PATIENT DEMOGRAPHICS FORM

INFORMATION PATIENT

Patient's Last Name:	First:	Middle:

Street Address:

City, State, Zip:

Home Phone: May we leave a voicemail message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended	Cell Phone: May we leave a voicemail message? ❑ Yes ❑ No May we leave a text message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended

Date of Birth:	Gender: ❑ Male ❑ Female
Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated	SSN:

Email Address:	Preferred Language: ❑ English ❑Spanish ❑ Other
Who is your family doctor?	Who referred you to Dr. Cluck?

Race: (Select one) ❑American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other Race	Ethnicity: (Select one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino

INSURANCE INFORMATION

Person Responsible for Bill:	Birth Date:	Home Phone:

Address (if different):

Primary Insurance Name:

Subscriber's Name:	Policy #:
Subscriber DOB: Subscriber SSN:	Group #:

Patient's Relationship to Subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other

Secondary Insurance Name:

Subscriber's Name:	Policy #:
Subscriber DOB: Subscriber SSN:	Group #:

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

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Contact Number:

PREFERRED PHARMACY

Name: Location:	Phone:	Fax:

Pain Diagram and Health Questionnaire Form

Please darken bubbles completely

PATIENT INFORMATION		
Patient Name:	**DOB:**	**Date:**
Height:	**Weight**	

What are you being seen for today?

O Neck	O Right Shoulder	O Left Wrist	O Right Knee	O Left Ankle
O Mid Back	O Left Shoulder	O Right Hand	O Left Knee	O Right Foot
O Low back	O Right Elbow	O Left Hand	O Right Calf/Leg	O Left Foot
O Ribs	O Left Elbow	O Right Hip/Thigh	O Left Calf/Leg	Other:
		O Left Hip/Thigh	O Right Ankle	________________

How long have symptoms been present or date of injury: ____

How did the pain occur? O Injury O Ongoing Problem O Spontaneous

Is this the result of a motor vehicle accident? O Yes O No

Is this work related? O Yes O No

What is your occupation? ____

Are you? O Right-Handed O Left-Handed **(Female) Pregnant:** O Yes O No

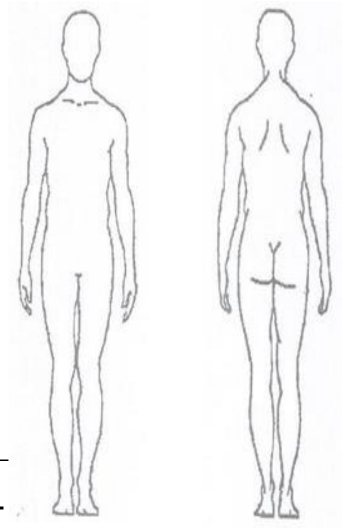
Medications: (Please list below the names of medication you are taking and the dosage.) or Check if List Provided ❑		

Allergies: (Please list the medications you are allergic to.) or Check if you have no known allergies ❑		

Surgery: **or Check if List Provided ❑**		

Pain Description:

Place marks in the affected areas:



What is the quality of your pain? O Mild O Moderate O Severe

How would you describe your pain? O Sharp O Dull O Burning

Pain Scale: On a scale of 0 to 10 (0 meaning no pain and 10 meaning worst pain), how would you rate the pain you are currently experiencing?

O 0/10 O 1/10 O 2/10 O 3/10 O 4/10 O 5/10

O 6/10 O 7/10 O 8/10 O 9/10 O 10/10

What makes your symptoms worse? O Standing O Walking O Lifting O Exercise O Twisting O Lying in Bed O Bending O Squatting O Kneeling O Stairs O Sitting

What makes your symptoms better? O Rest O Elevation O Ice O Heat

Do you have any numbness or tingling? O Yes O No**, If yes, where?** ____________________

Do you have any weakness? O Yes O No, **If yes, where?** ____________________________

Have you been treated elsewhere for this problem? O Yes O No
If yes, when and by whom? ______________________________

Which of the following treatments have you tried for this problem?

Type of Treatment	Date Started	Made it Worse	No Help	Somewhat Helpful	Very Helpful
Physical Therapy	___/___/_____	O	O	O	O
Brace	___/___/_____	O	O	O	O
Chiropractic/Massage	___/___/_____	O	O	O	O
Anti-Inflammatories	___/___/_____	O	O	O	O

(ex: Celebrex, Naproxen, Over the counter include Advil, Ibuprofen, Motrin, Aleve, etc.)
List here: ______________________________
If you cannot take anti-inflammatories, list why? ______________________________

Steroids	___/___/_____	O	O	O	O

(ex: Medrol Dose Pack, Prednisone, etc.)
List here: ______________________________

Narcotics	___/___/_____	O	O	O	O

(ex. Hydrocodone, Oxycodone, Tramadol, etc.)
List here: ______________________________

Muscle Relaxers	___/___/_____	O	O	O	O

(ex: Soma, Robaxin, Flexeril, etc.)
List here: ______________________________

Nerve Medication	___/___/_____	O	O	O	O

(ex: Neurontin, Lyrica, Elavil, etc.)
List here: ______________________________

Injections	___/___/_____	O	O	O	O

What type(s) (trigger point/epidurals/other):______________________________Percentage of Relief:______________%

Surgery	___/___/_____	O	O	O	O

Have you had any of the following diagnostic tests for the body part you are being seen for today?

O - X-Ray O – MRI O - EMG/NCS O - Bone Scan O - CT Scan O - CT Myelogram O - Bone Density Test

When and where did you have the test performed? ______________________________
Do you have any metal in your body? O Yes O No **If yes, where?** ______________________________
Do you have any stents or pacemaker? O Yes O No **If yes, which applies?** ______________________________

Do you use the following? O Cane O Walker O Wheelchair

Medical History – Have you ever had the following?

O Osteoporosis	O High Blood Pressure	O Diabetes	O DVT/Pulmonary Embolism
O Arthritis	O MRSA	O Cancer	O Asthma
O Poor Circulation	O Heart Disease	O Anemia	O Emphysema/COPD
O Epilepsy/Seizures	O Irregular Heartbeat	O Kidney Disease	O Hepatitis A___ B___ C___
O Stroke	O Heart Attack	O Thyroid Disease	O Other: ________________
O Tuberculosis			__________________________

Social History

Do you smoke cigarettes/cigars? O Yes O No

If yes, how many packs per day? ________________________ **How long?** ________________________

Did you smoke in the past? O Yes O No **If yes, how many years ago?** ______

Do you chew tobacco? O Yes O No **If yes, how many cans per day?** ______

Do you drink alcohol? O Yes O No **If yes, how many drinks per day?** _______

Do you exercise regularly? O Yes O No **If yes, how often?** ______

Review of Systems: Are you experiencing any of these symptoms now?

General

O	**Denies All**	O	Fatigue	O	Fever/Chills
O	Weight Change	O	Environmental Allergies	O	Problems w/ Anesthesia

Eyes/Ears

O	**Denies All**				
O	Glasses/Contacts	O	Eye Pain	O	Cataracts
O	Hearing Aids	O	Ringing/Buzzing	O	Eye or Ear Infection

Neurological

O	**Denies All**				
O	Fainting/Dizziness	O	Numbness/Tingling	O	Weakness
O	Headaches	O	Seizures	O	Blurred/Double Vision
O	Memory Loss	O	Paralysis	O	Loss of Consciousness

Respiratory

O	**Denies All**				
O	Wheezing	O	Chronic Coughing	O	Shortness of Breath

Cardiovascular

O	**Denies All**	O	Chest Pain	O	Heart Murmur
O	Phlebitis	O	Swelling of feet		

Musculosketal

O	**Denies All**	O	Joint Pain/Swelling	O	Joint Stiffness
O	Muscle Pain	O	Back Pain	O	Arthritis

Gastrointestinal

O	**Denies All**	O	Diarrhea	O	Ulcers
O	Heartburn	O	Nausea/Vomiting	O	Constipation
O	Abdominal Pain	O	Blood in Stool	O	NSAID Intolerance

Immune System

O	**Denies All**	O	AIDS	O	Diabetes

Genitourinary

O	**Denies All**	O	Painful Urination	O	Frequent Urination
O	Blood in Urine				

Hematological

O	**Denies All**	O	Easy Bruising	O	Bleeding Problem

Endorine.

O	**Denies All**	O	Blood Transfusion	O	Hormone Therapy
O	Thyroid Problems				

Bay Area Spine Care - Michael W. Cluck, MD, PhD
2516 Samaritan Drive, Suite B, San Jose, CA 95124
Phone: 408-295-2200 | Fax: 408-295-2202

PATIENT ACKNOWLEDGMENT

By signing this document below, the patient or responsible party acknowledges they have read and understand the following:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS

Bay Area Spine Care utilizes Physician Assistants in our office. Physician Assistants may provide care for you during your office visit. By signing this form, you give permission to have Physician Assistants assist in your care.

MEDICAL STUDENTS/INTERNS

Dr. Michael W. Cluck is a professor/faculty for medical students, interns, fellowship and residents. You agree to permit the students working in your physician's office to observe and participate in your medical care during your care with Bay Area Spine Care. Your physician has agreed to permit such students to observe and participate in his/her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision and observe during surgery.

CONSENT TO TREAT

I hereby volunteer consent to my treatment at Bay Area Spine Care and authorize such treatments, examinations, physical therapy and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending /covering physician.

E-PRESCRIBING

Bay Area Spine Care providers utilize e-Prescribing to electronically send an accurate, error free and understandable prescription directly to a pharmacy. By signing below, you are providing your consent for the pharmacy e-Prescription program.

_______________________________________ _________________
Signature of Patient/Legal Guardian Date

_______________________________________ _________________
Witness (BASC office employee) D ate

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FINANCIAL POLICY

PATIENTS WITH INSURANCE

Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/medical group, we may contact you for assistance. If your health plan/medical group denies coverage for any reason, you will be responsible for that payment.

PATIENTS WITHOUT INSURANCE

Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask the front desk personnel. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service.

CO-PAY POLICY

It is your obligation to be familiar with our insurance co-payment and/or deductible amounts. Your co-pay amount must be paid at the time of your visit.

DELINQUENT ACCOUNTS

Interest of 2% will be applied every month for any past due accounts.

RETURNED CHECKS

There will be a $25.00 service fee for returned checks.

24 HOUR CANCELLATION AND "NO SHOW" ADMINISTRATIVE FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Effective January 1, 2019, Bay Area Spine Care reserves the right to charge a fee for missed appointments ("no shows") and appointments not canceled with a 24-hour advance notice.

The following fees will be assessed for no-shows and late cancellations:

Office Visits within 24 hours	$100.00
2 weeks prior to surgery	$500.00
1 week prior to surgery	$1,000.00

"No Show" and late cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" and late cancellations in any 12- month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

________________________________ ________________
Signature of Patient/Legal Guardian — Date

________________________________ ________________
Witness (BASC office employee) — Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES & RELEASE AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164)

Patient Name____**DOB:** ________________

I authorize Bay Area Spine Care to use and/or disclose the Protected Health Information (‘‘PHI’’ or personal medical records) described below to: **(Note: this includes releasing prescriptions, medical forms, etc.)**

Name____ Relationship________________ Phone_______________________

Name____ Relationship________________ Phone_______________________

Name ____ Relationship ________________ Phone _______________________

I hereby authorize the release of my personal medical information as follows:
(Select One)

☐ a. My complete health record “PHI” (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

☐ *b.* My complete health record “PHI” *with the exception of the following information* **(circle as appropriate):**

Mental health records — Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment — Other (please specify): _______________________

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation,

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ _________________________
Signature of Patient/Legal Guardian — Date

____ _________________________
Witness (BASC office employee) — Date