ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of **Shenango Spine Centers** Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____

_____

_____

_____

Employee Signature:_____ Date:_____

PATIENT INFORMATION & CONDITION FORM

Patient Name: _____ Today's Date: ____/____/____

Birth Date: ____/____/____ Age: _____ Gender: F M U Decline

Last 4 of your social _____

Patient's E-mail address: _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____Date of Birth: ____/____/____ Phone: (_____) _____

Mother: _____Date of Birth: ____/____/____ Phone: (_____) _____

Guardian: _____Date of Birth: ____/____/____ Phone: (_____) _____

Who do you normally live with? □ Mother and Father □ Father □ Mother □ Legal Guardian □ None of these

Marital Status: □ Married □ Separated □ Widowed □ Single How many children? _____

CURRENT ADDRESS

Street:_____

City: _____State _____ Zip _____

Phone (_____) _____

Your Occupation _____Employer _____

Work Address _____

Work Phone (_____) _____

Student at _____ □ FULL-TIME □ PART-TIME

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____ Phone (_____) _____

Address of contact person

_____

Is your condition or injury due to an accident or work-related cause? □ YES □ NO Date of accident: ____/____/____

Did the condition or injury result from *automobile* accident? □ YES □ NO Please check ALL that apply.

Did it result from a *work-related* accident or cause? □ YES □ NO (briefly describe):

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur?

_____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? □ YES □ NO □ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

Health insurance Id: _____ Group number: _____ Does the policy holder have the insurance through his/her employer? ☐

YES ☐ NO If yes, who is the employer? _____

Attorney name: _____ Contact info: _____

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

Symptoms and Conditions

Do you now have or have you ever had? Please check all that apply.

CARDIOVASCULAR: ☐ Murmur ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Shortness of breath ☐ Swollen ankles ☐ Heart attack ☐ Irregular heartbeat ☐ Pressure over the chest ☐ Pain down the left arm ☐ High triglycerides ☐ High cholesterol levels ☐ Profuse sweating ☐ Nausea ☐ Vomiting ☐ Low blood pressure ☐ Fainting spells ☐ High blood pressure ☐ Difficulty lying flat

CONSTITUTIONAL: ☐ Weight loss ☐ Fatigue ☐ Fever

EAR/NOSE/THROAT: ☐ Difficulty hearing ☐ Buzzing in ears ☐ Ringing in ears ☐ Vertigo ☐ Sinus trouble ☐ Nasal stuffiness ☐ Hearing loss ☐ Ear pain ☐ Mouth sores ☐ Hoarseness ☐ Nose bleeds ☐ Dental problem ☐ Frequent sore throat ☐ Difficulty swallowing

ENDOCRINE: ☐ Loss of hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter

EYES: ☐ Glasses/Contacts ☐ Eye pain ☐ Light bothers eyes ☐ Double vision ☐ Cataracts ☐ Vision problems ☐ Blurred vision ☐ Glaucoma

GASTROINTESTINAL: ☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea ☐ Black or bloody BM ☐ Gallbladder problem ☐ Liver problem ☐ Hepatitis ☐ Distress from greasy food ☐ Ulcers ☐ Heartburn ☐ Hiatal hernia ☐ Colitis ☐ Blood in the stool ☐ Colon cancer ☐ Abdominal pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice ☐ Pain over stomach ☐ Mucus in stool

GENITOURINARY: ☐ Burning/Frequency ☐ Blood in urine ☐ Erectile dysfunction ☐ Abnormal discharge ☐ Leakage ☐ Incontinence ☐ Kidney infection ☐ Sexual difficulty ☐ Kidney stones ☐ Loss of libido

HEMATOLOGY/LYMPH: ☐ Easy bruising ☐ Gums bleed easily ☐ Enlarged glands ☐ Anemia ☐ Bleeding disorder ☐ Sickle cell anemia ☐ Lymphoma

MUSCULOSKELETAL: ☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle pain ☐ Neck pain ☐ Stiff neck ☐ Back pain ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Bone spurs ☐ Broken bones ☐ Compression fracture ☐ Head injury ☐ Back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Cancer ☐ Muscle weakness ☐ Muscular dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis ☐ Arthritis ☐ Neck injury ☐ Osteoporosis

NEUROLOGICAL: ☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy head ☐ Tremors ☐ Memory loss ☐ Difficulty speaking ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fainting ☐ Concussion ☐ Migraines ☐ Disorientation ☐ Loss of coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's disease ☐ Weakness ☐ Disk problem ☐ Light Headed/Dizzy ☐ Epilepsy/Seizure ☐ Tingling

RESPIRATORY: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia ☐ Asthma ☐ Superficial breathing ☐ Chest pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema ☐ Difficulty breathing ☐ Lung cancer

GENERAL: ☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of appetite ☐ Fatigue ☐ Polio ☐ Rheumatic fever ☐ Cancer of any kind ☐ Metal Rods ☐ Pins ☐ Screws ☐ Staples ☐ Any type of Metal Beneath Skin

OTHER: _____

_____

_____

_____

Have you had any recent imaging done? (in the last 2 years)

XRAY:_____ MRI:_____ CT:_____ other:_____

Where and approximately when were they taken?

_____

Are you currently taking any medications? If yes, please list the names of the medications. (if you have a list of your medications you can hand it to the receptionist to copy, no need to write it out)

_____

_____

_____

_____

Text message / E-mail Appointment reminder

I authorize _____ to send text message and/or email appointment reminders to me on my provided cell phone number. I understand that I may receive account information such as future appointments, office location and other alerts as described in our text message and/or email message. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply.

Check Preferred method

Name: _____

Cell Phone: _____ _____

E-mail: _____ _____

Additional Individuals Authorized to Receive Text Message and/or Email Account Alerts:

_____
Authorized individual and relationship

_____
cell phone/email

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the account(s), that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text and email messaging services. I understand that this authorization can only be revoked in writing.

_____ _____
Signature **date**

It is important to note that text and email communication is not always secure. Text and email messages can be intercepted and for this reason, we do not communicate personal health information through this method. Complete terms and conditions can be requested from office staff.

Medical Records Release Form

Patient Name: _____

Date of Birth: _____

I authorize the release of my medical records and/or other health care information, including intake forms, chart notes, reports, correspondence, care plans, pathology reports, radiology reports, operative reports, lab reports and other written information concerning my health and treatment during any period to be sent to the following practice

Shenango Spine Center
2540 New Butler Road, Suite 201
New Castle, PA 16101

Phone: 724-856-8390
Fax: 724-856-8573

Todays Date: _____

Signature of Patient or
Personal Representative: _____

Printed Name of Patient
Or Personal Representative: _____

Description of Personal
Representative Authority: _____