

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 _____

Filled out by: _____
Relationship to patient: _____

PEDIATRIC SPINE PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

DATE OF BIRTH: ___/___/___ HEIGHT: ___ FT. ___ IN. WEIGHT: ___ LBS. MALE FEMALE

AGE: ___ YEARS ___ MONTHS GROWTH IN PAST 6 MONTHS: _____

HEIGHT OF MOTHER: _____ FATHER: _____ SIBLINGS: _____

REFERRING PHYSICIAN'S NAME: _____

INTERNIST/FAMILY MEDICINE DOCTOR/PEDIATRICIAN'S NAME: _____

Why is the child seeing the doctor today? _____

How was the problem discovered? _____

How long has the problem been present? _____

Has the problem worsened recently? No Yes, how recently? _____

What makes the pain/problem better? _____

What makes the pain/problem worse? _____

Is the pain (check all that apply): Continuous Activity related Night pain Unpredictable

What treatments have you tried?

- | | | | |
|--|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Physical Therapy/Exercise | <input type="checkbox"/> TENS unit | <input type="checkbox"/> Narcotic medications | <input type="checkbox"/> Cast/boot |
| <input type="checkbox"/> Massage/Ultrasound | <input type="checkbox"/> Traction | <input type="checkbox"/> Anti-Inflammatories | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Chiropractic treatment | <input type="checkbox"/> Surgery | <input type="checkbox"/> Steroid injections | <input type="checkbox"/> Braces |

Does the patient have weakness/numbness in his/her legs? Yes No

Are there any problems with loss of bowel or bladder control? Yes No

Previous physicians consulted for this problem:

Physician	Specialty	City	Treatments

Menstrual History: Age at first menstrual period? _____ Not applicable/Male

Date of last period _____ Are the periods regular? Yes No

Is there any chance the patient could be pregnant? Yes No

Is the child allergic to any medication? No allergies Yes, please list: _____

Medications Patient Takes: No Medications

Medication	Dose	How long has the patient been taking?

BIRTH AND DEVELOPMENTAL HISTORY: Birth weight _____ lbs. _____ oz.

Please explain any birth complications: _____

Has the patient had any physical or mental developmental delays? No Yes, please explain:

MEDICAL HISTORY / REVIEW OF SYSTEMS:

Has the patient been diagnosed with having difficulties in any of the following areas?

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/Attention Deficit/Hyperactivity | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Marfan Syndrome |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Earache | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Hemophilia (bleeding disorder) | <input type="checkbox"/> Rickets |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Weight Gain/Loss |

Is the child's pediatrician aware of any of these problems to which you answered yes? No Yes

Is the child having any problems that were not listed above? No Yes, please explain: _____

Has the patient ever had general anesthesia? No Yes, please explain: _____

Hospitalizations? No Yes, please list cause and year of hospitalizations _____

Surgical History:

Hospital/Surgeon	Date	Type of Surgery

Social History:

Patient's parents are: Married Divorced Separated Not Married

Patient lives with: Both Parents Mother Father Foster Parents Other _____

Number of Brothers: _____ Sisters: _____

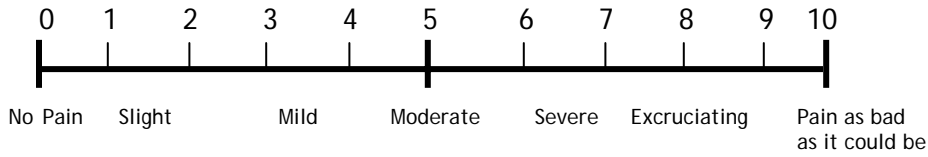
Does the patient smoke? No Yes If yes, _____ packs/day x _____ years.

Is there smoking in the house? Yes No

FAMILY HISTORY: Do the patient's parents or siblings have any of the following? Check all that apply.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bowlegs |
| <input type="checkbox"/> Hip dysplasia | <input type="checkbox"/> Leg Perthes | <input type="checkbox"/> Knock Knee | <input type="checkbox"/> Roundback |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Scoliosis (curved spine) | | |

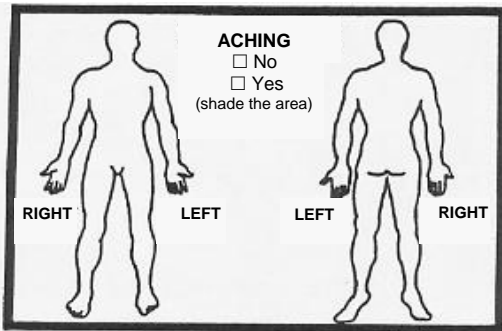
MY PAIN / DISCOMFORT IS (circle number)



****If back or leg pain or other symptoms are present, please complete the following diagrams.****

ACHING

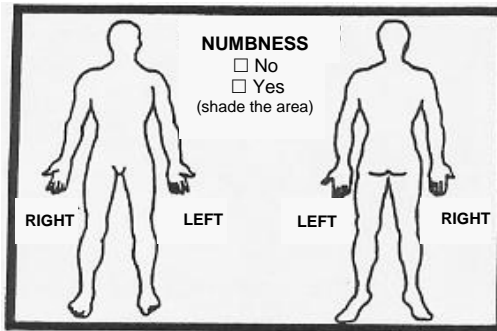
No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

NUMBNESS

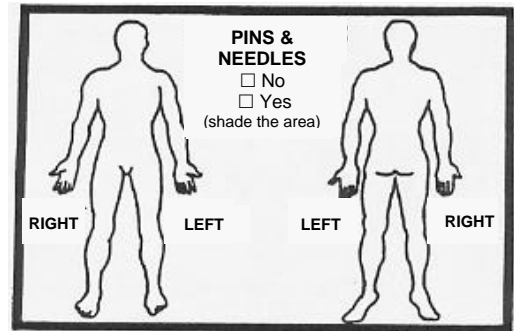
No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

PINS & NEEDLES

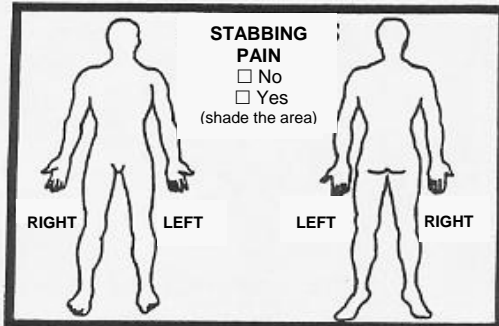
No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

STABBING PAIN

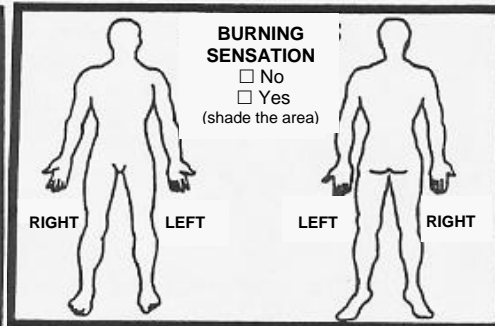
No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

BURNING SENSATION

No
 Yes
(shade the area)



RIGHT LEFT LEFT RIGHT

