SOUTHWEST
Spine & Sports

H:______________
W:______________
BP:______________
P:______________
BMI:______________

NEW PATIENT INFORMATION

NAME: ________________________________ AGE: ________ DATE: _____________

PHARMACY PHONE #:____________________________________

E-MAIL ADDRESS: ____

DOCTOR OR THERAPIST THAT REFERRED YOU TO US: _________________________________

SELF REFERRAL (if so, circle)

PRIMARY CARE PHYSICIAN'S NAME:____

Are you: Male Female

Right handed Left handed Ambidextrous

CHIEF COMPLAINT

Reason for visit: ____
Location of your pain:

Head Shoulder Mid Back Leg Ankle/Foot

Wrist/Hand

Neck Headaches Low Back Knee Hips/Buttocks

Arm

HISTORY OF PRESENT ILLNESS

Date of injury or symptom onset: ___________________

Type of injury: Sports Injury Job Accident

Car Accident (Were you the Driver or Passenger? Seatbelted? ☐No ☐Yes)

Other (explain): ____

Please describe how you injured yourself: ____

____

____

____

____

Please describe your current symptoms: ____

____

Circle the number that corresponds to the **severity** of your pain on a scale of 0-10.
"0" means no pain and "10" is the worst pain you can imagine.

At its worst:	0	1	2	3	4	5	6	7	8	9	10
At its best:	0	1	2	3	4	5	6	7	8	9	10

Which of the following best describes the **character** of your pain:

Timing:
☐Continuous, steady, constant
☐Rhythmic, periodic, intermittent
☐Brief, momentary, transient
(Frequency: ____ Duration: __________)

Quality:
☐Throbbing ☐Burning ☐Superficial
☐Aching ☐Tingling/numbness ☐Deep
☐Sharp ☐Dull ☐___________________

What makes your pain **worse**? ____

What makes your pain **better**? ____

How long/far can you: Sit ____________ Stand ____________ Walk ______________

Since your injury is your pain: ☐Better ☐Same ☐Worse

If your pain is changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? ☐No ☐Yes

PREVIOUS TREATMENT

Have you had treatment since your injury? ☐No ☐Yes Have you been to the ER for this? ☐No ☐Yes
Have you had any of the following tests or procedures performed:

X-Rays? ☐No ☐Yes MRI? ☐No ☐Yes Epidurals? ☐No ☐Yes

CT Scan? ☐No ☐Yes EMG? ☐No ☐Yes

Other (please explain) ____

Medical:
Dr. ___________ Date of 1st visit ____________________ Last visit ____________________
Diagnosis given ____
Medications given ____
Treatment provided ____

Chiropractic: ☐No ☐Yes
Dr. ___________ Date of 1st visit ____________________ Last visit ____________________
Diagnosis given ____
Frequency: ☐Every Day ☐Three times/week ☐Two times/week ☐Weekly
Has it helped? ☐No ☐Yes

Physical Therapy: ☐No ☐Yes
Therapist _____________ Date of 1st visit _____________ Last visit ____________________
Has it helped? ☐No ☐Yes Home exercise program given? ☐No ☐Yes

CURRENT MEDICATIONS:

NAME	DOSAGE	HOW OFTEN DO YOU TAKE THIS PER DAY
______________________	_______________	______________________________
______________________	_______________	______________________________
______________________	_______________	______________________________
______________________	_______________	______________________________
______________________	_______________	______________________________
______________________	_______________	______________________________

MEDICATION ALLERGIES ☐No ☐Yes

If yes, please list:

Name	Reaction
______________________	______________________________
______________________	______________________________
______________________	______________________________

Are you allergic or had any reaction to iodine, shellfish, IVP dye, or contrast media? ☐No ☐Yes

PAST MEDICAL HISTORY

☐Anxiety ☐Heart Attack ☐Polio ☐Thyroid trouble ☐Depression ☐Hypertension

☐Asthma ☐Heart Murmur ☐Stroke ☐High Cholesterol ☐Alcoholism ☐Liver disease

☐Cancer ☐Lung Disease ☐Parkinson's ☐Rheumatic Fever ☐Hepatitis ☐Chronic pain

☐Diabetes ☐Ulcers/PUD ☐Arthritis ☐Claustrophobia ☐Other ______________________

Have you ever had similar symptoms/injury before? ☐No ☐Yes

If yes, when: _________________ Please describe briefly: ____

____

PAST SURGICAL HISTORY

Have you had any surgeries? ☐No ☐Yes

If yes, please list type of surgery and approximate date:

1. ___________________________ 2. __________________________ 3. ____________________________

4. ___________________________ 5. __________________________ 6. ____________________________

FAMILY HISTORY

Please check box for any medical condition that a blood relative has a history of:

☐Anxiety ☐Heart Attack ☐Polio ☐Thyroid trouble ☐Depression ☐Hypertension

☐Asthma ☐Heart Murmur ☐Stroke ☐High Cholesterol ☐Alcoholism ☐Liver disease

☐Cancer ☐Lung Disease ☐Parkinson's ☐Rheumatic Fever ☐Hepatitis ☐Chronic pain

☐Diabetes ☐Ulcers/PUD ☐Arthritis ☐Claustrophobia ☐Psychiatric illness

☐Other ______________________

SOCIAL HISTORY
Marital Status: (Check one or more)

☐Single ☐Married ☐Divorced ☐Widowed ☐"Living together" ☐Separated
Number of children: __________ Ages: ______ ______ ______ ______ ______ ______

Do you smoke? ☐No ☐Yes How much? ______________________________
Previous Smoker? ☐No ☐Yes When stopped? ___________________________

Do you drink alcohol? ☐No ☐Yes How much? ______________________________
Coffee, tea, cola beverages (cups/glasses/cans per day) ______________________________

Do you use recreational drugs? ☐No ☐Yes What type/how often? ______________________________
Are you currently employed? ☐No ☐Yes If yes, type of job ________________________________

REVIEW OF SYSTEMS: Please mark those items which you currently experience:

GENERAL
☐Fever ☐Weight gain ☐Weight loss ☐Fatigue ☐Chills
☐Weakness ☐Night sweats

DERMATOLOGIC
☐Jaundice ☐Itching/rash ☐Lesions ☐Easy bruising

HEAD/HEARING& VISION
☐Trauma ☐Headaches ☐Tenderness ☐Dizziness
☐Ringing in ears☐Blindness ☐Blurred vision
☐Changes/loss ☐Discharge ☐Rings around lights
☐Double vision ☐Light sensitivity ☐Glasses

PULMONARY
☐Wheezing ☐Shortness of breath ☐Chronic cough ☐Coughing up blood

CARDIOVASCULAR
☐Chest pain ☐Leg swelling ☐Shortness of breath with exertion ☐Racing heart

GASTROINTESTINAL
☐Nausea ☐Abdominal pain ☐Bloody stool ☐Constipation ☐Diarrhea
☐Vomiting ☐Stool color changes ☐Heartburn ☐Incontinence of bowels

GENITOURINARY
☐Blood in urine ☐Vaginal discharge ☐Pregnancy ☐Pain/burning on urination
☐Incontinence ☐Venereal disease ☐Sexual problems ☐Painful menstruation
☐Menopause ☐Urgency/frequency with urination ☐Irregular menstruation

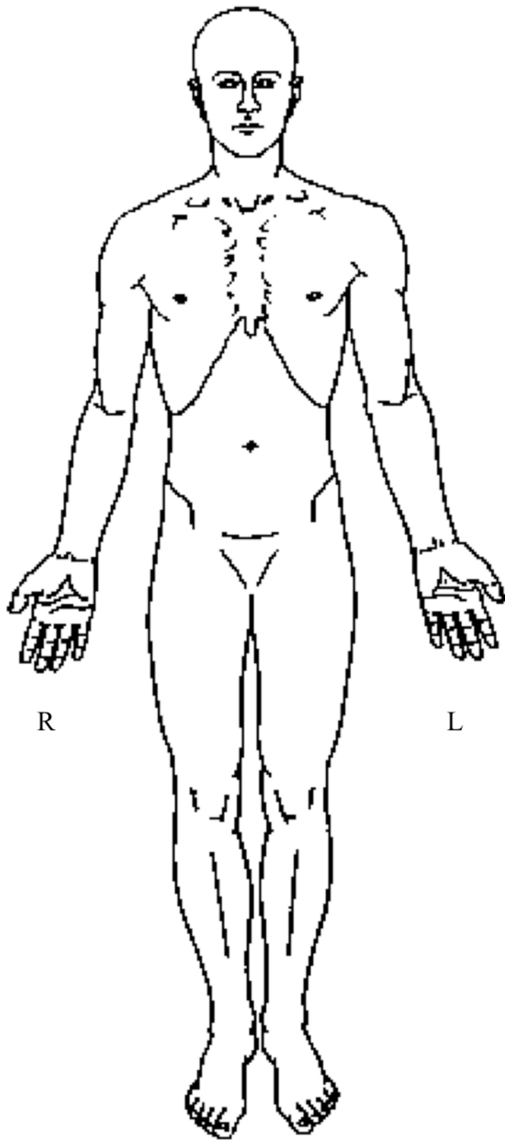
MUSCULOSKELETAL
☐Arthritis ☐Joint swelling ☐Trauma

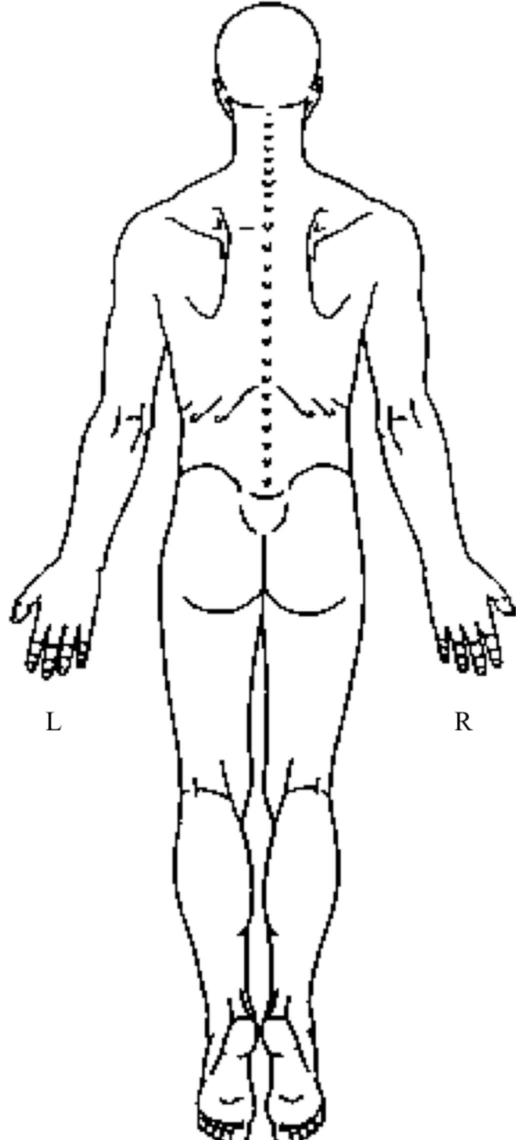
NEUROLOGICAL
Loss of Sensation Seizures Numbness and Tingling

PSYCHOLOGICAL
Sadness Anxiety Depression

Mark on the areas on your body where you feel the described sensations. Use the symbols listed.
Mark areas of radiating pain or numbness as well. Include all affected areas.

Numbness	**Tingling**	**Burning**	**Stabbing/Sharp**	**Aching**	**Cramping**
o o o	**: : : :**	**X X X**	////	^^^	□□□





SOUTHWEST
Spine & Sports

AUTHORIZATION TO RELEASE RECORDS

Patient: ____________________________ Social Security #: ____________________

Phone: ____________________________ DOB: _______________________________

To: ____

____

____

Phone: ____

Fax: ____

I hereby authorize and request the release of

[ ] ALL medical records and correspondence in my file.

[ ] The following records only ____

Please Send Records To:

Southwest Spine & Sports, P.C.
9913 N. 95th St.
Scottsdale, AZ 85258
Phone: (480) 860-8998 Fax: (480) 377-9245

____ _________________________

Patient Signature Date

____ _________________________

Witness Signature Date

SOUTHWEST
Spine & Sports

Notice To Patients

State law, A.R.S. §32-1401 (26)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. I support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that I have a direct financial interest in the diagnostic or treatment agency named below:

North Scottsdale Ambulatory Surgery Center
9439 E Ironwood Square Drive, Ste 100
Scottsdale, AZ 85258

Gateway Surgery Center
690 N Cofco Center Court, Ste 150
Phoenix, AZ 85008

Further, all goods or services that I have prescribed are available elsewhere on a competitive basis.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. I will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGEMENT: I HAVE READ THIS NOTICE AND UNDERSTAND THE DISCLOSURES THAT IT CONTAINS.

____________________________________ ____________
Signature of Patient or Guardian Date

SOUTHWEST
Spine & Sports

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature.	Date
Printed Name if signed on behalf of the patient	Relationship to patient

SOUTHWEST
Spine & Sports

Physicians
Michael W. Wolff, MD*
Jonathan C. Komar, MD*
Anthony A. Lee, MD*
Jason R. Sherman, MD*
Lata Kumaraswamy, DO
John C. Jones, MD
*Board-Certified: Physical Medicine & Rehabilitation Pain Management

Physician Assistants
Gretchen L. Post, PA-C**
Ashley E. Stowers, PA-C**
Lindsay H. Baumhefner, PA-C**
**Certified: Physician Assistant

Nonsurgical Solutions for:
- Sports Injuries
- Back & Neck Pain
- Herniated Discs
- Joint Pain
- Arthritis
- Nerve Injuries
- Industrial/Work Injuries
- Carpal Tunnel Syndrome
- Acute Injuries
- Muscle & Ligament Sprains & Strains

Leading-Edge Diagnostics & Treatments:
- EMG Testing/Nerve Studies
- Fluoroscopically Guided Injections
- IDET
- Radiofrequency Ablation
- Protein Rich Plasma Therapy (PRP)
- Epidurals
- Percutaneous Disc Decompression
- Provocation Discography
- Medical Acupuncture
- Botox®
- Medical Imaging
- Musculoskeletal Ultrasound

For Your Comfort & Convenience:
- State-of-the-Art Facilities
- Most Insurance Accepted
- Workers' Comp. Welcome
- Multiple Locations

Offices:
9913 N. 95th Street
Scottsdale, AZ 85258

1025 E. Broadway Road, Suite 201
Tempe, AZ 85282

18275 N. 59th Avenue, Suite F132
Glendale, AZ 85308

480-860-8998
480-377-9245 **fax**
www.swspineandsports.com

Southwest Spine & Sports, PC
Financial & Office Policies

Patient Name: _________________________ DOB: ___________

Payment Policy:
Payment is expected at time of service. Your copay, coinsurance, and/or deductible is due at time of visit. For your convenience, we accept checks, Visa, or MasterCard as a form of payment. Please note that the surgery centers charge additional and separate fees for any procedures at their offices. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

Insurance Policy:
As one of your insurance companies' network providers we require your copayment in advance of your appointment. We also will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.
For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.
Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

Non-Covered Service Policy:
Certain services performed by our office are NOT COVERED by all insurance plans. Some of these services include acupuncture, Durable Medical Equipment (DME), Urine Drug Screens (UDS) and certain injections. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

Delinquent Accounts Policy:
Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

Late Arrivals:
In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

Medical Records:
Should you request a copy of your medical records, please allow our office 7-10 business days for completion.

Forms Policy:

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of $25.00 per form. Payment of this charge is expected at time of completion.

SOUTHWEST
Spine & Sports

Southwest Spine & Sports, PC
Financial & Office Policies

Appointment Cancellations/No Shows/Reschedules:
There is a $25.00 charge for established patients and $75.00 charge for New Patients, EMG's and procedures who cancel, reschedule or no show for an appointment without giving 48 hours notice, these appointments times could have been given to another patient who needs medical care. We understand unusual circumstances may arise, please contact our office as soon as possible.

Prescriptions:
Appointments are required for medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

Returned Checks:
Our office charges a $25.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

Referrals & Authorizations:
If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

Workman's Compensation:
Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

Third Party Billing:
Our office does not accept medical liens or automobile cases. However, we do use a lien company, National Health Finance, who may be willing to handle your lien case. Please contact them at 602-347-8503.

___________________________________Date____________
(Patient/Guarantor Printed Name)

___________________________________Date____________
(Patient/Guarantor Signature)

Review by: _________________________Date____________

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Scottsdale, AZ 85258

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