PATIENT INFORMATION SHEET

PLEASE PRINT

Social Security #: _____-____-_____ Date: _____

Last Name: _____ Suffix: _____ (Sr., Jr., etc.) First Name: _____ Middle Initial: _____

Other Name: _____ Address: _____

Apt. # / P.O. Box: _____ City: _____ State: _____ Zip code: _____-_____

Home Phone: (____) _____-_____ Mobile Phone: (____) _____-_____ Work Phone: (____) _____-_____

Birthdate: ____/____/_____ (Month Day Year) Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer: _____ ☐ Full Time ☐ Part Time

Employer Address: _____ City: _____ State: _____ Zip code: _____

Referred by: _____ Pharmacy Name & Phone: _____ (____) _____-_____

Driver's License #: _____ Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: (____) _____-_____ Legal Guardian: _____ Relationship: _____

PARTY RESPONSIBLE FOR CHARGES

For Worker's Compensation, Accidents, etc.

☐ (Check box if you are the responsible party)

Bill To: _____
Full Name – First, Middle, and Last

Social Security #: _____-____-_____ Claim Type: ☐ Self ☐ Worker's Comp. ☐ PIP ☐ MVA

Name: _____ Address: _____

Apt. # / P.O. Box: _____ City: _____ State: _____ Zip code: _____-_____

Case Type: _____ File #: _____ Adjuster: _____

Accident or Illness Onset Date: ____/____/_____ (Month Day Year) Accident State: _____ First Dr. Visit Date: ____/____/_____ (Month Day Year)

Accident Description: _____

Accident Address: _____

Employer: _____ Employer Contact: _____

Employer Address: _____ City: _____ State: _____ Zip code: _____

Employer Phone: (____) _____-_____ Employer Fax: (____) _____-_____

Are you on disability? Yes No If yes, for what condition: _____

Last Worked: _____

Is there any workers compensation or litigation related to your condition? Yes No
(Please circle one, or both)

PRIMARY INSURANCE COVERAGE

Primary Insurance: _____

Responsible Party: Self Spouse Parent Other Subscriber: _____

Patient's Relationship to Subscriber: Self Spouse Parent Child Dependent Other: _____

Subscriber's Birthday: ____/____/____ Subscriber's Social Security #: _____-____-_____

Effective Date of Insurance: ____/____/_____

PATIENT INFORMTION SHEET

SECONDARY INSURANCE COVERAGE

Secondary Insurance: _____

Responsible Party: Self Spouse Parent Other Subscriber: _____

Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Parent ☐Child ☐Dependent ☐Other: _____

Subscriber's Address: _____ City: _____ State: _____ Zip code: _____

Subscriber's Birthday: ____/____/_____ Subscriber's Social Security #: _____-____-_____
Month Day Year

Subscriber's Phone Number: (____) _____-_____ Work Phone: (____) _____-_____ Extension: _____

Subscriber's Employer: _____

Employer Address: _____ City: _____ State: _____ Zip code: _____

Effective Date of Insurance: ____/____/_____ Copayment: $_____ Policy #: _____ Group #: _____
Month Day Year

FOR PEDIATRIC PATIENTS

Father's Name: _____

Address: _____

City, State, Zip: _____

Home Phone #: (____) _____-_____

Work Phone #: (____) _____-_____ Ext: _____

Mother's Name: _____

Address: _____

City, State, Zip: _____

Home Phone #: (____) _____-_____

Work Phone #: (____) _____-_____ Ext: _____

Patient's or Parent's Driver's License #: _____ State:_____

Name of Legal Guardian: _____ Address: _____

City: _____ State: _____ Zip code: _____ Primary Phone: (____) _____-_____

CONSENT AND ASSIGNMENT

PLEASE READ BEFORE SIGNING

***** Medicare *****

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediate or carriers any information needed for this or a related Medicare claim (Title XVIII) 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 accept assignment below. I understand that I am responsible for any health insurance deductibles co-insurance (co-pau) and non-covered charges.

*****Blue Shield of Maryland*****

I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment and, if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pays), and non-covered charges.

*****Legal Assignment***** (applicable to Physician Services)

The undersigned expressly agrees that if, upon default, this matter if referred for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

*****Insurance Assignment*****

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges **not covered** by my insurance.

*****Managed Care*****

I understand that, without an authorization/referral form from my HMO/PIPA/PPO, I will be financially responsible for the charges I incur.

*****GUARANTEE*****

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to SPPS and its successors and assigns, the full and complete payment due by the patient, as and when the same becomes due.

Signature: _____ Date: ____/____/_____
(Sign Here) Month Day Year

*****Signature of Patient, Responsible Party, Parent, or Legal Guardian*****

Signature: _____ Date: ____/____/_____
(Sign Here – I authorize a copy of this authorization to be used in place of the original) Month Day Year

Maryland Spine Center Patient Questionnaire

Name: _____ DOB: _____ Age: _____

Patient's preferred language: _____ Written language: _____

Marital Status: _____ Ethnicity: _____ Race: _____

Primary Care Physician: _____ Phone #: (____) _____-_____ Fax #: (____) _____-_____

Referring Physician: _____ Phone #: (____) _____-_____ Fax #: (____) _____-_____

Today's Date: _____ Current Height: _____ Weight: _____

Why are you being seen today? _____

_____

Date of onset pain/injury: _____ How did your symptoms start: □Fall □Accident □Gradual

Duration of symptoms: ____ months / years. Are the symptoms getting: □Better □Worse

The pain is principally in the: □Neck/Arms □Back/Legs □No Pain

What is the proportion of pain in the neck/back vs. arms/legs?

Neck/Arms	Back/Legs
◊ 0% arms & 100% neck	◊ 0% legs & 100% back
◊ 25% arms & 75% neck	◊ 25% legs & 75% back
◊ 50% arms & 50% neck	◊ 50% legs & 50% back
◊ 75% arms & 25% neck	◊ 75% legs & 25% back
◊ 100% arms & 0% neck	◊ 100% legs & 0% back

Do you have any numbness: □Yes □No Where: _____

Do you have any weakness: □Yes □No Where: _____

Do you have any bowel or bladder dysfunction: _____

What treatments have you received thus far for this condition?		Did it help?	
Physical Therapy:	□Yes □No	□Yes □No	
Brace:	□Yes □No	□Yes □No	
Epidural Steroid Injection:	□Yes □No	□Yes □No	Levels: _____
Spine Surgery:	□Yes □No	□Yes □No	
Other: _____		□Yes □No	

If you have had previous spine surgery, please describe below:

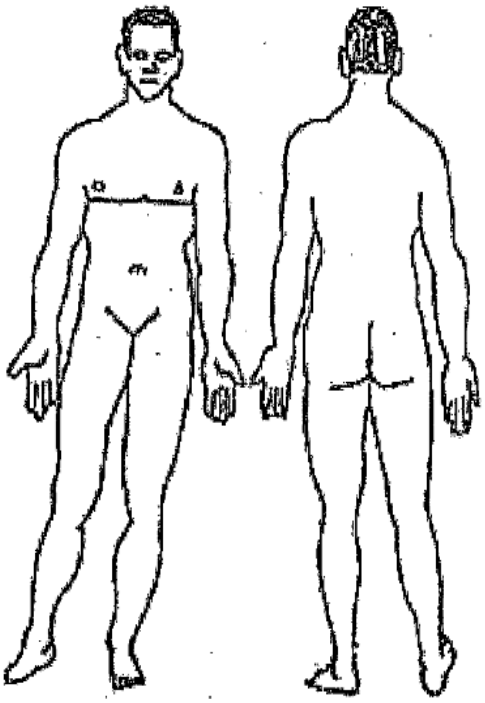
Date	Surgeon	Procedure
1.		
2.		
3.		

Are you currently working? □Yes □No Retired: □Yes □No

Present Occupation: _____

Maryland Spine Center Patient Questionnaire

On the diagram below, please mark where you have pain:



CURRENT MEDICATION (dosage and name of drug, please include any OTC medication; if more than 8 please attach separate sheet with list of medication)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Are you allergic to any medications? If yes, please list medications and reaction: _____

_____

SOCIAL HISTORY

Marital Status: □Married □Single □Divorced □Separated □Widowed

Do you smoke: □Yes □No If yes, how many packs per day: _____, for how many years: _____

Do you use other tobacco products: □Yes □No Which ones: □Cigars □Chewing Tobacco □Snuff □Other

Do you drink alcoholic beverages: □Yes □No How much, how often: _____

Illicit or recreational drugs / non-prescription drugs: _____

Maryland Spine Center Patient Questionnaire

PLEASE LIST ALL SURGERIES THAT YOU HAVE HAD:

SURGERY	DATE	SURGERY	DATE
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

PAST MEDICAL HISTORY: conditions for which you have had or are currently receiving treatment:

Please circle type / location of condition in parenthesis if applicable.

□ Anemia	□ Arthritis	□ Asthma
□ Blood clots *(Legs / Arms)*	□ Cancer (Location: _____)	□ Coronary Artery Dis.
□ Current Chest Pain	□ Diabetes *(Non-insulin dep. / insulin dep)*	□ Emphysema
□ Gastric Reflux	□ Heart Attack	□ Heart Disease
□ Hepatitis *(treated: y / n)*	□ High Cholesterol	□ Hypertension
□ Kidney Failure	□ Liver / Pancreatic Disease	□ Other Kidney Disease
□ Peptic Ulcer	□ Positive for HIV / AIDS	□ Received Blood Trans.
□ Seizure Disorder	□ Sleep Apnea *(CPAP: yes / no)*	□ Stroke
□ Thyroid Disease	□ Tuberculosis	

□ Other: _____

FAMILY HISTORY: for blood relatives only: please check if any relative had any of the following:

	Living	High blood pressure	Heart disease	Diabetes	Stroke	Bleeding Problems	Cancer	Other problems: (please describe)
MOTHER	□Yes □No	□	□	□	□	□	□	
Grandmother	□Yes □No	□	□	□	□	□	□	
Grandfather	□Yes □No	□	□	□	□	□	□	
FATHER	□Yes □No	□	□	□	□	□	□	
Grandmother	□Yes □No	□	□	□	□	□	□	
Grandfather	□Yes □No	□	□	□	□	□	□	
Brother	□Yes □No	□	□	□	□	□	□	
Sister	□Yes □No	□	□	□	□	□	□	

REVIEW OF SYSTEMS:

(Please Circle)

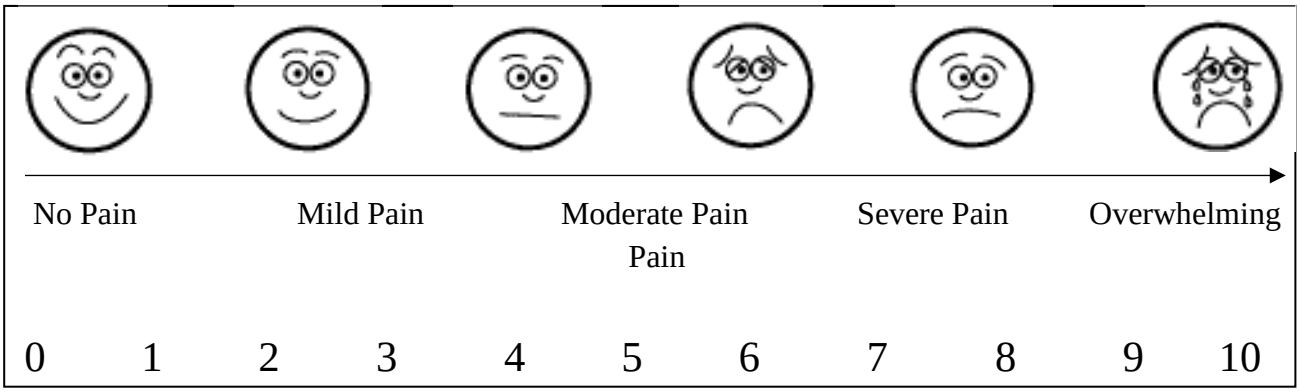
Abnormal Bleeding	Burning on Urination	Chills
Constipation	Cough	Diarrhea
Difficulty Swallowing	Fevers	Headaches
Heartburn	Imbalance / Dizziness	Nausea
Poor Appetite	Swelling of Ankles	Undesired Weight Gain
Undesired Weight Loss	Vomiting	

The Maryland Spine Center
Pain Assessment Form

If you are in physical pain or discomfort, you have the right to proper pain management. Talk to your doctor about. Here's why:

- No one should have to live with pain or discomfort.
- There are treatments and medications that really work.
- The Doctor can't help you unless you tell them about the pain.
- Your Doctor will need to know the following about your pain:
    1. Where do you feel your pain?
    2. Is this a new pain?
    3. How does your pain feel (sharp, dull, stabbing, aching, burning, shooting, numbing, constant)?
    4. What makes your pain worse?
    5. What are you doing to currently ease your pain?

This questionnaire helps the physicians and nurses evaluate your health and plan your care.
Please rate your pain on the numerical pain rating scale below by circling number from 1 -10.



Do you want your doctor to address your pain during today's visit? ____Yes ____No
Please list any medications (with dosages) or treatments that you are using for pain relief:

_____
_____
_____

_____ _____
Patient Signature Date

BILLING NOTICE TO OUR PATIENTS

The Maryland Spine Center is an outpatient department of Mercy Medical Center. Accordingly, you will receive two bills for your appointments in the Center. You will receive a physician services bill from the physician group and an outpatient clinic bill from Mercy. Together, these two bills represent charges incurred during your visit to the Center and we provide this notice to help avoid confusion when you receive two separate bills.

Depending on your insurance coverage, you may be responsible for some or all of both bills. All charges are billed to the patient's insurance company to determine the amount of patient responsibility. If in doubt, please contact your insurance carrier to determine the co-pay, deductible, and/or coinsurance amounts.

Thank you.

I have read and understand this billing notice:

_____	_____
Patient Name – Printed	Date of Birth
_____	_____
Patient Signature	Date of Signature

Welcome to

As part of our electronic medical record (EMR) system, we invite you to be an active member in your health care and to improve the high-quality care you already receive. Through this system, you will have access to a secure website called **MyChart**.

MyChart gives you direct online access to portions of your EMR where your doctor stores your health information. Your lab results, appointment information, medications, immunizations, and more are all securely stored for quick retrieval.

MyChart shows you that same information – so you see what your doctor sees!

MyChart also provides new, convenient methods of communication with your doctor's office and ability to make secure, online payments. Renew prescriptions, send messages, schedule appointments, and pay your bill – all online.

Mercy
HEALTH SERVICES

MyChart Sign Up

You will get this copy back.

Name: _____

Date of Birth: _____/_____/_____

Desired Username: _____
Username needs to be 5 characters or more.

Desired Password: _____
Password needs to be at least 8 characters with one number and one capital letter.

Email: _____

Security Question: _____
(Make of first car)
Answer: _____