

EXPERTISE IN SPINE • EXCLUSIVELY SPINE**WHAT TO BRING**

- Sonoran Spine Center Information Sheet**
Complete this information sent to you.
- Medication List / Drug Allergies**
Make a list of any medications you are currently taking including dosages and frequency. Include a list of any drug allergies you may have.
- Insurance Company Information**
Please have your insurance card and insurance company information, including the group number and address where claims should be sent.
- Workers Compensation Information**
Bring the claim number, insurance carrier, address, contact person and phone number if you are covered by workers compensation.
- Co-pay**
If your insurance has a co-pay, you must pay this amount before being seen.
- Insurance Authorization / Doctor Referral**
We are on most insurance plans, but be sure your visit with us has been authorized by your insurance company - if this is required. We will not see you if we don't have a required referral and authorization. Any questions you may have should be directed to your primary care provider. This is your responsibility. Please have your authorization number when you make your appointment with us.
- X-rays, MRI Scan, CT Scan, Other Studies**
Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiologist reports. Bring all studies that have been done.
- If You Require Disability Forms -**
We will fill out forms required by the government such as those from the State of Arizona or the Social Security Administration free of charge. However, If you require disability forms completed for privately-held policies such as those that protect your car, wages, home or credit cards, we charge \$5 per page up to a maximum of \$25/form. Your insurance plan will not reimburse you for the preparation of these forms nor will it reimburse Sonoran Spine Center, PC; therefore, we require payment before completing the form. Upon receipt of payment in full and your signature which acknowledges your understanding of our policy, we will complete your forms. Ask to sign our Disability Form Acknowledgement if you need disability forms filled out.

P A T I E N T I N F O R M A T I O N R E C O R D

P A T I E N T I N F O R M A T I O N

Patient Name _____ Age _____ Male Female
 Date of Birth: _____ / _____ / _____ Social Security Number _____ - _____ - _____ Marital Status: S M W D Sep
 Mailing Address _____ City _____ State _____ Zip Code _____
 Daytime phone Number (____) _____ Cell phone (____) _____ Work phone (____) _____
 Email address (PRINT) _____ How did you hear about us? _____
 Employer _____ Occupation _____
 Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____
 Patient's Referring Doctor _____ Phone (____) _____
 Patient's Primary Care Doctor _____ Phone (____) _____
 Office Location: Street Address _____ City _____ State _____ Zip _____

A D D I T I O N A L I N F O R M A T I O N

Spouse (parent, if minor) _____
 Date of Birth: _____ / _____ / _____ Social Security Number _____ - _____ - _____ Phone (____) _____
 Street Address _____ City _____ State _____ Zip Code _____
 Employer _____ Occupation _____
 Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____
 Name of Nearest Relative Not Living With You _____ Relationship _____
 Street Address _____ City _____ State _____ Zip Code _____ Phone (____) _____

I N S U R A N C E I N F O R M A T I O N

Primary Insurance Company _____ Is this a work-related injury? (Circle one) Yes No
 ID# _____ Policy # _____ Group # _____
 Policy Holder's Name _____ Date of Birth _____ / _____ / _____ Relationship to Patient _____
 Policy Holder's Address (if other than patient's) _____ City _____ State _____ Zip _____
 Policy Holder's Employer Address _____ City _____ State _____ Zip Code _____
 Secondary Insurance Company _____
 ID# _____ Policy # _____ Group # _____
 Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____ / _____ / _____
 Policy Holder's Address (if other than patient's) _____ City _____ State _____ Zip _____
 Policy Holder's Employer Address _____ City _____ State _____ Zip Code _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim. I also authorize the release of any medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for \$50 or a fee of 45% of the balance due, whichever is higher. I have read and understand this form.

X _____ Date _____

Medical History

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MUSCULOSKELETAL MEDICINE • SPINAL & PERIPHERAL INJECTIONS • PAIN MANAGEMENT

Name _____ Date _____
 Primary Doctor _____ Referring Doctor _____
 Attorney (if applicable) _____
 Female Male Left Handed Right Handed Height _____ Weight _____ Age _____

CHIEF COMPLAINT

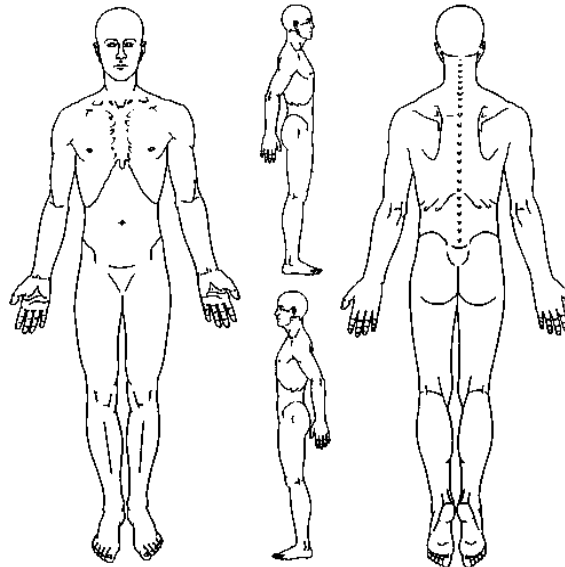
Main Problem:

(mark those which apply)

- pain
- numbness
- weakness
- stiffness
- gradual onset
- sudden/traumatic

How & when did your complaint/injury occur. Give us a short history: (What happened) PLEASE PRINT:

Please indicate where you are experiencing pain on the diagram.
 Do not indicate pains which are not related to your present injury or condition.



- vvvv = Aching/Dull
- oooo = Pins and needles
- xxxx = Burning
- ///// = Stabbing/sharp
- ==== = Numbness

Please rate your pain—

(no pain)	0	1	2	3	4	5	6	7	8	9	10 (extreme pain)
-----------	---	---	---	---	---	---	---	---	---	---	-------------------

Please circle the activities that **INCREASE** your pain:

- Writing Gripping Pinching Arm Raising Lying Down Sitting Standing
 Walking Driving Lifting Bending Twisting Cough Other: _____

Please circle the activities that **IMPROVE** your pain:

- Lying Down Sitting Standing Walking Driving Lifting Bending
 Other: _____

PAIN TREATMENT HISTORY - MEDICATIONS

Name of Previous Pain Medications	Any Adverse Reaction

PAIN TREATMENT HISTORY - INTERVENTION

Treatment	When (Date)	% Helped
Physical Therapy		
Chiropractic		
Pain Clinic		
Manual Manipulation		
Massage		
TENS		
Injections		

LIST PREVIOUS SURGERY AND/OR INJECTIONS (Include Dates)

Have you ever had General Anesthesia (put to sleep)? Yes No If yes, describe any problems: _____

1.	
2.	
3.	
4.	
5.	

PREVIOUS IMAGING FOR THIS CONDITION

None
 Plain x-rays MRI Scan CT Scan Myelogram Nerve Tests (EMG, NCS)
 Other: _____

ALLERGIES

Are you allergic to Latex? Yes No No Known Allergies

List Any Medications You Are Allergic To:	Describe Reaction:

CURRENT PAIN MEDICATIONS

Include all prescription and non-prescription pain medications

List Names of Medications	Dose or Strength	How Often Taken

OTHER MEDICATIONS YOU CURRENTLY TAKE

Include any vitamins or nutritional supplements

1.	4.	7.
2.	5.	8.
3.	6.	9.

Are you taking any blood thinners? yes no If yes, which one: _____
 Do you have a Pacemaker? yes no
 Do you have a defibrillator? yes no

MEDICAL HISTORY

Are you affected by any of the following? No Medical problems

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel syndrome | |
| <input type="checkbox"/> Other Medical Conditions: _____ | | |

CURRENT MEDICAL SYMPTOMS

Are you currently experiencing any of the following: (check all that apply) None apply

- General:* Fever Chills Sweats Fatigue Falls Unexplained weight loss
- Ears, Nose, Throat:* Headaches Vision problems Hearing changes
- Heart or Vascular System:* Chest pain Palpitations Dyspnea on excursion Edema
- Respiratory System:* Cough Shortness of breath Home oxygen TB
- Digestive System:* Nausea Vomiting Diarrhea Constipation Incontinence
- Urinary:* Frequency Urgency Incontinence Bladder infections
- Muscles or Joints:* Muscle asymmetry Joint pain Stiffness Spasms
- Nervous System:* Numbness Tingling Burning Weakness Memory problems
- Skin:* Rash Itching Wounds or ulcers Hair loss
- Psychological:* Mood Sleep Depression Anxiety

FAMILY HISTORY (Parents, siblings)

- | | |
|---|---|
| <input type="checkbox"/> Diabetes: | <input type="checkbox"/> Unknown: |
| <input type="checkbox"/> Heart Disease: | <input type="checkbox"/> Stroke: |
| <input type="checkbox"/> Obesity: | <input type="checkbox"/> Spinal Stenosis: |
| <input type="checkbox"/> Cancer: | <input type="checkbox"/> Back Surgery: |

SOCIAL/FUNCTIONAL HISTORY

- A. Marital Status: Single Married Widowed Divorced
- B. Current Work Status: Employed Unemployed Disabled _____ Retired Student
Occupation: _____
- C. Do you use tobacco: No Yes If yes, how much and how long? _____
- D. Do you use alcohol? No Minimal Moderate Heavy Previous user
- E. Do you exercise? Daily Regularly Weekly Occasionally Never
- F. Living status: Alone Spouse Parents Roommate
 Assisted living Nursing Home
- G. Do you use an assistive device (cane, walker, wheelchair, etc): _____

X _____
Signature of patient, parent, or guardian Date