ENTRANCE APPLICATION

We realize your time is valuable to you, so in order to lessen your time in our office please complete this set of health information forms prior to your first visit.

The PDF forms are fillable and saveable with Adobe Reader, so you should be able to fill them out directly. When you do this, please be sure to save your file from time to time to avoid accidental data loss. If you prefer to fill them out manually or have difficulties with your software, then please print these forms out and fill them in by hand.

You may email the completed forms to us at sw@SpinalWorks.com, or bring signed copies along to your first visit.

Thank you!

To the NEW PATIENT

STEP ONE:

All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:

A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:

A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:

The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:

You will be given a Report of Findings at which time the cause of your problem will be discussed.

It includes how our treatment works and what results can be obtained. You will also he advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:

Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:

An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:

After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.

SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, PLEASE FILL OUT THESE FORMS.
IF YOU NEED ASSISTANCE PLEASE CONTACT US AT 602-298-1600. THANK YOU!

First Name_____ Middle _____ Last _____

Gender ❑ Male ❑ Female Home Phone _____ Cell Phone _____

Address _____

City _____ State_____ ZIP _____

Social Security Number _____ E-mail Address _____

Birthdate_____ Age _____ Marital Status ❑S ❑M ❑W ❑D

Job Title _____ Work Phone_____

Spouse's Name _____ Spouse's Birthdate_____

Social Security Number _____

Person responsible for this account _____

Name of person on your health insurance card _____

Name of their employer _____ City_____

Employer Phone _____

Children–Names & Ages _____

_____

In case of emergency, whom should we contact? _____

Phone _____ Relationship: _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

_____

IS THIS WORKMAN'S COMPENSATION? _____ IS THIS PERSONAL INJURY?_____

Assignment & Release

In considering the medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage and hereby directly assign to SpinalWorks, Inc ("SpinalWorks") all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for any services rendered in conjunction with these expenses.

I authorize SpinalWorks to release any personal and medical information to any plan administrator or fiduciary, insurer or attorney as necessary to apply for and/or process reimbursement of my medical expenses incurred at SpinalWorks.

I authorize any plan administrator or fiduciary, insurer and my attorney to release to SpinalWorks any plan documents, insurance policy and/or settlement information as necessary to apply for, understand and/or process reimbursement of my medical expenses incurred at SpinalWorks.

I understand that I am and remain financially responsible for all charges regardless of any applicable insurance or benefit payments.

If so requested, I agree to cooperate with SpinalWorks in any attempts by SpinalWorks to secure reimbursement of medical expenses incurred at SpinalWorks from my plan administrator or fiduciary, insurer or attorney.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement

Patient Name: _____

Responsible Party: _____
(if not same as Patient Name listed above)

Signature: _____

Date: _____

Our Financial policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies to avoid any future misunderstandings.

Treatment Plan- It is very important to follow the schedule outlined in the prescribed treatment plan. Missed appointments and treatment gaps slow the healing process and may increase the number of treatments required. In this case, you will be responsible for the cost of the extra appointments beyond those outlined in the prescribed treatment plan.

Insurance Benefits- Benefit estimates given by your insurance company are no guarantee of payment, and your portion may be different from what we were told when we verified coverage. In this case, we will either refund you the excess or invoice you the difference.

Insurance Co-Pay & Deductibles- When your insurance company specifies a co-pay or deductible; this payment is due at the time of service unless arranged otherwise with us.

Insurance Filings- As a service to you, we will file your insurance claim, if you assign the benefits to us so that your insurance company can pay us directly. We will also follow up for you, but if your insurance company does not pay the claim within a reasonable period, you are responsible for payment.

Self-pay- If you do not have insurance, or if we cannot verify your coverage, payment is due at time of service unless arranged otherwise with us.

Returned Checks- We will charge a fee of $25 for all checks returned unpaid.

Collections - if your account is ever assigned to an attorney or outside agency for collections or litigation, SpinalWorks shall be entitled to reasonable attorney's fees and the cost of collections.

Missed Appointments- As a way to honor everyone's schedule, we reserve the right to charge a $25 fee for appointments missed without a one day advance notice.

Credit Payments- We gladly accept Visa and MasterCard, and offer CareCredit for treatment financing. Other credit arrangements may be possible, please ask if these are of interest.

Refunds- We will normally make full refund of any unapplied funds within .30 days of cancellation in case of an unfinished prepaid treatment program. The credit balance is calculated as the amounts paid, less the list price of any treatments received to date.

Your Agreement- I have read and understand the practice's financial policy. I agree to be bonded by its terms as indicated by my signature below. I authorize the release of any information necessary to determine liability for payment and reimbursement for any claim.

I hereby authorize the doctors at SpinalWorks to treat my condition as he deems appropriate. It is understood and agreed the amount paid to Health Works Spine & Sport, for x-rays is for the examination and interpretation of the X-ray negatives and will remain the property of the clinic, being on file where they can be seen at any time while patient at this office. The patient also agrees that he/she is responsible for any bills incurred at Health Works Spine & Sport.

Patient Signature _____ Date _____

In case of treatment to a Minor, please complete the section below:

Name of Minor to be Treated: _____

Guardian or Spouse
Signature of Authorizing Care _____ Date _____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected-Health Information

Your Protected Health Information will be used by SpinalWorks and may be disclosed to ethers for the purposes of treatment obtaining payment or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health information may be used or disclosed. it describes your rights as they concern the, limited use of health information, including your demographic information, collected from you and created or received by this office..

You may review the Notice-prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use of disclosure of your Protected Health Information, however, we may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of Protected information in violation of an agreed upon restriction will be violation of the federal privacy standards.

Revocation of Consent.

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change privacy practice.

This office reserves the right to modify the privacy practices outlined in the Notice.

Signature

I have reviewed this consent from and give my permission to this office to use and disclose my health information in accordance with it.

Name of Patient _____

Signature of Patient _____ Date _____

Are you signing on behalf of someone else? Then please complete the following:

Name of Patient Representative _____

Relationship to Patient _____

Signature of Patient Representative _____ Date _____

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: _____

_____

What caused the onset? _____

_____

Date of onset? _____

TIMING AND DURATION

How often do you experience this pain? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Moderate 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity 9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the least intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the most intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ❑ Inflexibility ❑ Stiffness ❑ Spasms ❑ Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

❑ Deadness	❑ Prickly	❑ Numb	❑ Crawling	❑ Tingling
❑ Stabbing	❑ Hurting	❑ Pulsating	❑ Pins & Needles	❑ Pounding
❑ Burning	❑ Shooting	❑ Throbbing	❑ Stinging	
❑ Dull	❑ Sharp	❑ Aching	❑ Excruciating	

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

MODIFYING FACTORS

What aggravates the pain/symptom?

❑ Flashing lights	❑ Sneezing	❑ Lifting	❑ Exercising	❑ Looking up/down
❑ Coughing	❑ Sitting	❑ Stooping	❑ Looking side/side	❑ Anger
❑ Standing	❑ Depression	❑ Stress	❑ Driving	❑ Walking
❑ Getting out of bed	❑ Pushing	❑ Emotional upset	❑ Pulling	❑ Repetitive movement
❑ Carrying	❑ Straining at BM	❑ Climbing stairs	❑ Walking uphill	❑ Getting in/out of car

Other: _____

What relieves this pain/symptom?

❑ Resting	❑ Lifting	❑ Stooping	❑ Looking side/side
❑ Shower	❑ Advil	❑ Exercising	❑ Looking up/down
❑ Sleeping			
❑ Ice / Heat	**Other** (please describe): _____		

Over the past weeks/months this complaint is: ❑ Improving ❑ Getting worse ❑ About the same

Patient history was obtained from: ❑ Patient ❑ Father ❑ Mother ❑ Son ❑ Daughter

OTHER INFORMATION

Have you seen anyone for your condition? ❑ YES ❑ NO If so, then whom have you seen?_____

Do you have a pacemaker? ❑ YES ❑ NO

Are you Pregnant? ❑ YES ❑ NO

Number of Children: _____

Do you think you may be pregnant? ❑ YES ❑ NO

Describe your job: ❑ Sedentary ❑ Moderate activity ❑ Heavy labor ❑ Non-Working

Frequency of Exercise ❑ Never ❑ Rarely ❑ Occasionally ❑ Moderately ❑ Regularly

Intensity of Exercise ❑ Low Level ❑ Medium Level ❑ High Level ❑ Competition Level

Please list your favorite Hobbies & Sports

_____

_____

Do you feel that you get sufficient rest ❑ Never ❑ Rarely ❑Occasionally ❑Moderately ❑Yes

How many Hours of Sleep do you get per night: ❑Less than 4 ❑4-6 hours ❑6-8 hours ❑9-10 hours ❑More than 10 hours

Do you have a well-balanced diet ❑ Never ❑ Rarely ❑Occasionally ❑Moderately ❑Yes

Do you smoke? ❑No ❑Occasionally ❑1 to 2 ❑2 to 3 ❑4 to 5 ❑5+ per day

Do you drink caffeinated beverages? ❑No ❑Occasionally ❑1 to 2 ❑2 to 3 ❑4 to 5 ❑5+ per day

Do you drink alcoholic beverages? ❑No ❑Occasionally ❑1 to 2 ❑2 to 3 ❑4 to 5 ❑5+ per day

Do you use street drugs? ❑Never ❑ Not anymore ❑Occasionally ❑Sometimes ❑Yes

How did you hear about us? ❑Internet ❑ Newspaper/Magazine ❑Friend/Neighbor/Coworker ❑HealthFair ❑Existing Patient
❑Flyer ❑ Sporting Event ❑ Your Doctor ❑One of our staff members ❑email ❑Family Member

If from Internet please give us detail: _____

If from one of the following sources, then please give us his/her name so we may thank them:

Friend/Neighbor/Coworker: _____

Existing Patient: _____

Your Doctor: _____

One of our Staff: _____

Family Member:_____

CURRENT & PRIOR MEDICAL CONDITIONS (place an "x" in "Past" or "Now" columns, with additional information as appropriate)

Past	Now	Condition	Dates & Explanation of Condition
❑	❑	Cancer	
❑	❑	Balance Problems	
❑	❑	Stroke	
❑	❑	Thyroid Problems	
❑	❑	Asthma	
❑	❑	Heart Attack	
❑	❑	HIV	
❑	❑	Angina/Chest Pain	
❑	❑	Diabetes	
❑	❑	Gout	
❑	❑	Broken Bones	
❑	❑	Arthritis	
❑	❑	Serious Depression	
❑	❑	Other	

SURGERY	YES	NO	YEAR	SURGERY	YES	NO	YEAR
Tonsils	❑	❑		**WOMEN**			
Colon	❑	❑		Breast	❑	❑	
Hernia	❑	❑		Uterus	❑	❑	
Appendix	❑	❑		Ovaries	❑	❑	
Gall Bladder	❑	❑		Other			
Stomach	❑	❑		**MEN**			
Heart	❑	❑		Prostate	❑	❑	
Kidney	❑	❑		Other			
Other							

What other major injuries have you had?	Date
What medications are you currently taking?	**Date**

Have you ever taken:	YES	NO	YEAR
Insulin	❑	❑	
Cortisone	❑	❑	
Thyroid Medicine	❑	❑	
Male/Female Hormones	❑	❑	
Blood Pressure	❑	❑	
Tranquilizers/Sedatives	❑	❑	
Birth Control	❑	❑	

Hospitalizations: *(Please provide details including date & length of stay)*

CURRENT & PRIOR MEDICAL CONDITIONS (place an "x" in "Now", "Previously" or "Never" columns)

Fatigue	❑ Now	❑ Past	❑ Never	Masses	❑ Now	❑ Past	❑ Never
Fever	❑ Now	❑ Past	❑ Never	Seizures	❑ Now	❑ Past	❑ Never
Chills	❑ Now	❑ Past	❑ Never	Vertigo	❑ Now	❑ Past	❑ Never
Night Sweats	❑ Now	❑ Past	❑ Never	Dizziness	❑ Now	❑ Past	❑ Never
Fainting	❑ Now	❑ Past	❑ Never	Tremors	❑ Now	❑ Past	❑ Never
Nervousness	❑ Now	❑ Past	❑ Never	Loss of Sensation	❑ Now	❑ Past	❑ Never
Concentration Loss	❑ Now	❑ Past	❑ Never	Coordination Loss	❑ Now	❑ Past	❑ Never
Dizzy Spells	❑ Now	❑ Past	❑ Never	Weak Grip	❑ Now	❑ Past	❑ Never
Irritability	❑ Now	❑ Past	❑ Never	Paralysis	❑ Now	❑ Past	❑ Never
Depression	❑ Now	❑ Past	❑ Never	Difficulty of Speech	❑ Now	❑ Past	❑ Never
Memory Loss	❑ Now	❑ Past	❑ Never	Tingling	❑ Now	❑ Past	❑ Never
Loss of Sleep	❑ Now	❑ Past	❑ Never	Numbness	❑ Now	❑ Past	❑ Never
Headache	❑ Now	❑ Past	❑ Never	Weakness	❑ Now	❑ Past	❑ Never
Apprehension	❑ Now	❑ Past	❑ Never	**ALLERGIES….**			
Muscle Pain	❑ Now	❑ Past	❑ Never	Animal Dander	❑ Now	❑ Past	❑ Never
Muscle Weakness	❑ Now	❑ Past	❑ Never	Latex	❑ Now	❑ Past	❑ Never
Muscle Cramps	❑ Now	❑ Past	❑ Never	Food Allergies	❑ Now	❑ Past	❑ Never
Joint Stiffness	❑ Now	❑ Past	❑ Never	Penicillin	❑ Now	❑ Past	❑ Never
Joint Tenderness	❑ Now	❑ Past	❑ Never	Pollen	❑ Now	❑ Past	❑ Never
Spinal Curvature	❑ Now	❑ Past	❑ Never	2nd Hand Smoke	❑ Now	❑ Past	❑ Never
Back Pain	❑ Now	❑ Past	❑ Never	Grasses	❑ Now	❑ Past	❑ Never
Hot Joints	❑ Now	❑ Past	❑ Never	Sulfa Drugs	❑ Now	❑ Past	❑ Never
Joint Swelling	❑ Now	❑ Past	❑ Never	Dairy Products	❑ Now	❑ Past	❑ Never
Stiff Neck	❑ Now	❑ Past	❑ Never	Perfumes	❑ Now	❑ Past	❑ Never
Soreness	❑ Now	❑ Past	❑ Never	Hay	❑ Now	❑ Past	❑ Never
Lumps	❑ Now	❑ Past	❑ Never				

For your SECONDARY COMPLAINT & LOCATION *(if applicable)*

Give a brief description of your additional pain or issue that we might help you with:

_____

_____

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Moderate 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity 9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the least intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the most intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ❑ Inflexibility ❑ Stiffness ❑ Spasms ❑ Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

❑ Deadness	❑ Prickly	❑ Numb	❑ Crawling	❑ Tingling
❑ Stabbing	❑ Hurting	❑ Pulsating	❑ Pins & Needles	❑ Pounding
❑ Burning	❑ Shooting	❑ Throbbing	❑ Stinging	
❑ Dull	❑ Sharp	❑ Aching	❑ Excruciating	

If this pain radiates or travels, please identify where to: _____

Over the past weeks/months this complaint is: ❑ Improving ❑ Getting worse ❑ About the same

For your TERTIARY COMPLAINT & LOCATION *(if applicable)*

Give a brief description of your additional pain or issue that we might help you with:

_____

_____

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the least intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the most intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ❑ Inflexibility ❑ Stiffness ❑ Spasms ❑ Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

❑ Deadness	❑ Prickly	❑ Numb	❑ Crawling	❑ Tingling
❑ Stabbing	❑ Hurting	❑ Pulsating	❑ Pins & Needles	❑ Pounding
❑ Burning	❑ Shooting	❑ Throbbing	❑ Stinging	
❑ Dull	❑ Sharp	❑ Aching	❑ Excruciating	

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

Over the past weeks/months this complaint is: ❑ Improving ❑ Getting worse ❑ About the same

For any ADDITIONAL COMPLAINT & LOCATION *(if applicable)*

Give a brief description of your additional pain or issue that we might help you with:

_____

_____

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the least intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

What is the most intense the symptom has been on a scale of 0 to 10?

❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

ASSOCIATED SIGNS AND SYMPTOMS

How does this symptom affect your movement? ❑ Inflexibility ❑ Stiffness ❑ Spasms ❑ Cramps

Other: _____

QUALITY

How would you best describe the sensation of the pain/symptom:

❑ Deadness	❑ Prickly	❑ Numb	❑ Crawling	❑ Tingling
❑ Stabbing	❑ Hurting	❑ Pulsating	❑ Pins & Needles	❑ Pounding
❑ Burning	❑ Shooting	❑ Throbbing	❑ Stinging	
❑ Dull	❑ Sharp	❑ Aching	❑ Excruciating	

ADDITIONAL ASSOCIATED SIGNS AND SYMPTOMS

If this pain radiates or travels, please identify where to: _____

Over the past weeks/months this complaint is: ❑ Improving ❑ Getting worse ❑ About the same

PATIENT ACKNOWLEDGMENT

I hereby certify that the information provided in this Patient Information package to SpinalWorks is true and correct to the best of my knowledge. I understand that making false statements in this Patient Information package may disqualify me from insurance or other benefits, and may also be in violation of state and federal law.

Patient Name: _____

Patient Signature: _____ Date: _____

If this Patient Information package has been completed for treatment of a Minor, then please complete the following:

Name of Guardian/Trustee: _____

Relationship to Patient:_____

Signature:_____ Date: _____