Austin SPINE HEALTH

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Esther Yaniv, M.D.

PATIENT INFORMATION: Today's Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Home Phone: _____

Date Of Birth: _____ Sex: ○ Male ○ Female

Marital Status: ○ Single ○ Married ○ Legally Separated ○ Divorced ○ Widowed ○ Partner

Employment: ○ Student ○ Employed ○ Not Employed ○ Self Employed ○ Retired ○ Active Military

Preferred Language: _____ Race/Ethnicity: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

REASON FOR TREATMENT:

Condition Related to:

○ None (No trauma/unknown cause)
○ Accident: Date of Accident: _____
○ Motor Vehicle Accident: Date of Accident: _____
○ Employment: Workers Comp Claim# _____ Date of Injury: _____
Employer: _____ SSN: _____

INSURANCE:

Primary Carrier: _____ ID# _____ Group# _____

Secondary Carrier: _____ ID# _____ Group# _____

PRIMARY CARE PHYSICIAN: ○ No Primary Care Physician

Name: _____ Phone: _____

PREFERRED PHARMACY:

Pharmacy: _____ Phone: _____ Cross Streets: _____

HOW DID YOU HEAR ABOUT AUSTIN SPINE HEALTH?

○ **Physician Referral:**
Name: _____ Facility: _____ Phone: _____
○ **Internet:** Search Engine: ○ Google ○ Yahoo ○ Bing ○ Other: _____
○ **Other:** ○ Previous Patient ○ Insurance Carrier

Name: _____ **Date:** _____ **DOB:** _____

Chief Complaint:

Pain in: □ Head □ Neck □ Shoulder □ Arm □ Mid back
□ Low back □ Buttock □ Leg □ Other_____

History of Present Illness:

When did your pain begin?_____ □ work-related?
How did your pain begin?
□ No apparent reason □ Bending □ Lifting □ Fall
□ Motor Vehicle Accident □ Other_____
Have you had a similar episode before? □ Yes □ No
What have you been told is wrong? _____

Prior tests for your pain:

Test/Results:
□ X-ray_____
□ MRI_____
□ CT_____
□ Lab_____
□ Other_____

Prior treatment for your current problem:

Anti-inflammatory: □ Ibuprofen □ Aleve □ Celebrex □ Mobic
□ Other_____ Results: _____
Steroids: □ Cortisone pills □ Cortisone injection
□ Other_____ Results: _____
Other medications: _____ Results: _____
Injections: □ Epidural □ Facet □ Other Results: _____
Spinal surgery: □ Year/Procedures/Results_____
Physical therapy: □ Year/Procedures/Results_____
Chiropractic: □ Year/Procedures/Results_____
Other Treatments: □ Year/Type/Results _____
Has your pain : □ Improved □ Worsened □ Not changed
Is your pain: □ Constant □ Intermittent

How do the following affect your pain?

	Worse	Better	No change
Cough/sneeze	□	□	□
Sitting	□	□	□
Sit to Stand	□	□	□
Bending forward	□	□	□
Morning	□	□	□
Lifting	□	□	□
Bending backward	□	□	□
Standing	□	□	□
Walking	□	□	□
Lying on stomach	□	□	□
Nighttime	□	□	□
Looking down	□	□	□
Looking up	□	□	□
Turning head	□	□	□

What level would you rate your pain right now? (please circle)
None 0 1 2 3 4 5 6 7 8 9 10 Most severe

Family Medical History: □ Heart disease □ Cancer □ Lupus □ Diabetes
□ Arthritis □ Abnormal bleeding □ Muscle disease □ Scoliosis
□ Rheumatoid Arthritis □ Drug allergies □ Other _____
Living parents? Mother □ Yes □ No; Died at age _____ of _____
Father □ Yes □ No; Died at age _____ of _____

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_____
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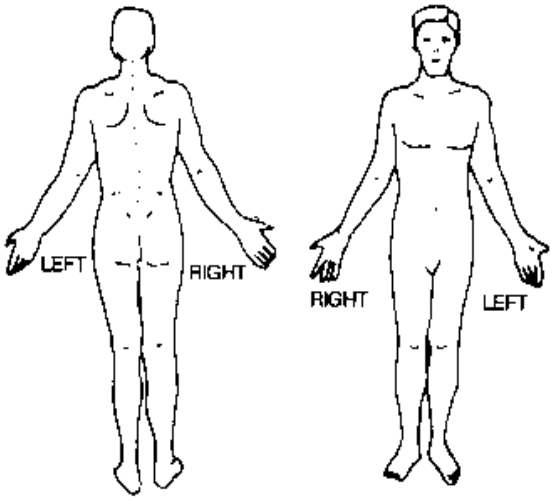
_____

Please fill out the pain drawing below

Use these symbols on the drawings:
>>>> Ache **□□□□ Numbness**
X X X X Burning **0 0 0 0 Pins and Needles**
//////// Stabbing



Name: _____ **Date:** _____ **DOB:** _____

Current Work Status:

Employer _____ Job Title_____ Time at this position _____

□ Regular Duty □ Modified Duty - Date began:_____ □ Off work – Date began:_____

Description of your Normal Job Activities

	Sitting	Standing	Walking	Driving	Lifting
Total hours in a normal work day					
Max. time at one time at work					

* If lifting at work, what is the average weight? _____lbs. How many times per hour? _____

Lifestyle Habits:

□ Tobacco _____ (# of cigs/day) □ Sleep _____ (hours/day)

How long have you smoked? _____ (years)

□ Alcohol _____ (# of drinks/day) □ Caffeine beverages _____ (#/day)

Are you currently exercising regularly? □ Yes; how long: _____

□ No; last regular exercise:_____

Has your condition prevented you from doing exercise? □ Yes □ No

Past Medical History:

□ Cancer □ Arthritis □ Alcoholism □ Kidney disease
□ Diabetes □ Seizures □ Lung Disease □ Thyroid Disease
□ Ulcers □ Glaucoma □ Heart Disease □ Tuberculosis
□ AIDS/HIV □ Hepatitis □ Diverticulitis □ High Blood Pressure
□ Stroke □ Anemia □ Pacemaker □ Joint Replacement
□ Blood Thinners □ Depression/Anxiety
□ Other_____

Surgeries/Hospitalizations:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

Injuries/Fractures/Dislocations:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

List all medications you are currently taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies: □ No □ Yes; _____

Review of Systems: (Please check all that apply):

Constitutional: □ Fever □ Night sweats □ Unexplained weight loss
Eyes: □ Abrupt change in vision
Ears, Mouth, and Throat: □ Abrupt change in hearing □ Difficulty swallowing □ Sore throat
Cardiovascular: □ Chest Pain □ Poor circulation
Respiratory: □ Cough □ Difficulty breathing
Gastrointestinal: □ Nausea □ Vomiting □ Bleeding □ Diarrhea
Musculoskelatal: □ Pain/swollen joints
Skin □ Rash
Neurologic: □ Dizziness □ Numbness □ Muscle weakness
Endocrine: □ Hot flashes
Hematologic/Lymphatic: □ Bruise easy
Allergic/Immunologic: □ Allergies to pollen, etc
Genitourinary: □ Burning on urination □ Loss of bladder/bowel control
Infection (recent): □ Urinary tract □ Respiratory □ Skin □ Immune system dysfunction □ Other _____
Psychosocial: □ Depression □ Anxiety □ Difficulty sleeping

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Austin SPINE HEALTH

CONSENTS AND POLICIES

Authorization to File Insurance

I authorize Austin Spine Health to file claims through my insurance carrier. (Information Provided)
I assign, transfer, and release to Austin Spine Health all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy.
I authorize the release of any medical information needed to determine these benefits/claims.
I understand that I am ultimately financially responsible for all charges whether or not they are covered by insurance.

Verification of Benefits

Policyholder is responsible to know/understand their insurance benefits. As a courtesy, our office will attempt to contact your carrier to determine your eligibility/benefits as applied to services performed at Austin Spine Health.

Insurance referrals

For insurance policies that require insurance referrals/authorization from a primary care physician (PCP) it is the patient's responsibility to obtain this referral from their PCP as per provisions of the carrier. The insurance referral is necessary in order for the claims to process in-network and without penalty or denial.

Payment Policy

You will be responsible to pay the co-payment, deductible, coinsurance, or fees not covered by your insurance carrier at the time services are rendered.

Workers Compensation/Motor Vehicle Accidents

All necessary information must be provided and authorized prior to services if a third party billing request is made by patient.

Payment Estimates

Our financial staff is available to obtain a payment *estimate* of patient's responsibility prior to services rendered based on the benefits and eligibility obtained by insurance carrier or self pay. Please make request to any staff member. Note that we are only able to provide estimates for the physician' components. Please check with other entities/facilities for additional financial responsibilities prior to services rendered.

Cancellation Fee

A $50.00 fee for no show/no cancellation appointments (24 hour cancellation notice required)

Disclosure of Unencrypted Emails

Austin Spine Health will only provide PHI and other correspondence via email address if address provided and authorized by you, but advising you of potential risk of release of medical information to unattended party due to our unencrypted email software. If you do not wish to be exempt from email correspondence please do not provide your email address or notify the front office staff. By providing an email address and signing below you give permission to receive office information and/or patient satisfaction surveys. To opt out of this correspondence please notify front office staff.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been afforded the opportunity to read the Notice of Privacy Practices, ask questions, and receive a paper copy.

By signing below I consent that I have read and understand the information above and acknowledge to the policies and disclosures expressed on this document.

Signature: _____ **Date:** _____

Patient Name: _____