Precision Spine Center
Centura Health.

REGISTRATION FORM

(Please Print)

Referring Physician:	
Referring Physician Phone:	**Primary Physician:**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑Ms. ❑Miss	❑Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Your Email:	Ethnicity ❑Hispanic ❑Non-Hispanic	Race

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Internet ❑ Yellow Pages ❑ Other:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ AETNA ❑ Medicare ❑ Medicaid ❑ Blue Cross/Shield ❑ Cigna

❑ Workers Comp ❑ Self-Pay ❑United HealthCare ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Workers Comp.

Claim Number______________________________ ***Case Manager*** ______________________________

Case manager Phone: (   ) _________________ ***Case Manager Fax: (   )*** ____________________

Date of Injury____________________________

Address: _____________________________________ ***Workers Comp Claim Insurance Name:***_____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Precision Spine or Insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Precision Spine Center

Name: ______________________________ **Date:** __________

Which treatments have you tried for this problem?

Treatment	Was it helpful?	Number of treatments?	Date of most recent?
Physical Therapy			
Acupuncture			
TENS			
Massage			
Psych Therapy			
Chiropractor			
Injections			
Braces			
Exercise			
Surgery			

Review of Symptoms:
Have you ever had?

Difficulty swallowing Y / N
Chest Pain/Palpitations Y / N
Nausea/Vomiting Y / N
Loss of Bowel or bladder control Y / N
Rashes Y / N
Depression/sleep problems Y / N
Easy bleeding on blood thinners Y / N

Headaches Y / N
Shortness of breath/Asthma Y / N
Black Stools Y / N
Urinary or prostate/gynecologic issues Y / N
Dizziness/weakness/numbness/tingling Y / N
Prior musculoskeletal problems Y / N

Medications: (include doses, over the counter medications and vitamin/herbal supplements)

____

____

____

ALLERGIES AND ADVERSE REACTIONS: (tell us HOW the allergy affects you)

____

____

____

Precision Spine Center

Name: ___________________________________ **Date:** ____________________

Past Medical History: Please check **ALL** that apply

______ Heart Disease **
______ Diabetes – (TYPE I or II) circle
______ Lung Disease
______ High Blood Pressure
______ Kidney Problems
______ Cancer
______ Stroke
_______Thyroid Problems
______ Seizures
______ Arthritis
______ Depression
______ Asthma
______ Heartburn
______ Ulcers
______ Migraines
______ Other (Please Specify) __________________

** **Do you have a pacemaker fitted**? Y / N (**If Y**, please supply a copy of the pacemaker card)

** **Have you had bypass surgery or stents implanted**? Y / N

(**If Y**, year and doctor ________________________________)

Past Surgical History: (include approximate dates, facility and surgeon's name for spine surgeries ONLY)

____

____

____

Family History:

____

____

____

Social History:
Tobacco Use: Current/Never/ Quit: **Packs per day:** ____ How many years Current or Quit?

_________ **Alcohol Use:** Yes/No Drinks per week: ___________

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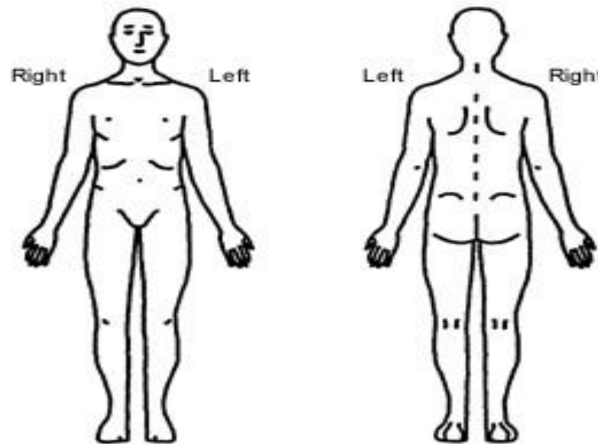
Name: ______________________ **Date:** ____________

EVALUATION FORM

Demographics:
Height: ______________ Weight: _________ Handedness: Right / Left

Reason for today's visit: ____
How and when did the pain/problem start? ____

On the diagram below please mark the location of your pain. Use the key to specify what type of pain. S = Sharp pain
D = Dull pain
N = Numbness
T = Tingling



PAIN:
Using the pain scale below, please rate how your pain is TODAY:

	0	1	2	3	4	5	6	7	8	9	10
No pain	Mild Pain			Mod Pain		Severe Pain		Very Severe		Worst Possible	

Pain History:
What makes the pain worse? ___________________________ Sitting/Standing/Walking/Lying/Moving

What makes the pain better? ___________________________ Sitting/Standing/Walking/Lying/Moving

Is this related to an accident or Motor Vehicle Accident? Y / N : Date of Injury: _________
Is this a work related injury? Y / N : Date of Injury: _______
Is there litigation pending? Y / N

What tests have you had? X-rays / EMG / MRI / CT Scan - **films/CDs with you today**? Y / N

Name of imaging Facility: ____