ADVANCED SPINE & ORTHOPAEDICS, LLC

PATIENT INFORMATION SHEET

DATE: _____

NAME: _____ BIRTHDATE: ____/____/____ AGE: ____ SEX: ____
LAST FIRST MIDDLE

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: ( ) _____ SS#: _____

CELL PHONE: ( ) _____

IS PATIENT EMPLOYED? YES ___ NO ___ OCCUPATION: _____ MARITAL STATUS _____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

EMPLOYER'S PHONE: ( ) _____

REFERRED BY: _____ FAMILY PHYSICIAN _____

IN CASE OF EMERGENCY, PERSON WHO SHOULD BE NOTIFIED _____

PHONE #: ( ) _____ RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

DOES PATIENT HAVE CURRENT INSURANCE COVERAGE? YES ____ NO ____

RESPONSIBLE PARTY FOR ACCOUNT: _____ RELATIOSHIP TO PATIENT _____

ADDRESS (If different from the patient): _____

HOME PHONE: ( ) _____ BIRTHDATE: ____/____/_____ SS#: _____

EMPLOYER: _____ EMPLOYER PHONE ( ) _____

PRIMARY INSURANCE: _____ ID#: _____ GRP# _____

SECONDARY INSURANCE: _____ ID#: _____ GRP# _____

RELATED TO EMPLOYMENT? YES ____ NO ____ PA COMP: _____ OH COMP: _____

CLAIM/FILE#: _____ INJURY DATE: _____

RELATED TO AUTO ACCIDENT? YES ____ NO ____ STATE ACCIDENT OCCURRED: _____

CLAIM/FILE#: _____ INJURY DATE: _____

INSURANCE & ASSIGNMENT and RELEASE OF INFORMATION:

I consent to treatment necessary for the above named patient. I authorize the release, via fax if necessary, of all medical records, including any and all records containing HIV and substance abuse, to the referring and family physician and to my insurance company, if applicable. I agree to pay for all charges for treatment and understand that payment is due at the time of service. I further authorize and request insurance payments be made directly to the physician. I herby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to the physician. I agree to notify this facility of any change in insurance, address, or other information including on this form. I understand I am responsible for all charges not paid by my insurance.

_____ DATE: _____
Signature of Patient or Guardian

OFFICE USE ONLY: A good forth effort was made to obtain acknowledgement of Notice of Privacy Practices, but acknowledgement was not returned.

Signature of Employee _____ DATE: _____

Health History Questionnaire

Please Complete Both Sides

Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ Birthdate: _____ Handed: (R) _____ (L) _____

PAST MEDICAL HISTORY:

OPERATIONS / HOSPITALIZATIONS None _____

Type of Surgery: Date of Procedure:

_____

_____

_____

_____

_____

MEDICAL ILLNESSES None _____

_____

_____

_____

_____

_____

_____

MEDICATIONS None _____

Name of Medication: Strength / How Often Taken:

_____

_____

_____

_____

_____

_____

_____

ALLERGIES TO MEDICATIONS None _____

Name of Medication: Type of Reaction:

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:

PARENTAL STATUS **(If deceased, please list cause of death)** FATHER: Living _____ Deceased _____

MOTHER: Living _____ Deceased _____

Do these problems run in your family? (Please mark an "X" in the space provided below that applies to your family history)

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Other
Diabetes									
Heart Disease									
High Blood Pressure									
Stroke									
Cancer									
Gallbladder Disease									
Ulcer/Colitis/Crohn's									
Asthma / Respiratory									
Thyroid Disease									
Bleeding Disorders									
Tuberculosis									
Anemia									

HEALTH HABITS:

Yes	No		
___	___	Smoke cigarettes?	___ packs per day
___	___	Chew tobacco?	___ how much?
___	___	Drink beer?	___ bottles per _____
___	___	Drink wine?	___ on per _____
___	___	Drink hard liquor?	___ on per _____
___	___	Use Aspirin or Ibuprofen?	___ how much?

Yes	No		
___	___	Drink regular coffee	___ if so, cups / day?
___	___	On a special diet?	___ what type?
___	___	Do you exercise less than twice per week?	
___	___	Use recreational drugs?	___ how often?
		_____	___ what type?
___	___	Have a Living Will?	

REVIEW OF SYSTEMS

PLEASE PLACE AN "X" BESIDE THOSE CONDITIONS WHICH AFFECT YOU

GENERAL
___FAINTING
___UNEXPECTED WEIGHT LOSS
___RECENT WEIGHT GAIN
___FEVER OR SHAKING CHILLS
___NIGHT SWEATS
___SWOLLEN GLANDS
___OTHER: _____

SKIN
___SEVERE ITCHING
___PERSISTENT RASH
___CHANGING MOLES
___PSORIASIS
___OTHER: _____

HEAD
___GLAUCOMA
___CATARACTS
___DOUBLE VISION
___GLASSES
___CONTACTS (R) ___ (L) ___
___DIFFICULTY HEARING
___RINGING IN EARS
___WEAR HEARING AID (R)___ (L)___
___WEAR DENTURES ↑___ ↓___
___LOOSE TEETH
___REMOVABLE BRIDGE ↑___ ↓___
___BLEEDING GUMS
___SEVERE NOSEBLEEDS
___FREQUENT SORE THROAT
___PERSISTENT HOARSENESS
___OTHER: _____

BLOOD
___BLOOD TRANSFUSION PAST 6 MONTHS
___PROLONGED BLEEDING FROM SURGERY
___ANEMIC IN PAST
___EVER TREATED FOR CANCER
___THINK I'M AT HIGH RISK FOR AIDS
___COUMADIN USE
___OTHER: _____

MUSCLES & JOINTS
___MUSCLE CRAMPS
___MUSCLE WEAKNESS
___ARTHRITIS OR JOINT PAIN
___FREQUENT BACK PAIN
___OTHER: _____

HEART & LUNGS
___HIGH BLOOD PRESSURE
___HEART ATTACK IN PAST
___HEART MURMUR
___MITRAL VALVE PROLAPSE
___ARTIFICIAL VALVE
___RHEUMATIC FEVER AS CHILD
___HEART DISEASE
___HIGH CHOLESTEROL
___FAINTING SPELLS
___IRREGULAR HEARTBEAT
___WEAR PACEMAKER
___CHEST PAIN
___SHORTNESS OF BREATH
___CAN'T BREATH WHEN FLAT
___AWAKEN SHORT OF BREATH
___ANKLES SWELL
___FREQUENT COUGH
___COUGH UP SPUTUM
___COUGH UP BLOOD
___WHEEZING OR ASTHMA
___OTHER: _____

NEUROLOGICAL
___EPILEPSY OR SEIZURES
___PAST STROKE
___OTHER: _____

DIGESTIVE TRACT
___HIATAL HERNIA IN PAST
___ULCERS IN PAST
___COLON POLYPS IN PAST
___COLON CANCER IN PAST
___LIVER DISEASE OR JAUNDICE
___POOR APPETITE
___NAUSEA
___VOMITING
___FREQUENT HEARTBURN
___TROUBLE SWALLOWING
___RECTAL BLEEDING
___BLACK BOWEL MOVEMENTS
___VOMITED BLOOD
___ABDOMINAL PAIN
___DIARRHEA
___LOST BOWEL CONTROL OR SOILING
___BOWEL HABIT UNPREDICTABLE
___MILK OR LACTOSE INTOLERANCE
___GALLSTONES
___OTHER: _____

KIDNEYS
___KIDNEY STONES
___KIDNEY DISEASE
___FREQUENT URINATION
___UP AT NIGHT TO URINATE
___BLOOD IN URINE
___PAINFUL URINATION
___SLOW URINATION
___LEAKAGE OF URINE
___OTHER: _____

EMOTIONS
___OFTEN DEPRESSED
___CRY EASILY
___OVERLY ANXIOUS
___CAN'T HANDLE STRESS
___OTHER: _____

EXPOSURE TO INFECTIOUS DISEASE
___TUBERCULOSIS
___RHEUMATIC FEVER
___GONORRHEA
___SYPHILIS
___MEASLES
___MUMPS
___CHICKEN POX
___WHOOPING COUGH
___CONTAGIOUS DISEASE
___HIV
___AIDS
___OTHER: _____

MEN ONLY
___LUMP IN TESTICLE
___PENIS DISCHARGE
___ERECTION DIFFICULTIES
___OTHER: _____

WOMEN ONLY
___PREGNANT NOW
___PLANNING PREGNANCY
___NIPPLE DISCHARGE
___LUMP IN BREAST
___VAGINAL DISCHARGE
___HOT FLASHES
___NON-PERIOD BLEEDING
___PAST MENOPAUSE
___PAINFUL INTERCOURSE
___PAINFUL PERIODS
___PAST ENDOMETRIOSIS
___OTHER: _____

_____ _____
DATE SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

_____ _____
DATE SIGNATURE OF REVIEWER

ADVANCED SPINE & ORTHOPAEDICS, LLC

PATIENT AUTHORIZATIONS AND DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications so that a communication of PHI may be made by alternative means, such as sending correspondence to the individual's office instead of the individual's house.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY)

____**Home Telephone** _____

____OK to leave message with detailed information.

____Leave message with call back number only.

____**Work phone** _____

____OK to leave message with detailed information.

____Leave message with call back number only.

____**Written Communication**

____OK to mail to my home address.

____OK to mail to my work/office address.

____OK to fax to _____

____**Other:** _____

_____

I authorize the person(s) listed below to speak to the doctor/office on my behalf.

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

_____ _____

PRINT PATIENT NAME **PATIENT (GUARDIAN) SIGNATURE**

DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Notice of Privacy Practices. ADVANCED SPINE & ORTHOPAEDICS, LLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information, how you can access your protected health information, and other rights concerning your protected health information.

I acknowledge that I received or was offered a copy of ADVANCED SPINE & ORTHOPAEDICS, LLC Notice of Privacy Practices.

_____

Print name of patient

_____ _____

Signature of patient/personal representative Date

_____ _____

Name of personal representative Relationship to patient

GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

(For office use only when efforts to obtain acknowledgment of receipt of notice are unsuccessful)

- ❑ Individual refused copy of NPP
- ❑ Individual accepted copy of NPP; refused to sign Acknowledgement of Receipt
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other _____

_____ _____

Signature of staff member Date

_____

Print name of staff member

ADVANCED SPINE & ORTHOPAEDICS, LLC
BRIAN D. SHANNON, M.D.
752 Brookshire Drive, Suite 3
Hermitage, PA 16148
(724) 981-9310

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

_____ Payment by cash

_____ Payment by check

_____ Payment by credit card

_____ Automatic monthly billing to your Visa or MasterCard

_____ Guarantee any amount not covered by insurance with Visa or MasterCard

Please make you choice, sign below and return to Office Manager before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your Visa or Master Card on a monthly basis.

If none of the above apply, please see the Office Manager. Thank you.

_____

Print your name here and sign below

X_____ Date: _____