

## NEW PATIENT HISTORY – Dr. Gabriel

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **DOB:** \_\_\_/\_\_\_/\_\_\_\_ **Date:** \_\_\_/\_\_\_/2017

Reason for today's visit: \_\_\_\_\_

Hand Dominance: Right Left      Date of Onset: \_\_\_\_\_      Date of Injury: \_\_\_\_\_

Injury occurred at: \_\_\_ Home \_\_\_ Work \_\_\_ MVA Other: \_\_\_\_\_

This condition is: \_\_\_ New \_\_\_ Chronic \_\_\_ Recurring \_\_\_ Reinjured

**WHAT MAKES YOUR PAIN WORSE?**

- |              |              |
|--------------|--------------|
| ___ Sitting  | ___ Stooping |
| ___ Standing | ___ Twisting |
| ___ Walking  | ___ Coughing |
| ___ Bending  | ___ Sneezing |
| ___ Lying    | ___ Other    |

\_\_\_ Difficulty with sleeping      Are you on aspirin or another blood thinner? \_\_\_ No \_\_\_ Yes

Allergies: \_\_\_\_\_

Past medical history: \_\_\_\_\_

Past surgical history: \_\_\_\_\_

Family history: \_\_\_\_\_

Social history: Do you **smoke**? \_\_\_ No \_\_\_ Yes \_\_\_ Quit \_\_\_ Packs/Day \_\_\_ How many years?

**Illicit drug** abuse/overuse: \_\_\_ Never \_\_\_ Currently \_\_\_ In the past **Alcohol:** \_\_\_ No \_\_\_ Yes How often \_\_\_\_\_

Working: \_\_\_ No \_\_\_ Yes Retired: \_\_\_ No \_\_\_ Yes Occupation: \_\_\_\_\_

(please circle) **NO PAIN** 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 **SEVERE PAIN**

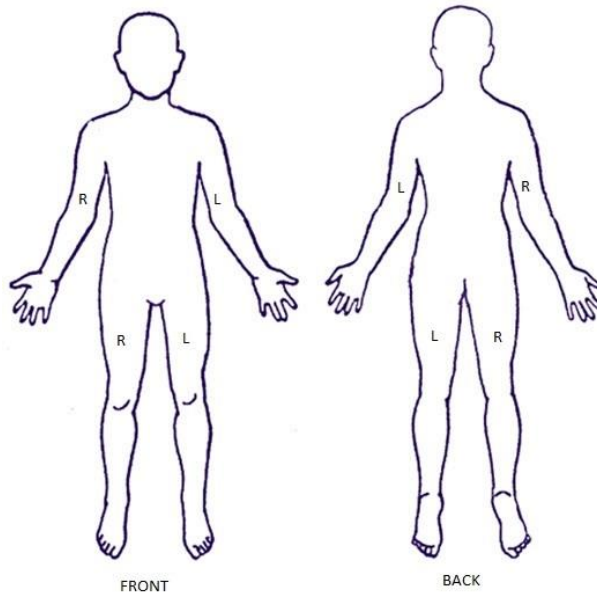
**Types of pain:**

**Dull:**  
uuuuuuu

**Pins and Needles:**  
+++++++

**Sharp:**  
!!!!!!!!!!

**Numbness:**  
oooooooo



**Pain is:**  
\_\_\_ Constant  
\_\_\_ Intermittent

**Patient signature** \_\_\_\_\_

**Vital Signs:** Temp \_\_\_ BP \_\_\_/\_\_\_ Pulse \_\_\_ Respirations \_\_\_ Weight \_\_\_ lbs, Height \_\_\_ in. BMI \_\_\_



# CHIEF COMPLAINT

Spine Institute of Ohio

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ DOV: \_\_\_/\_\_\_/\_\_\_

Chief Complaint: \_\_\_\_\_

Date on Injury/Onset: \_\_\_\_\_ Problem: New / Chronic / Re-injury

## Pain Location(s):

- Neck
- Interscapular
- Thoracic
- Low Back Pain
- Buttock Pain- R L
- Back of thigh- R L
- Anterior/ Lateral Thigh Pain / Numbness- R L
- Flank Pain- R L
- Groin Pain- R L
- Headaches- Yes / No
- Pain back of head (occipital) Yes / No
- Migraines: Yes / No

## Pain Duration:

Days \_\_\_\_\_  
Weeks: \_\_\_\_\_  
Months: \_\_\_\_\_  
Years: \_\_\_\_\_

## Treatment History: (Please Circle)

Physical Therapy	Help	No Help
NSAIDs/Medication	Help	No Help
Chiropractic	Help	No Help
Bracing	Help	No Help
Steroids/Medrol Pack	Help	No Help
Prior Spine Surgery	Help	No Help
Water Therapy	Help	No Help
TENS Unit	Help	No Help
Acupuncture	Help	No Help
Epidural Injections	Help	No Help
Facet Injections	Help	No Help
RFA/Nerves Burned	Help	No Help
Medial Branch Blocks	Help	No Help

Leg pain **MORE THAN** back pain \_\_\_\_\_

Back pain **MORE THAN** leg pain \_\_\_\_\_

Complains of **Weakness** in **Legs**: Right / Left

Complains of **Weakness** in **Arms**: Right / Left

Thigh / Leg / Foot / Toes: **Pain** / Radiculopathy:

Right / Left

Thigh / Leg / Foot / Toes: **Parasthesias** / Numbness / Tingling:

Right / Left

Arm / Forearm / Hand / Fingers: **Pain** / Radiculopathy:

Right / Left

Arm / Forearm / Hand / Fingers: **Parasthesias** / Numbness / Tingling

Right / Left

## Myelopathy Cord Symptoms:

Drop Small Items    Loss of Dexterity Hands    Difficulty with Zippers/Buttons

(Cervical / Thoracic)

Loss of Balance    Wobble    Unsteadiness

- Urinary Retention**
- Perineal Numbness**
- Wetting**
- BM –Unable to Control**
- Urinary Frequency
- Difficulty Starting Urinary stream
- Occasional wetting with couging

## STENOSIS / Neurogenic Claudication Symptoms:

\_\_\_ **Leans on Counters / Shopping Cart**

Walking Distance: \_\_\_ <1/2 block    \_\_\_ 1 block    \_\_\_ > 1 block    Uses Aide: Wheelchair / Walker / Cane

How many Minutes Can You Stand Without Pain? \_\_\_ 0-10    \_\_\_ 15-30    \_\_\_ 30-60+    \_\_\_ Jog / Run

Thoracic: Pain / Radiculopathy / Parasthesias / Numbness / Tingling: Right / Left

Physician Signature: \_\_\_\_\_ MA Initials \_\_\_\_\_

## REVIEW OF SYSTEMS

Check all that apply

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

### General:

\_\_\_ Fevers

\_\_\_ Chills

\_\_\_ Sweats

\_\_\_ Anorexia

\_\_\_ Fatigue

\_\_\_ Malaise

\_\_\_ Weight gain

\_\_\_ Weight loss

### Eyes:

\_\_\_ Wears glasses

\_\_\_ Wears contacts

\_\_\_ Blurring vision

\_\_\_ Double vision

\_\_\_ Change in vision

\_\_\_ Wears bifocals

\_\_\_ Discharge

\_\_\_ Watering

\_\_\_ Vision loss

\_\_\_ Eye pain

\_\_\_ Photophobia

\_\_\_ Glaucoma

### Ears/Nose/Throat

\_\_\_ Ear ache

\_\_\_ Ear discharge

\_\_\_ Ringing in ear

\_\_\_ Hearing loss

\_\_\_ Sinus problems

\_\_\_ Nosebleeds

\_\_\_ Sore throat

\_\_\_ Hoarseness

\_\_\_ Difficulty swallowing

\_\_\_ Nasal polyps

\_\_\_ Mouth lesions

\_\_\_ Bleeding gums

\_\_\_ Change in your voice

### Cardiovascular:

\_\_\_ Chest pain

\_\_\_ Palpitations

\_\_\_ Dyspnea on exertion

\_\_\_ Syncope

\_\_\_ Peripheral edema

\_\_\_ Heart murmur

\_\_\_ Hypertension

\_\_\_ Heart attack

\_\_\_ Stroke

\_\_\_ Heart disease

### Respiratory:

\_\_\_ Cough

\_\_\_ Short of breath

\_\_\_ Excessive sputum

\_\_\_ Cough up blood

\_\_\_ Wheezing

\_\_\_ Tuberculosis

\_\_\_ Recent pneumonia

\_\_\_ Chest tightness

\_\_\_ Inspiration pain

\_\_\_ Snoring

\_\_\_ Asthma

\_\_\_ COPD

### Genitourinary:

\_\_\_ Difficulty with urination

\_\_\_ Blood in urine

\_\_\_ Discharge

\_\_\_ Frequent urination

\_\_\_ Urinary hesitancy

\_\_\_ Urinary urgency

\_\_\_ **Urinary retention**

\_\_\_ Flank pain

\_\_\_ Urination at night

\_\_\_ Burning on urination

\_\_\_ **Bowel incontinence**

\_\_\_ Genital sores

\_\_\_ Decreased libido

\_\_\_ Pregnant

\_\_\_ **Bladder incontinence**

### Gastrointestinal:

\_\_\_ Nausea

\_\_\_ Heartburn

\_\_\_ Loss of appetite

\_\_\_ Hemorrhoid

\_\_\_ Vomiting

\_\_\_ Gastric reflux

\_\_\_ Abdominal pain

\_\_\_ Hematocheza

\_\_\_ Difficulty swallowing

\_\_\_ Bloody stool

\_\_\_ Diarrhea

\_\_\_ Melena

\_\_\_ Change in bowel habits

\_\_\_ Hepatitis

\_\_\_ Black tarry stool

\_\_\_ Constipation

\_\_\_ Jaundice

\_\_\_ History of Ulcers

### Musculoskeletal:

\_\_\_ Back pain

\_\_\_ Stiffness

\_\_\_ Joint pain

\_\_\_ Joint swelling

\_\_\_ Muscle cramps

\_\_\_ Muscle weakness

\_\_\_ Arthritis

\_\_\_ Instability

\_\_\_ Redness to joints

\_\_\_ Joint feels hot

### Skin:

\_\_\_ Rash

\_\_\_ Itching

\_\_\_ Dryness

\_\_\_ Suspicious lesions

\_\_\_ Excessive bruising

\_\_\_ Skin changes

\_\_\_ Redness

\_\_\_ Poor healing

### Circulatory:

\_\_\_ Swollen ankles

\_\_\_ Calf cramps with walking

### Neurologic:

\_\_\_ Transient paralysis

\_\_\_ Vertigo

\_\_\_ Seizures

\_\_\_ Tremors

\_\_\_ Dizziness

\_\_\_ Blackouts

\_\_\_ Headaches

\_\_\_ Migraines

\_\_\_ Weakness

\_\_\_ Numbness

\_\_\_ Tingling

### Psychiatric:

\_\_\_ Depression

\_\_\_ Anxiety

\_\_\_ Mental disturbance

\_\_\_ Memory loss

\_\_\_ Suicidal ideations

\_\_\_ hallucinations

\_\_\_ Paranoia

\_\_\_ Chronic pain

### Endocrine:

\_\_\_ Cold intolerance

\_\_\_ Heat intolerance

\_\_\_ Frequently thirsty

\_\_\_ Frequently hungry

\_\_\_ Recent weight change

\_\_\_ History of diabetes

\_\_\_ Changes in skin texture

\_\_\_ Thyroid disease

### Heme/Lymphatic:

\_\_\_ Abnormal bruising

\_\_\_ Enlarged lymph nodes

\_\_\_ Takes blood thinners

\_\_\_ Bleeding

### Allergic/Immunologic:

\_\_\_ Hives

\_\_\_ Hay fever

\_\_\_ Persistent infections

\_\_\_ HIV exposure

## MEDICAL HISTORY QUESTIONNAIRE

Please check any of the following that apply to your medical history

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Hives                   |
| <input type="checkbox"/> Migraines            | <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Chronic Rash            |
| <input type="checkbox"/> Seizures/Epilepsy    | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Tuberculosis (TB)     | <input type="checkbox"/> Weight Loss             |
| <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Weight Gain             |
| <input type="checkbox"/> Insomnia             | <input type="checkbox"/> Ulcer                 | <input type="checkbox"/> Measles                 |
| <input type="checkbox"/> Sleep Apnea          | <input type="checkbox"/> Abdominal Pain        | <input type="checkbox"/> Mumps                   |
| <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Bowel Irregularity    | <input type="checkbox"/> Chickenpox              |
| <input type="checkbox"/> Ringing in the Ears  | <input type="checkbox"/> Rectal Bleeding       | <input type="checkbox"/> Whooping Cough          |
| <input type="checkbox"/> Glaucoma/Cataracts   | <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Polio                   |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Gallbladder Disease   | <input type="checkbox"/> Tetanus                 |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Bladder Infections    | <input type="checkbox"/> Erectile Difficulties   |
| <input type="checkbox"/> Thyroid Disease      | <input type="checkbox"/> Incontinence          | <input type="checkbox"/> Blood Transfusion       |
| <input type="checkbox"/> Dizziness/Fainting   | <input type="checkbox"/> Prostate Problems     | <input type="checkbox"/> Leg Pain/Swelling       |
| <input type="checkbox"/> Weakness             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Back Pain               |
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> STD                   | <input type="checkbox"/> Bursitis/Tendonitis     |
| <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> HIV +/- AIDS          | <input type="checkbox"/> History of + Antibodies |
| <input type="checkbox"/> Heart Palpitations   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Sexual Dysfunction    |  |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Infertility           |  |
| <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Arthritis             |  |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Osteoporosis          |  |
| <input type="checkbox"/> Bleeding Tendency    | <input type="checkbox"/> Gout                  |  |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Neck Pain             |  |

**SPINE INSTITUTE OF OHIO**

**New Patient Registration Form**

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
Nickname: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone – Home: \_\_\_\_\_  
Phone – Cell: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT EMPLOYMENT**

( ) Employed ( ) Disabled ( ) Retired  
( ) Not employed ( ) Student ( ) Other  
Occupation: \_\_\_\_\_  
Work phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
( ) Work Comp ( ) Liability Claim ( ) Auto  
Case/Injury #: \_\_\_\_\_

**PRIMARY INSURANCE**

( ) Same as patient ( ) Same as guarantor ( ) Other  
Insured's Name: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's SSN: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Policy Group #: \_\_\_\_\_

**SECONDARY INSURANCE**

( ) Same as patient ( ) Same as guarantor ( ) Other  
Insured's Name: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's SSN: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Policy Group #: \_\_\_\_\_

**Patient Confidentiality Release:**

In the event that we/Spine Institute of Ohio cannot reach you, we would like your permission to leave a message on your voicemail or home answering machine regarding upcoming appointments, tests, surgical procedures, and test results.

- ( ) I agree to this authorization
- ( ) I deny this authorization

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_  
**Co-pay \$** \_\_\_\_\_ **EMR ID#:** \_\_\_\_\_  
**Email:** \_\_\_\_\_  
Sex: ( ) Male ( ) Female  
**Date of Birth:** \_\_\_\_\_  
**Social Security #:** \_\_\_\_\_  
**Marital Status:** ( ) Married ( ) Divorced ( ) Single  
( ) Widowed ( ) Separated  
**Emergency Contact:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Race:** \_\_\_\_\_ **Ethnicity:** \_\_\_\_\_ **Language:** \_\_\_\_\_  
**Smoking Status:** ( ) Never ( ) Current  
( ) Former ( ) Packs per Day \_\_\_\_\_

**CONTACTS**

**Family Physician:** Dr. \_\_\_\_\_  
**Referring Physician:** Dr. \_\_\_\_\_  
**Other Physician:** Dr. \_\_\_\_\_

**GUARANTOR**

( ) Same as patient ( ) Same as guarantor ( ) Other  
Insured's Name: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_  
Policy Group #: \_\_\_\_\_

**Authorization to Provide Care:**

**( ) I authorize the providers of the Spine Institute of Ohio to provide any medical care deemed necessary according to their professional opinions.**

I also authorize my Physician(s) and Spine Institute of Ohio to photograph me for medically related documentation purposes.

**Notice to Patients: Receipt of Privacy Practices**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish.

- ( ) I acknowledge that I have received a copy of the Spine Institute of Ohio's notice of Privacy Practices.**
- ( ) I was offered a copy of the Spine Institute of Ohio's notice of Privacy Practices, but declined it.**



## MEDICATION POLICY

Due to the increased scrutiny by State and Federal regulators, it has become necessary to further enhance our compliance program as it relates to controlled substance prescriptions and the management of your pre and post-operative pain. Therefore, **one or all of the following conditions of treatment may be in effect** in order to receive your prescriptions with our office:

1. A signed Medication Policy Agreement
2. Random/scheduled toxicology screenings
3. Random pill count
4. Any other practice imposed conditions of care.

**By signing this Medication Policy, you are agreeing to the following;**

- I do not have current problems with substance abuse or dependence (addiction).
- I am not currently involved in the sale, diversion, illegal possession or transport of controlled substances.
- **I agree to take my medications exactly as prescribed by my doctor.**
- I agree to submit a urine specimen at my doctor's request to test for compliance.
- I agree to allow my doctor to contact family members or friends to help monitor my progress if necessary.
- I will allow other relevant healthcare providers to communicate with my physician regarding my medication use.
- I understand that **NO ALLOWANCE** will be made for lost or stolen prescriptions of drugs.
- If I am a female, I certify that I am not pregnant and will use appropriate measures to prevent pregnancy during the course of this treatment.
- I agree to follow the advice of healthcare providers in regard to stopping controlled substances if it is felt necessary.
- No refills of medications will be made after hours, during weekends, or during holiday periods.
- I am responsible for making an appointment or calling the office for a refill at least **72 hours** before running out of my medication.
- I will obtain my prescriptions from the following pharmacy: \_\_\_\_\_ located at \_\_\_\_\_ and give Spine Institute of Ohio permission to contact any other pharmacy to enquire about additional medications.
- Dr. Gabriel will prescribe pain medications up to **3 months after surgery**. If you continue to need narcotics after this time, you will be referred to a pain management physician.
- I understand that SIO will only refer me to a **maximum of TWO** pain management offices. If I am discharged from a pain management office, Dr. Gabriel **WILL NOT** refer me to another doctor. I will be responsible for obtaining my own appointment with no referral from SIO.
- If you are called in for a urine drug screen or pill count and do not show to your appointment you will not be given any medication.
- If your urine drug screen discloses non-prescribed medication in your urine, illegal drugs, or the medication that we prescribe does not show in your urine, you will not receive a prescription.
- **Patient Authorization for Pharmacy Benefits Manager**  
 I authorize the physician and/or staff of Spine Institute of Ohio to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager, and/or any third party pharmacy payors for treatment purposes.

I have read this document, understand it, and have had all questions answered satisfactorily. I consent to the use of medications to help control my pain and I understand that this treatment will be conducted in accordance with the conditions stated above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## PATIENT FINANCIAL RESPONSIBILITY POLICY and HIPAA

### Insurance/ Billing

**\*It is important for you to be an informed consumer, who understands the specifications of your insurance policy (e.g., Specialty doctor visit coverage, referral/authorization requirements for specialty care,).** Your health insurance policy is a contract between you and your Health Insurance Company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

\*Spine Institute of Ohio contracts with many insurance plans. Before your appointment, please be sure we are in-network and the services are covered under your plan. If we are out-of-network, you will be billed for the cost of care.

\*If your insurance carrier is not one with which we participate, you will be responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full.

**\*You must present your insurance card at each visit.** As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. . After hearing from your insurance company we will send you a bill that reflects your balance due. Payment in full is expected at this time. If payment cannot be made in full, you are expected to contact our billing company to make payment arrangements.

\*It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information. We mail out appointment information, surgery information, in addition to billing statements.

\*If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

### **\*All co-pays must be paid at the time of your visit**

\*Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We accept cash, check and most major credit cards. There will be a **\$30.00 fee for all returned checks.**

\*Refunds from services charged on a credit card will be returned to the same credit card. I understand that I am financially responsible for services rendered in the office and surgical procedures. Failure to pay for services or any residual account balance that is not paid will be placed to a collection agency and possibly negatively affect my credit report. I authorize my insurance benefits to be paid directly to Spine Institute of Ohio. I authorize the release of any information by the Spine Institute of Ohio and/or Billing Contractor Agency to my insurance carrier, pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made. Also, to release any medical information that may be necessary to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted. We participate in an organized healthcare arrangement through OhioHealth Group, Ltd. Health4 consists of an organized system of healthcare in which multiple covered entities participate. Through Health4, we participate in joint activities that include utilization review, quality assessment and improved activities, and certain payment activities. We may disclose your PHI to other participants in this organized healthcare arrangement in order to facilitate the healthcare operations activities of Health4.

\* **Spine Institute of Ohio requires a 24hr cancellation notice,** Failure to give 24 hours cancellation notice or failure to keep your scheduled appointment **you will be required to pay a \$25.00 rescheduling fee** prior to rescheduling your next appointment. Payment can be made via cash or credit card only.

**\*There will be a fee for filling out forms of \$25.00 per form** (disability, etc.), the fee is to be paid in advance. It may take up to a week to fill out the form, and we will notify you when it is done.

**\*Medical records requests may take up to 30 days for processing and can incur charges of up to \$25.00.**



**Patient Authorization for PPO and HMO Patients**

I authorize the physician and/or staff of Spine Institute of Ohio to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named Insurance Company to pay directly to Spine Institute of Ohio the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my Insurance company.

**Patient Authorization for Medicare Patients**

I authorize the physician and/or staff of Spine Institute of Ohio to release to Social Security Administration, Health Care Financing Administration, or its Intermediaries or Carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare. Spine Institute of Ohio is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare or my supplement insurer.

**Patient Authorization for Medicaid patients**

Spine Institute of Ohio is **not** a contracted provider with any Medicaid product, therefore we cannot bill for any services provided by us to any Medicaid carrier. I understand that by continuing to be seen as a patient at Spine Institute of Ohio I assume all financial responsibility for services provided.

I, the undersigned, agree that if payment on this patient's account is not made, I will pay reasonable attorney's fees and collection fees incurred for the collection process. I authorize the release of credit information to the appropriate information gathering services. I certify that I have read the forgoing and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms.

Responsible Party: \_\_\_\_\_ Relationship to patient: Self Parent Guardian



**Patient Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Sharing of Medical Information**

I give the physician(s)/office staff of Spine Institute of Ohio permission to discuss my medical condition with the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Messages**

Please call:  my home  my work  my cell Number: \_\_\_\_\_

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call



**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Special Accommodation Authorization**

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Spine Institute of Ohio of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Spine Institute of Ohio is the patient's responsibility.



**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guarantor/Guardian Signature:** \_\_\_\_\_

**SF-12©****Patient Questionnaire**

Patient Initials: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patkey: \_\_\_\_\_

Surgeon Name: Josue P. Gabriel, M.D.

Date: \_\_\_\_\_

Examination Period: \_\_\_\_\_ Preop (1) \_\_\_\_\_ 1 Year (3)  
\_\_\_\_\_ Immediate postop (2) \_\_\_\_\_ 3 Year (4)\_\_\_\_\_ 5 Year (5)  
\_\_\_\_\_ Other (specify)(6): \_\_\_\_\_**SF-12©**

This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a checkmark on the line in front of the appropriate answer. It is not specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:

- \_\_\_\_\_ Excellent (1)      \_\_\_\_\_ Fair (4)  
 \_\_\_\_\_ Very Good (2)      \_\_\_\_\_ Poor (5)  
 \_\_\_\_\_ Good (3)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf:

- \_\_\_\_\_ Yes, limited a lot (1)  
 \_\_\_\_\_ Yes, limited a little (2)  
 \_\_\_\_\_ No, not limited at all (3)

3. Climbing SEVERAL flights of stairs:

- \_\_\_\_\_ Yes, limited a lot (1)  
 \_\_\_\_\_ Yes, limited a little (2)  
 \_\_\_\_\_ No, not limited at all (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:

- \_\_\_\_\_ Yes (1)      \_\_\_\_\_ No (2)

5. Were limited in the KIND of work or other activities:

- \_\_\_\_\_ Yes (1)      \_\_\_\_\_ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:

- \_\_\_\_\_ Yes (1)      \_\_\_\_\_ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:

- \_\_\_\_\_ Yes (1)      \_\_\_\_\_ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

- \_\_\_\_\_ Not at all (1)      \_\_\_\_\_ Quite a bit (4)  
 \_\_\_\_\_ A little bit (2)      \_\_\_\_\_ Extremely (5)  
 \_\_\_\_\_ Moderately (3)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?

- \_\_\_\_\_ All of the time (1)      \_\_\_\_\_ Some of the time (4)  
 \_\_\_\_\_ Most of the time (2)      \_\_\_\_\_ A little of the time (5)  
 \_\_\_\_\_ A good bit of the time (3)      \_\_\_\_\_ None of the time (6)

10. Did you have a lot of energy?

- \_\_\_\_\_ All of the time (1)      \_\_\_\_\_ Some of the time (4)  
 \_\_\_\_\_ Most of the time (2)      \_\_\_\_\_ A little of the time (5)  
 \_\_\_\_\_ A good bit of the time (3)      \_\_\_\_\_ None of the time (6)

11. Have you felt downhearted and blue?

- \_\_\_\_\_ All of the time (1)      \_\_\_\_\_ Some of the time (4)  
 \_\_\_\_\_ Most of the time (2)      \_\_\_\_\_ A little of the time (5)  
 \_\_\_\_\_ A good bit of the time (3)      \_\_\_\_\_ None of the time (6)

12. During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

- \_\_\_\_\_ All of the time (1)      \_\_\_\_\_ Some of the time (4)  
 \_\_\_\_\_ Most of the time (2)      \_\_\_\_\_ A little of the time (5)  
 \_\_\_\_\_ A good bit of the time (3)      \_\_\_\_\_ None of the time (6)

Surgeon Signature \_\_\_\_\_

Date \_\_\_\_\_

# Oswestry Disability Index for Back Pain

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which closely describes your problem *right now*.

## Section 1 – Pain intensity

- A. My pain is mild to moderate. I do not need painkillers.
- B. The pain is bad, but I manage without taking painkillers.
- C. Painkillers give complete relief from pain.
- D. Painkillers give moderate relief from pain.
- E. Painkillers give very little relief from pain.
- F. Painkillers have no effect on the pain.

## Section 2 – Personal Care (washing, dressing, etc.)

- A. I can look after myself without causing extra pain.
- B. I can look after myself normally, but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help everyday in most aspects of self-care.
- F. I do not get dressed. I wash with difficulty and stay in bed.

## Section 3 – Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

## Section 4 – Walking

- A. I can walk as far as I wish.
- B. Pain prevents me from walking more than 1 mile.
- C. Pain prevents me from walking more than ½ mile.
- D. Pain prevents me from walking more than ¼ mile.
- E. I can walk only if I use a cane or crutches.
- F. I am in bed or in a chair for most of every day.

## Section 5 – Sitting

- A. I can sit in any chair for as long as I like.
- B. I can sit in my favorite chair only, but for as long as I like.
- C. Pain prevents me from sitting for more than 1 hour.
- D. Pain prevents me from sitting for more than ½ hour.
- E. Pain prevents me from sitting for more than 10 minutes.
- F. Pain prevents me from sitting at all.

## Section 6 – Standing

- A. I can stand as long as I want without extra pain.
- B. I can stand as long as I want, but it gives me extra pain.
- C. Pain prevents me from standing for more than 1 hour.
- D. Pain prevents me from standing for more than ½ hour.
- E. Pain prevents me from standing for more than 10 minutes.
- F. Pain prevents me from standing at all.

## Section 7 – Sleeping

- A. Pain does not prevent me from sleeping well.
- B. I sleep well but only when taking medicine.
- C. Even when I take medication I sleep for less than 6 hours.
- D. Even when I take medication I sleep for less than 4 hours.
- E. Even when I take medication I sleep for less than 2 hours.
- F. Pain prevents me from sleeping at all.

## Section 8 – Social Life

- A. My social life is normal and causes me no extra pain.
- B. My social life is normal but increases the degree of pain.
- C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- D. Pain has restricted my social life and I do not go out as often.
- E. Pain has restricted my social life to my home.
- F. I have no social life because of pain.

## Section 9 – Sexual Activity

- A. My sexual activity is normal and causes no extra pain.
- B. My sexual activity is normal but causes some extra pain.
- C. My sexual activity is nearly normal but is very painful.
- D. My sexual activity is nearly absent because of pain.
- E. Pain prevents any sexual activity at all.

## Section 10 – Traveling

- A. I can travel anywhere without extra pain.
- B. I can travel anywhere but it gives me extra pain.
- C. Pain is bad, but I manage journeys over 2 hours.
- D. Pain restricts me to journeys of less than 1 hour.
- E. Pain restricts me to necessary journeys under ½ hour.
- F. Pain prevents traveling except to the doctor/hospital.

Score % \_\_\_\_\_

Signature \_\_\_\_\_

# BACK PAIN & LEG PAIN

## Visual Analog Scale

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### Interval:

- |                                   |                                  |                                  |   |
|-----------------------------------|----------------------------------|----------------------------------|---|
| <input type="checkbox"/> Baseline | <input type="checkbox"/> 42-day  | <input type="checkbox"/> 90-day  | <input type="checkbox"/> 180-day              |
| <input type="checkbox"/> 365-day  | <input type="checkbox"/> 730-day | <input type="checkbox"/> 3 years | <input type="checkbox"/> 4 years              |
| <input type="checkbox"/> 5 years  | <input type="checkbox"/> 6 years | <input type="checkbox"/> 7 years | <input type="checkbox"/> Other, specify _____ |

### Leg pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your leg pain by marking a single | on the line that describes your current level of leg pain TODAY, ranging from “no pain” to “worst possible pain.”

**Right leg** |-----|-----|  
No pain 5 Worst possible pain  
0 10

**Left leg** |-----|-----|  
No pain 5 Worst possible pain  
0 10

### Back pain visual analog scale (to be completed by patient)

Directions: Indicate the severity of your back pain by marking a single | on the line that describes your current level of back pain TODAY, ranging from “no pain” to “worst possible pain.”

|-----|-----|  
No pain 5 Worst possible pain  
0 10

Patient initials \_\_\_\_\_ Date \_\_\_\_\_

### Confirmation of investigator review

Signature of investigator \_\_\_\_\_ Date \_\_\_\_\_

# Neck Disability Index

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Please read: This questionnaire is designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and circle the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement relate to you, but please just circle the one choice which closely describes your problem *right now*.

## Section 1 – Pain intensity

- G. I have no pain at the moment
- H. The pain is mild at the moment.
- I. The pain comes and goes and is moderate.
- J. The pain is moderate and does not vary much.
- K. The pain is severe but comes and goes.
- L. The pain is severe and does not vary much.

## Section 2 – Personal Care (washing, dressing, etc.)

- G. I can look after myself without causing extra pain.
- H. I can look after myself normally, but it causes extra pain.
- I. It is painful to look after myself and I am slow and careful.
- J. I need some help but manage most of my personal care.
- K. I need help everyday in most aspects of self-care.
- L. I do not get dressed. I wash with difficulty and stay in bed.

## Section 3 – Lifting

- G. I can lift heavy weights without extra pain.
- H. I can lift heavy weights but it gives extra pain.
- I. Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned, for example on a table.
- J. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- K. I can lift very light weights.

## Section 4 – Reading

- G. I can read as much as I want to with no pain in my neck.
- H. I can read as much as I want with slight pain in my neck.
- I. I can read as much as I want with moderate pain in my neck.
- J. I cannot read as much as I want because of moderate pain in my neck.
- K. I cannot read as much as I want because of severe pain in my neck.
- L. I cannot read at all.

## Section 5 – Headache

- G. I have no headaches at all.
- H. I have slight headaches which come infrequently.
- I. I have moderate headaches which come infrequently.
- J. I have moderate headaches which come frequently.
- K. I have severe headaches which come frequently.
- L. I have headaches almost all the time.

Score % \_\_\_\_\_

Signature: \_\_\_\_\_

## Section 6 – Concentration

- G. I can concentrate fully when I want to with no difficulty.
- H. I can concentrate fully when I want to with slight difficulty.
- I. I have a fair degree of difficulty in concentrating when I want to.
- J. I have a lot of difficulty in concentrating when I want to.
- K. I have a great deal of difficulty in concentrating when I want to.
- L. I cannot concentrate at all.

## Section 7 – Work

- G. I can do as much work as I want to.
- H. I can only do my usual work but no more.
- I. I can do most of my usual work but no more.
- J. I cannot do my usual work.
- K. I can hardly do any work at all.
- L. I cannot do any work at all.

## Section 8 – Driving

- G. I can drive my car without neck pain.
- H. I can drive my car as long as I want with slight pain in my neck.
- I. I can drive my car as long as I want with moderate pain in my neck.
- J. I cannot drive my car as long as I want because of moderate pain in my neck.
- K. I can hardly drive my car at all because of severe pain in my neck.
- L. I cannot drive my car at all.

## Section 9 – Sleeping

- F. I have no trouble sleeping.
- G. My sleep is slightly disturbed (less than 1 hour sleepless).
- H. My sleep is mildly disturbed (1-2 hours sleepless).
- I. My sleep is moderately disturbed (2-3 hours sleepless).
- J. My sleep is greatly disturbed (3-5 hours sleepless).
- K. My sleep is completely disturbed (5-7 hours sleepless).

## Section 10 – Recreation

- G. I am able to engage in all recreational activities with no pain in my neck at all.
- H. I am able to engage in all recreational activities with some pain in my neck.
- I. I am able to engage in most but not all recreational activities because of pain in my neck.
- J. I am able to engage in few of my usual recreational activities because of pain in my neck.
- K. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all

**NECK PAIN & ARM PAIN**

**Visual Analog Scale**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

**Interval:**

- Baseline
- 42-day
- 90-day
- 180-day
- 365-day
- 730-day
- 3 years
- 4 years
- 5 years
- 6 years
- 7 years
- Other, specify \_\_\_\_\_

**Arm pain visual analog scale (to be completed by patient)**

Directions: Indicate the severity of your arm pain by marking a single | on the line that describes your current level of arm pain TODAY, ranging from “no pain” to “worst possible pain.”

**Right arm** |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

No pain 1 5 10 Worst possible pain

**Left arm** |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

No pain 1 5 10 Worst possible pain

**Neck pain visual analog scale (to be completed by patient)**

Directions: Indicate the severity of your neck pain by marking a single | on the line that describes your current level of neck pain TODAY, ranging from “no pain” to “worst possible pain.”

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

No pain 1 5 10 Worst possible pain

Patient initials \_\_\_\_\_ Date \_\_\_\_\_

**Confirmation of investigator review**

Signature of investigator \_\_\_\_\_ Date \_\_\_\_\_