO

Animas Spine, endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, *you may choose to opt-out* of participation in the CORHIO HIE, or cancel an opt-out choice, at any time. ***If you choose to opt-out, please let a staff member know prior to your visit with our clinic.***

My signature below also constitutes my acknowledgement that I agree to participate through the HIE.

_____ _____

Signature of Patient or Legal Representative Date

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PATIENT:

CHIEF COMPLAINT:

INTERMITTENT CONSTANT

NECK PAIN or **LOW BACK PAIN** RIGHT LEFT BILATERAL

NO RADIATION RADIATION

WHAT DOES THE RADIATION FEEL LIKE?

NUMBNESS TINGLING BURNING PINS AND NEEDLES WEAKNESS

WHERE DOES IT RADIATE?

_____

IS THIS A CHRONIC HISTORY OR WAS THERE AN INJURY OR ACCIDENT?

WHEN AND WHAT HAPPENED?

_____
_____
_____
_____
_____

TREATMENTS TRIED FOR THESE ISSUES:

PHYSICAL THERAPY CHIROPRACTICS MASSAGE THERAPY HOME EXERCISE PROGRAM

STRETCHING YOGA HEAT ICE TOPICAL RUBS

NSAID's (IBUPROFEN, TYLENOL, ALEVE, ASPIRIN ETC)

OTHER MEDICATIONS TRIED:

_____
_____

OTHER TREATMENTS TRIED:

_____
_____

IS THERE ANYTHING YOU CAN THINK OF THAT MAKES YOUR SYMPTOMS SIGNIFICANTLY BETTER?

_____
_____

IS THERE ANYTHING YOU CAN THINK OF THAT MAKES YOUR SYMPTOMS SIGNIFICANTLY WORSE?

_____
_____

IF YOU HAVE A HISTORY OF ANY OF THE FOLLOWING PLEASE CIRCLE:

OSTEOPOROSIS **UNHEALTHY ALCOHOL USE/ABUSE** **HISTORY OF FALLS** **CURRENT TOBACCO**

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Please PRINT and fill out completely.

Date: ____/____/____ Physician: O Dr. McLaughlin
Name: _____ DOB: _____ Age: _____
Height ____ft. ____in. Weight_____lbs Sex: _____ Are you or could you be pregnant? _____
Your Occupation: _____ Employer: _____
Who referred you to this office? O Dr. _____ O PA/NP _____
O Family/Friend _____ O Physical Therapist _____
O Other _____
Pharmacy Name and Location: _____

HISTORY OF CARE

Who is your primary care physician? _____ Location: _____
Address: _____ Phone: _____
Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name:	*City:*	*Date of First Visit:*	*Currently Continuing?:*

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:
1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:
_____
_____
_____
_____

Is there current imaging available (i.e. MRI, CT) regarding this current spinal condition? _____
If so, at what facility was this performed? _____
Please bring a copy (CD or films) of your imaging to your appointment.

CURRENT SYMPTOMS

What time of day is your pain at its worst? O Morning O Afternoon O Evening O Night O N/A
Does the pain wake you up at night? O Yes O No
In the past six months have you experienced: O Fever O Weight Loss _____lbs
O Chills O Night Sweats
How would you describe your pain? O Constant O Constant, but worse with activity
O Intermittent (comes and goes)
O Intermittent, but worse with activity
Do you have full control of your bladder? O Yes O No
Do you have full control of your bowels? O Yes O No

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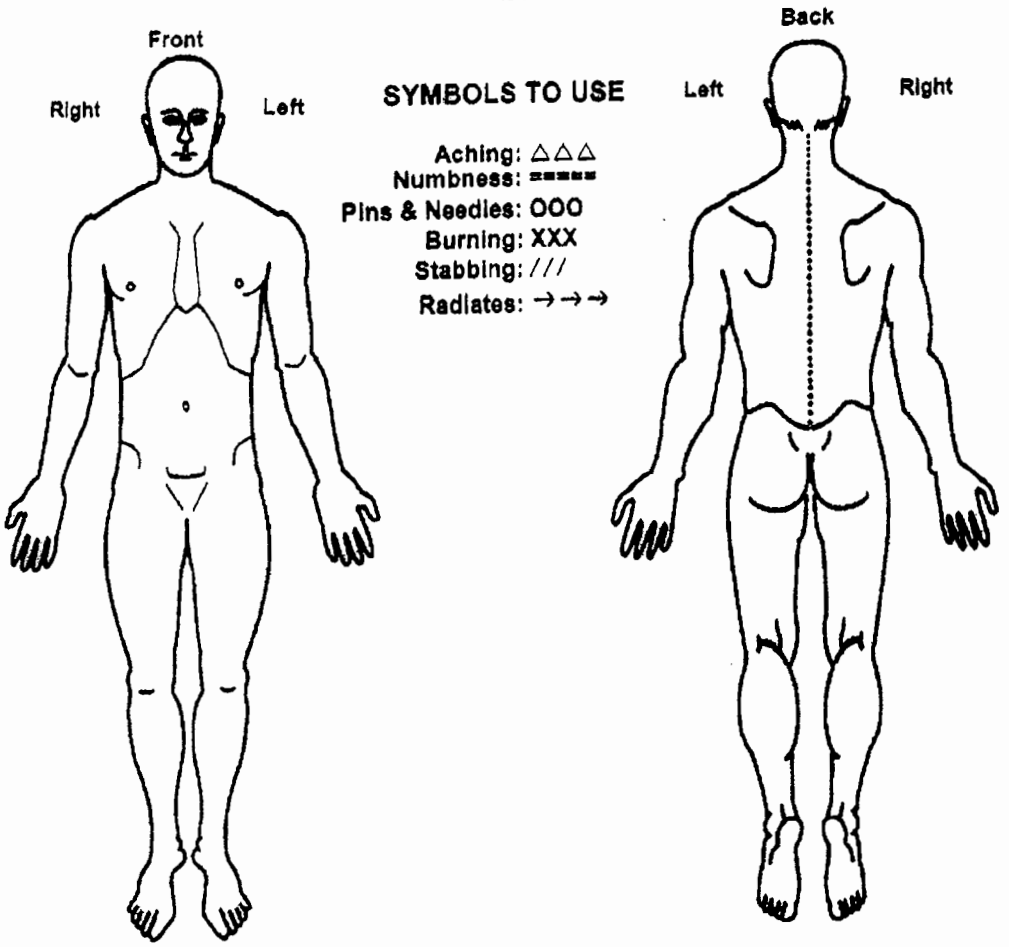
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, including all affected areas.



Mark where any symptoms (pain, numbness, weakness, etc) exist on average (most of the time) and at their worst.

	Current pain: None										Unbearable
Average	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

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MEDICAL HISTORY

Check if you are being treated for or have been diagnosed with:

	When?		When?
O High Blood Pressure	_____	O Osteoporosis	Bone Density test? O Yes O No
O Diabetes	_____	O Kidney Disease/Problem	_____
O Liver Disease	_____	O Seizures	_____
O Heart Disease or Attack	_____	O Arthritis	_____
O Stroke	_____	O Thyroid	_____
O Cancer	_____	O Tuberculosis	_____
O High Cholesterol	_____	O Psoriasis	_____
O Ulcer Disease	_____	O Polio	_____
O Gastritis	_____	O Rheumatic Fever	_____
O Reflux Disease (GERD)	_____	O Gout	_____
O Asthma	_____	O Herpes Simplex	_____
O Depression	_____	O Bipolar Disease	_____
O Other Psychiatric	_____	O *Pacemaker/ *Stent(s)	* PLEASE PROVIDE CARD

Have you ever had a history of blood clots or pulmonary embolus? O Yes O No
Have you had a recent history of falls? O Yes O No

SURGERIES

Please list all ***spine*** surgeries you have had in the past:

Type of Surgery: *Date:* *Surgeon:*

_____
_____
_____
_____

Please list all ***other*** surgeries you have had in the past:

Type of Surgery: *Date:* *Surgeon:*

_____
_____
_____
_____

MEDICATIONS

Please list ALL medications you are **currently** taking, including prescription and ***over the counter***:

Medication: *Dosage :* *Frequency: (how many pills in 24 hours)*

O _____
_____
_____

I take Tylenol_____ I take Aspirin _____ I take Ibuprofen _____

ALLERGIES

Please list any ***allergies or adverse reactions*** you have to medications:

Medication: *What Happened?:*

_____
_____
_____

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FAMILY HISTORY

Is your father alive? O Yes O No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did he have? _____
Is your mother alive? O Yes O No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did she have? _____
Any siblings? O Yes O No How many? _____

SOCIAL HISTORY

Marital Status: O Married O Single O Divorced O Widowed O Living with other
Do you have children? O Yes O No Ages: _____
Education level achieved: O Grade School O Jr. High O High School O College O Post Graduate
DO you currently smoke cigarettes? O Yes O No Number of Years Smoked: _____ **FOR DR. USE:** P YRS _____
Packs per Day: (please choose the closest) O < ½ O ½ O 1 O 2 O >2
DID you smoke cigarettes in the past? O Yes O No Number of Years Smoked: _____ Quit Date: _____
Packs per Day: (please choose the closest) O < ½ O ½ O 1 O 2 O >2
Do you use any other tobacco products? O Yes O No What kind? _____ Quantity? _____
Do you use recreational drugs? O Yes O No What kind? _____
Do you drink alcohol? O Yes O No Drinks per Day _____ Drinks per Week _____
DO YOU OR HAVE YOU HAD an unhealthy relationship with alcohol? O Yes O No
Type of alcohol consumption: O Beer O Wine O Mixed Drinks

WORK HISTORY

Are you currently: O employed O unemployed O retired O on sick leave O on disability O stay at home parent
Has your job changed since your symptoms started? O Yes O No O Not working
If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? O Yes O No
If you are working, are you on: O Normal duties O Light duties
If you are on light duty, did your symptoms play a role? O Yes O No
Are you applying for disability? O Yes O No
Please describe your job: _____

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? O Yes O No
Have you had any PRIOR car accidents? O Yes O No If yes, how many? _____
Please list: *Date:* *Area Injured:* *Time Off Work:* *Who Treated You?:*

_____
_____
_____

Do you currently have an attorney for this episode? O Yes O No

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REVIEW OF SYMPTOMS

Check Yes or No in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL
   - A. Recent Weight Change? O Yes O No _____
   - B. Change or loss of appetite? O Yes O No _____
   - C. Fevers? O Yes O No _____
   - D. Chills? O Yes O No _____
   - E. Night Sweats? O Yes O No _____
   - F. Weakness/Fatigue? O Yes O No _____
2. EYES
   - A. Vision change? O Yes O No _____
   - B. Glasses/contacts? O Yes O No _____
   - C. Glaucoma? O Yes O No _____
   - D. Eye infections (iritis)? O Yes O No _____
   - E. Loss of Vision? O Yes O No _____
3. EARS, NOSE AND THROAT
   - A. Decrease or loss of hearing? O Yes O No _____
   - B. Earache or infection? O Yes O No _____
   - C. Tinnitus (ringing in ear)? O Yes O No _____
   - D. Nasal stuffiness/discharge? O Yes O No _____
   - E. Nosebleeds? O Yes O No _____
   - F. Sore throat? O Yes O No _____
   - G. Hoarseness? O Yes O No _____
   - H. Dental problems? O Yes O No _____
   - I. Dentures? O Yes O No _____
   - J. Difficulty swallowing? O Yes O No _____
4. CARDIOVASCULAR
   - A. Chest pain? O Yes O No _____
   - B. Shortness of breath? O Yes O No _____
   - C. Palpitations? O Yes O No _____
   - D. Swelling in the legs? O Yes O No _____
   - F. Pacemaker? O Yes O No
   - E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER

     _____
5. RESPIRATORY
   - A. Cough? O Yes O No _____
   - B. Wheezing/asthma? O Yes O No _____
   - C. Pneumonia or bronchitis? O Yes O No _____
   - D. Shortness of breath? O Yes O No _____
6. GASTROINTESTINAL
   - A. Abdominal pain? O Yes O No _____
   - B. Nausea or vomiting? O Yes O No _____
   - C. Constipation? O Yes O No _____
   - D. Diarrhea? O Yes O No _____
   - E. Heartburn/acid reflux? O Yes O No _____
   - F. Rectal bleeding or black, tarry stools? O Yes O No _____

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7. GENITOURINARY
   - A. Increase frequency of urination? O Yes O No _____
   - B. Pain/burning when you urinate? O Yes O No _____
   - C. Frequent infection of urine? O Yes O No _____
   - D. Incontinence (loss of control)? O Yes O No _____
   - E. Reduced force of urination? O Yes O No _____

8. MUSCOLOSKELETAL
   - A. Muscle aches? O Yes O No _____
   - B. Joint pains/stiffness (arthritis)? O Yes O No _____
   - C. Swelling of joints? O Yes O No _____

9. SKIN
   - A. Rash? O Yes O No _____
   - B. Lumps or sores? O Yes O No _____
   - C. Changes in hair or nails? O Yes O No _____
   - D. Dryness? O Yes O No _____
   - E. Ulcers? O Yes O No _____
   - F. Abnormal scars? O Yes O No _____

10. NEUROLOGICAL
   - A. Headaches? O Yes O No _____
   - B. Fainting/blackouts? O Yes O No _____
   - C. Tremors/involuntary movements? O Yes O No _____
   - D. Numbness, tingling? O Yes O No _____
   - E. Dizziness? O Yes O No _____
   - F. Muscle weakness? O Yes O No _____

11. PSYCHIATRIC (If yes, please rank 1-10, 1 being manageable and 10 being unmanageable)
   - A. Depression? O Yes O No - O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
   - B. Mood swings? O Yes O No - O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
   - C. Anger? O Yes O No - O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
   - D. Nervousness/anxiety O Yes O No - O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10
   - E. General unmanageable stress levels? O NO - O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

12. ENDOCRINE
   - A. Excessive thirst or hunger? O Yes O No _____
   - B. Hot/cold intolerance? O Yes O No _____
   - C. Hot flashes? O Yes O No _____

13. HEMATOLOGICAL
   - A. Easy bruising or bleeding? O Yes O No _____
   - B. Past blood transfusions? O Yes O No _____

Patient Signature: _____ Date: _____

Additional comments:

_____

_____

_____

Physician Signature: _____ Date: _____

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