

**PACIFIC SPINE SPECIALISTS, LLC – PATIENT REGISTRATION**

Patient Name: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Okay to leave messages Home Phone – Yes/No Cell Phone - Yes/No Work Phone - Yes/No *Circle One*

Preferred Language: English \_\_\_\_\_ Other \_\_\_\_\_ Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

Ethnic Group: Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino \_\_\_\_\_

Race (circle one): American Indian or Alaska Native/Asian/Black or African American/  
Native Hawaiian or Other Pacific Islander/Other Race/White/Unknown

Primary Care Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Birth date: \_\_\_\_\_

Responsible Party Address: \_\_\_\_\_

Responsible Party Phone numbers: \_\_\_\_\_

ID Verified \_\_\_\_\_

Patient or Responsible Party's Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

**ACCIDENT INFORMATION**

*Circle One:* WORKERS COMPENSATION OR MOTOR VEHICLE

**Date of Injury:** \_\_\_/\_\_\_/\_\_\_ **Employer Name:** \_\_\_\_\_

**Claim #:** \_\_\_\_\_ **Work Comp Name or MVA CO:** \_\_\_\_\_

**Claims Address:** \_\_\_\_\_

**Adjuster Name:** \_\_\_\_\_ **Phone #:** (\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE COVERAGE**

Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to Patient  Self  Mother  Father  Spouse  Stepparent  Other: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Employer Name & Phone: \_\_\_\_\_

**SECONDARY INSURANCE COVERAGE**

Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to Patient  Self  Mother  Father  Spouse  Stepparent  Other: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_/\_\_\_/\_\_\_ Employer Name & Phone #: \_\_\_\_\_



19260 SW 65<sup>th</sup> Ave. Suite 270  
 Tualatin, OR 97062 (503) 885-9391

NAME: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Current Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

When did your spine problem first begin? \_\_\_\_\_

Did your pain start because of an: Accident at work Accident away from work Motor vehicle accident Sports Unknown cause

If there was an accident, the pain started due to a:  
 Fall Lifting object Pushing Struck by falling or moving object Repetitive activity Other

Workers Compensation Claim?  Yes  No

Present symptoms existed before injury?  Yes  No

Circle or check the following if they apply:  
 I have missed no work because of this condition.  
 I have missed work, but I am now back at light duty.  
 I have missed work, but I am now back without limitation.  
 I have been off work since: (please give date) \_\_\_\_\_

The symptoms are better with: Lying down Sitting Standing Walking  
 The symptoms are worse with: Lying down Sitting Standing Walking

Do you have any problems controlling your bowel and / or bladder?  Yes  No

Hand dominance: Right Left

**NEW NECK PAIN: Circle all those that apply**

**Chief Complaint:** Neck Bilateral Upper extremities Right Upper Extremities Left Upper Extremities  
 Left Shoulder Right Shoulder Bilateral Shoulder Headache

**Overall Neck Pain:** 1...2...3...4...5...6...7...8...9...10

**Neck pain: choose most applicable:**  
 Neck pain > Upper extremity pain  
 Upper extremity pain > neck pain  
 Upper extremity pain = neck pain

Neck Pain Quality	Arm Pain Quality	Numbness	Weakness
Aching	Aching	None	None
Burning	Burning	Right shoulder	Right shoulder
Stabbing	Stabbing	Right arm	Right arm
Throbbing	Throbbing	Right forearm	Right forearm
Tingling	Tingling	Right thumb	Right thumb
Constant	Constant	Right long finger	Right long finger
Intermittent	Intermittent	Right small finger	Right small finger
Gradually improving	Gradually improving	Left shoulder	Left shoulder
Rapidly improving	Rapidly improving	Left arm	Left arm
Gradually worsening	Gradually worsening	Left forearm	Left forearm
Rapidly worsening	Rapidly worsening	Left thumb	Left thumb
		Left long finger	Left long finger
		Left small finger	Left small finger



**Treatments**

**Physical Therapy**     never tried     helpful     not helpful    Last treatment \_\_\_\_\_    Where \_\_\_\_\_

What treatment was performed?     exercises     stretching     TENS unit     ultrasound     massage

**Spine Injections**     never tried     helpful     not helpful    Last treatment \_\_\_\_\_    Where \_\_\_\_\_

**Acupuncture**     never tried     helpful     not helpful    Last treatment \_\_\_\_\_    Where \_\_\_\_\_

**Chiropractics**     never tried     helpful     not helpful    Last treatment \_\_\_\_\_    Where \_\_\_\_\_

**Please list any spine surgeries**     NONE

<u>Lumbar</u>	Type of Surgery	Date	Surgeon	Helpful	SX
1				Yes No	
2				Yes No	
3				Yes No	
4				Yes No	

<u>Cervical</u>	Type of Surgery	Date	Surgeon	Helpful	SX
1				Yes No	
2				Yes No	
3				Yes No	

**MEDICAL HISTORY**

- |  |                                       |                                  |                                       |  |
|--|---------------------------------------|----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Depression   | <input type="checkbox"/> Diabetes        |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> GERD    | <input type="checkbox"/> Heart attack | <input type="checkbox"/> HIV             |
| <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> _____                   | <input type="checkbox"/> _____        | <input type="checkbox"/> _____   | <input type="checkbox"/> _____        | <input type="checkbox"/> _____           |

**Please check / list all operations:**     none

- |   |             |   |             |
|---|-------------|---|-------------|
| <input type="checkbox"/> Appendectomy         | When: _____ | <input type="checkbox"/> Eye Surgery        | When: _____ |
| <input type="checkbox"/> Tonsillectomy        | When: _____ | <input type="checkbox"/> Heart surgery      | When: _____ |
| <input type="checkbox"/> Gall bladder removal | When: _____ | <input type="checkbox"/> Hysterectomy       | When: _____ |
| <input type="checkbox"/> Knee arthroscopy     | When: _____ | <input type="checkbox"/> Prostate surgery   | When: _____ |
| <input type="checkbox"/> Knee replacement     | When: _____ | <input type="checkbox"/> Surgery for cancer | When: _____ |
| <input type="checkbox"/> Hip replacement      | When: _____ | Type _____                                  |             |
| <input type="checkbox"/> _____                | When: _____ | <input type="checkbox"/> _____              | When: _____ |

**Blood Products / Transfusions**

- YES, if necessary I am able to be transfused with blood products  
 NO, if necessary I am not able to be transfused with blood products

PACIFIC SPINE SPECIALISTS, LLC.

SOCIAL HISTORY

Current Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] N/A

Number of Children: \_\_\_\_\_ Ages of children \_\_\_\_\_

Living Status: [ ] alone [ ] with spouse [ ] with parents [ ] with roommate [ ] assisted living [ ] nursing home

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_ Previous Occupation: \_\_\_\_\_

Highest education level: [ ] Grade School [ ] Middle School [ ] High School [ ] College [ ] Post Graduate

Are you on any type of disability [ ] Yes [ ] No

Do you use tobacco now or in the past? [ ] Yes, use now [ ] Never used [ ] Previous user Quit \_\_\_\_\_ years ago

Cigarettes How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_
Cigars How many per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcoholic beverages? [ ] Yes, drink now [ ] Never drank [ ] Previous Quit \_\_\_\_\_ years ago

Beer How many per day? \_\_\_\_\_
Wine How many per day? \_\_\_\_\_
Other How much per day? \_\_\_\_\_

Have you ever felt the need to cut down on drinking? [ ] Yes [ ] No
Have you ever felt annoyed by criticism of your drinking? [ ] Yes [ ] No
Have you ever felt guilty about your drinking? [ ] Yes [ ] No
Have you ever felt the need for a morning eye-opener? [ ] Yes [ ] No

Have you ever had or been treated for a drug or alcohol dependency problem? [ ] Yes [ ] No

FAMILY HISTORY

Please check the box if anyone in your immediate family has had any of the following conditions: (note relationship)

[ ] Arthritis [ ] Asthma [ ] Blood Disorder
[ ] Cancer [ ] Diabetes [ ] Epilepsy
[ ] Gout [ ] Heart Disease [ ] Hypertension
[ ] Kidney Disease [ ] Stroke [ ] Thyroid Disorder

REVIEW OF SYSTEMS

Please indicate below if you currently have any symptoms/conditions noted below.

Constitutional/General

Fever [ ] Yes [ ] No
Chills [ ] Yes [ ] No

Psychiatric

Depression [ ] Yes [ ] No
Anxiety [ ] Yes [ ] No

Ears/Nose/Mouth/Throat

Dizziness [ ] Yes [ ] No
Difficulty Swallowing [ ] Yes [ ] No

Cardiovascular

Hypertension [ ] Yes [ ] No
Stroke [ ] Yes [ ] No

Endocrine

Diabetes [ ] Yes [ ] No
Fatigue [ ] Yes [ ] No

Neurologic

Headache [ ] Yes [ ] No
Seizures [ ] Yes [ ] No

Gastrointestinal

Ulcers [ ] Yes [ ] No
GERD [ ] Yes [ ] No

Genitourinary

Urgent urination [ ] Yes [ ] No
Frequent urination [ ] Yes [ ] No

Hematologic/Lymphatic

Anemia [ ] Yes [ ] No
Bleeding Problem [ ] Yes [ ] No

Pulmonary

Shortness of Breath [ ] Yes [ ] No
Pulmonary Embolism [ ] Yes [ ] No
Asthma [ ] Yes [ ] No



# Pacific Spine Specialists, LLC

Pediatric & Adult Spinal Conditions

19260 SW 65th Ave., Suite #270

Tualatin, OR 97062

Phone: 503-885-9391 Fax: 503-783-0909 www.orspine.com

## BILLING AND FINANCE POLICY

### FINANCE POLICY

Your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account. We will assist by billing all insurance companies. Please provide us with complete insurance information (copy of insurance cards(s)) and inform our clinic of any changes in your insurance, address, telephone number, employer, or primary care physician.

Any outstanding balances not paid by your insurance after 90 days are your responsibility.

### PATIENT CO-PAYS

Patient co-pays are due at the time of your appointment. There will be an additional charge of \$25.00 if we have to bill you for your co-payment.

### NO INSURANCE COVERAGE/PORTION OF SERVICES NOT COVERED

If you have no insurance, or request that we not bill your insurance, payment in full is due at the time of service. In the event your health insurance or worker's compensation carrier determines a service we provide is excluded from coverage or not medically necessary you will be responsible for paying for those non-covered services. We will work with you to try to determine when services are/are not covered and what your anticipated responsibilities will be.

### MOTOR VEHICLE ACCIDENT CLAIMS

If the problem for which you are seen is due to a motor vehicle accident, a down payment may be expected at your first visit. If you want us to bill *any* insurance, please provide us with any pertinent insurance information; motor vehicle and medical.

### WORKER'S COMPENSATION CLAIMS

If we are seeing you for a condition that is part of a Worker's Compensation injury/case please be sure we have accurate information about your claim prior to your visit. If we are unable to get prior authorization from your adjustor for the visit, we will need to reschedule your appointment. For workers compensation claims that are in litigation, we will bill your private health insurance as well as worker's compensation to ensure timely filing of claims in the event needed.

### REFERRALS AND AUTHORIZATIONS

You are responsible for securing referrals from your primary care physician if required by your insurance. If a written authorization of a referral has not been received by our clinic at the time for your appointment, we will need to reschedule your appointment.

### DISABILITY FORMS

A fee of \$40 will be charged to complete disability forms. This fee will be waived if you have surgery *scheduled* with our physicians or you are in the three month window following your spine surgery.

### NSF CHECKS

A \$30.00 NSF Fee will be charged for any returned checks.

### AUTHORIZATION TO BILL FOR SERVICES

***I have read and understand this finance policy. I authorize the release of all medical information necessary to process claims and I authorize my Insurance Company to make payments directly to Pacific Spine Specialists.***

I understand I will be required to make payment in full at the time of my appointment if I choose to not sign this form.

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

Patient Name: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

If an attorney is involved in your claim provide his/her name here: \_\_\_\_\_

Attorney Phone Number: \_\_\_\_\_