Demographic Information				
Patient Name:				
Mailing Address:	City:	State:	Zip Code:	
Home Phone:	OK to Leave Message:	Brief	Extended	
Cell Phone:	OK to Leave Message:	Brief	Extended	
Work Phone:	OK to Leave Message:	Brief	Extended	
Date of Birth:	Marital Status:			
Patient Email:				
Spouse's Name:	Spouse's Phone Number:			
Do you authorize your spouse to receive medical information on your behalf?	Yes	No		
Primary Care Provider:				
Referring Provider:				
Preferred Pharmacy Name:	Phone Number:			
Pharmacy Address:				
Pharmacy City:	State:	Zip Code:		
Race: American Indian	Asian	Native Hawaiian	Black	White	Hispanic	Other
Language Spoken:				
Sex: Male	Female	Transgender	Ethnicity:	Hispanic or Latino	Not Hispanic or Latino	
Emergency Contact Information/ Release of Information other than Spouse				
Emergency Contact Name:				
Phone Number:				
Address:				
Relationship to Patient:	Medical information may be released			
Secondary Contact Name:				
Phone Number:				
Relationship to Patient:	Medical information may be released			
Guarantor/ Responsible Party (if other than self)				
Guarantor Name:				
Guarantor Phone Number:				
Guarantor Date of Birth:				

Patient Name:	Patient Date of Birth:
Additional Information	
Do you have an Advanced Directive? Yes No	Can you provide us with a copy? Yes No
IF CURRENT CARD(S) ARE NOT PRESENT	
Primary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Secondary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Additional Billing Information	
Is this a Workers Compensation Case?	**Yes No**
Workers Compensation Company/Employer:	
Is this a Motor Vehicle Accident Case?	**Yes No**
Automobile Insurance Carrier:	Policy Number:
Insurance Carrier's Phone Number:	
Insurance Carrier's Address:	
Agent:	

Patient Name: _____ **Patient Date of Birth:** _____

I attest that the information provided is correct and I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Alliance Spine and Pain Centers to view my medication history from external sources.

_____ _____

Patient, Please sign for permission to treat **Date**

_____ _____

Guardian, Please sign for permission to treat in your absence **Date**

* Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.

NEW PATIENT HEALTH HISTORY

Patient's Name:		Date of Birth:
Height:	Weight:	Dominant Hand: ☐ R ☐ L

Reason for Visit:

_____

Past Medical History		Past Surgical History		
	YES		YES	YEAR
Do you have a history of cancer?		Appendectomy		
Do you have a history of diabetes?		Gall Bladder Removal		
Do you have a history of irregular heartbeat?		Tubal Ligation		
Do you have a history of chest pain?		Hysterectomy		
Do you have a history of a bleeding disorder?		Kidney Surgery		
Do you have a history of high blood pressure?		Heart Surgery		
Do you have a history of heart failure?		(Specify) _____		
Do you have a history of a heart attack(s)?		Neck Surgery		
Do you have a history of having a stroke?		(Specify) _____		
Do you have a history of asthma?		Back Surgery		
Do you have a history of COPD		(Specify) _____		
Do you have a history of osteoporosis?		Knee Surgery		
Do you have a history of arthritis?		Hip Surgery		
Do you have a history of kidney disease?		Other_____		
Do you have a history of stomach ulcers?				
Do you have a history of reflux?				
Do you have a history of HIV/Aids?				
Do you have a history of anxiety?				
Do you have a history of depression?				

Who were you referred by: _____

Patient Name: _____ **Patient DOB:** _____

Are you taking any medications now? ☐ **Yes** ☐ **No (This includes prescription, over the counter, vitamins or herbal medications)**

If yes, please list below including dosages.

MEDICATIONS			
DRUG	**DOSE**	**TIMES PER DAY**	**WHY**
Example: Lortab	*5mg*	*3*	*Pain*

** PLEASE REMEMBER TO LIST ANY BLOOD THINNERS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN, COUMADIN, WARFARIN, PLAVIX, EFFIENT, PLETAL, AGGRENOX, GOODY'S POWDER, LOVENOX, AND PRADAXA **

Are you allergic to any medications? ☐ **Yes** ☐ **No** **If yes, please list them below.**

ALLERGIES	
Name of Medication	**Type of Reaction (Rash, Swelling, Etc.)**

Alliance Spine AND PAIN CENTERS

Patient Name: _____ **Date of Birth:** _____

FAMILY HISTORY									
Is your Father Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**
Is your Mother Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**
Are your siblings (sisters, brothers) Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**

SOCIAL HISTORY
Occupation:
Marital Status: ☐ M ☐ S ☐ D ☐ W
Alcohol Use: ☐ Yes ☐ No
Tobacco Use: ☐ Yes ☐ No
Recreational Drug Use: ☐ Yes ☐ No
History of Alcohol Abuse: ☐ Yes ☐ No
History of Prescription or Illicit Drug Abuse: ☐ Yes ☐ No
Other Information?

ONSET OF PAIN AND DURATION
Briefly describe when and how your current pain started.

_____

_____

_____

Is this a Workers Comp accident? ☐ **Yes** ☐ **No** **If yes, what was the date of injury?** _____

Is this related to an auto accident? ☐ **Yes** ☐ **No** **If yes, what was the date of the accident?** _____

Alliance Spine AND PAIN CENTERS

Patient Name: _____ **Date of Birth: _____**

PREVIOUS DIAGNOSTIC STUDIES – Please indicate approximate date and locations, if known.

Type	Date	Location
MRI		
CT		
X-RAYS		
EMG		

How would you describe your pain? (Choose as many as are applicable)

☐ Aching ☐ Dull ☐ Shooting ☐ Weakness

☐ Burning ☐ Intermittent ☐ Spasm

☐ Constant ☐ Pins and Needles ☐ Sore

☐ Cramping ☐ Sharp ☐ Stabbing

Circle the pain intensity with a "0" representing no pain and "10" the most severe pain imaginable.

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

What has been your average pain level for the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your lowest pain level in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your worst pain in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

How long have you been in Pain? ____Hours _____Days _____Months _____Years

Alliance Spine AND PAIN CENTERS

Patient Name: _____ **Date of Birth: _____**

How often do you have your pain? (Please check one)

- ☐ Constantly (100% of the time)
- ☐ Waxes and Wanes
- ☐ Intermittently (50% of the time)

What activities are you unable to do well because of your pain?

- ☐ Climb Stairs
- ☐ Walk long distances
- ☐ Sleep
- ☐ Sit for long periods
- ☐ Lift greater than 5 lbs.
- ☐ Meal Preparation
- ☐ Stand for long periods
- ☐ Go shopping
- ☐ Housework
- ☐ Yard work
- ☐ Work

What activities make your pain worse?

- ☐ Sitting
- ☐ Car Rides
- ☐ Work
- ☐ Standing
- ☐ Exercise
- ☐ Walking
- ☐ Weather
- ☐ Position change
- ☐ Hot/Cold

What activities make your pain better?

- ☐ Nothing
- ☐ Sitting
- ☐ Position change
- ☐ Medications
- ☐ Standing
- ☐ Rest
- ☐ Exercise
- ☐ Walking
- ☐ Massage
- ☐ Lying down
- ☐ Heat/Ice
- ☐ Chiropractic

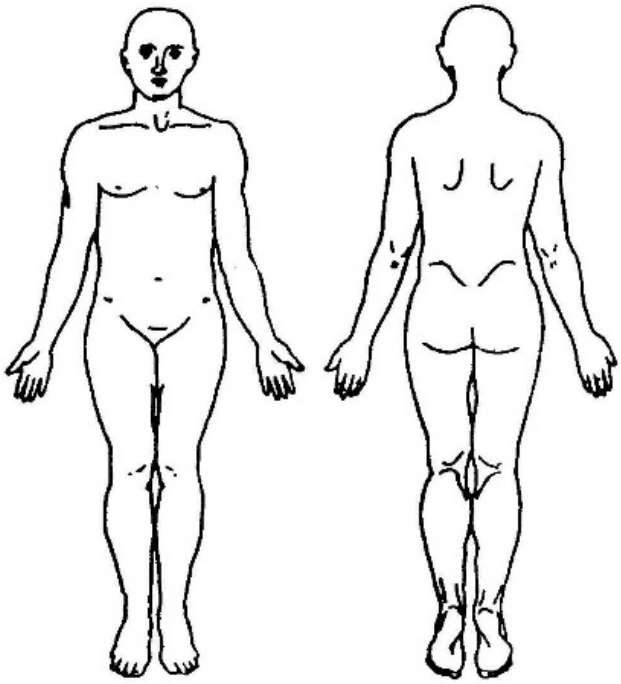
Patient Name: _____ Date of Birth: _____

What previous pain treatments have you tried?

Treatment	Date	How Long (1 month, 6 weeks)	Excellent Relief	Moderate Relief	No Relief
☐ Physical Therapy					
☐ Chiropractic					
☐ Medications					
☐ Injections					
☐ Surgery					
☐ Other					

PAIN LOCATION

Please mark the locations of your pain on the diagrams below with an "X". If whole areas are painful, please shade in the painful area.



Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

Have you had any of the following symptoms within the last 30 days?

Constitutional Symptoms:
☐ chills ☐ difficulty sleeping ☐ fatigue ☐ fever ☐ low sex drive ☐ night sweats ☐ unexplained weight change

Eyes:
☐ blurred vision ☐ changes in vision ☐ dry eyes ☐ eye pain

Ears, Nose, Mouth, Throat:
☐ changes in hearing ☐ congestion ☐ dental problems ☐ difficulty swallowing ☐ drainage ☐ dry mouth
☐ sore throat

Cardiovascular:
☐ chest pain ☐ fainting ☐ palpitations ☐ swelling in legs/feet

Respiratory:
☐ cough ☐ shortness of breath ☐ wheezing

Gastrointestinal:
☐ abdominal pain ☐ acid reflux ☐ blood in stool ☐ constipation ☐ diarrhea ☐ incontinence of bowel
☐ nausea/vomiting

Genitourinary:
☐ difficulty urinating ☐ impotence ☐ incontinence of urine ☐ painful urination

Musculoskeletal:
☐ back pain ☐ hip pain ☐ joint pain ☐ joint stiffness ☐ knee pain ☐ muscle spasm ☐ neck pain ☐ shoulder pain

Integumentary:
☐ dryness ☐ hives ☐ incisions ☐ lesions ☐ rash ☐ wounds

Neurological:
☐ daytime sedation ☐ difficulty sleeping ☐ dizziness ☐ insomnia ☐ headache ☐ memory loss
☐ numbness/tingling ☐ seizures ☐ tremors ☐ weakness

Psychiatric:
☐ depressed mood ☐ feeling anxious ☐ hallucinations ☐ high stress level ☐ suicidal thoughts

Patient Name: _____ **Date of Birth:_____**

Endocrine:

☐ easy bruising ☐ excessive thirst

Hematologic/Lymphatic:

☐ bleeding disorder ☐ blood clot ☐ varicose veins

Allergic, Immunologic:

☐ difficulty breathing ☐ runny nose ☐ hives ☐ itching ☐ rash ☐ swollen glands

_____ _____

PATIENT SIGNATURE **DATE**

Patient Name:_____

Patient DOB: _____

Financial Policy for Patient Care Services and Assignment of Benefits

We are happy that you have selected Alliance Spine & Pain Centers* for your healthcare needs and we look forward to working with you. At Alliance Spine & Pain Centers, we are committed to meeting your healthcare needs. Our goal is to make your insurance or other financial arrangements as simple as possible.

Patients are responsible for their co-payments, coinsurances and deductibles according to their plan at the time of service. We ask that you provide us with your current insurance information so we can file an insurance claim with your carrier. If you do not have active insurance you will be considered a "Self-Pay" patient. Our "Self-Pay" financial policy is based on very reasonable rates.

We have a dedicated team of Patient Concierges that will work with you on your financial responsibilities while ensuring your healthcare needs are being met. In the rare occasion your insurance does not make a payment to Alliance Spine & Pain Centers on your behalf, placing the financial responsibility on you for the services provided, a member from our Patient Concierge team will contact you prior to your scheduled procedure.

In the event you are not able to maintain your scheduled appointment we ask you provide us with 24 hour notice. This will allow our practice to treat another patient. If we have not received a 24 hour notice prior to your appointment you will be charged a "No Show" fee of $50.00.

By signing this form you are acknowledging you have read and understand you are assigning and transferring to Alliance Spine & Pain Centers all of the benefits due to you under Medicare, Medicaid or any insurance policy or health plan providing benefits for the services being rendered. You authorize Alliance Spine & Pain Centers to receive payment, file an appeal, and determine medical coverage from your health plan. You understand you are responsible for charges that are not covered by your health plan or that your health plan has assigned to you.

I have read and understood the above statements and certify that this form applies to all visits and procedures at any Alliance Spine & Pain Center.

_____ _____

Patient Signature Date

*Alliance Spine and Pain Centers includes Interventional Spine and Pain Management, PC dba Alliance Spine & Pain Centers its affiliates and subsidiaries.