INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Welcome to our office! We are committed to providing the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and will only be released with your consent.

PATIENT REGISTRATION FORM (PI)

General Information

Name (Last, First, MI): _____ Date: _____ Sex:____

Address (Street, City, State, Zip): _____

Date of Birth: _____ Age:_____

Best phone # to reach you: (*circle: home, work, cell)*_____

Email:_____

Social Information

Marital Status: *S M W D* Spouse's Full Name:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Healthcare Professionals

Have you been treated by another physician since the accident?: ___ Yes ___ No

If yes: Specialty:_____ Name:_____

Specialty:_____ Name:_____

Specialty:_____ Name:_____

Treatments: _____

I authorize payment of medical benefits be made directly to **MATTHEW ROOT, D.O.** for services rendered.

Date: _____ Signature:_____

I authorize any insurance company, employer, physician to release any information to this claim and the expenses reported.

Date:_____ Signature:_____

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PI Questionnaire

Date & Time of Injury:_____ _____ AM/PM

Location: (ie. street, intersection, freeway) _____

Type of Injury *(circle)*: *AUTO Slip & Fall Assault Other (specify:_____)*

Attorney Information:

Name:_____ Address:_____

Phone #:_____ Fax #:_____

PATIENT INFORMATION:

Name (Last, First, M.I.):_____D.O.B.:_____

HISTORY OF PRESENT INJURY:

Body Part(s) Affected:_____

IF AUTO ACCIDENT:

Were you wearing your seatbelt?: ___No ___Yes

Were you the: ___Driver ___Passenger ____Front Seat ___Back Seat

Number of people in YOUR vehicle (excluding yourself): _____

Number of people in OTHER vehicle (excluding the driver): _____

Which direction were you headed?: ___North ___South ___East ___West

Were you struck from: ___Behind ___Front ___Left Side ___Right Side

Did the airbags deploy? ___ No ___ Yes

Were you knocked unconscious?: ___No ___Yes If yes, for how long?:_____

In your own words, please describe the events of the accident:

_____

_____

_____

_____

Describe what you felt IMMEDIATELY after the accident:

_____

_____

Were the police notified? ___Yes ___No Was there a police report?: ___Yes ___No

Where were you taken after the accident? *(please check):* ___*Home* ___*Work* ___*Hospital* ___*Dr. Office* ___*Other:*_____ *By Whom?:*_____

Describe what you felt LATER that day:

_____

_____

INNOVATIVE PAIN *and* SPINE CENTER

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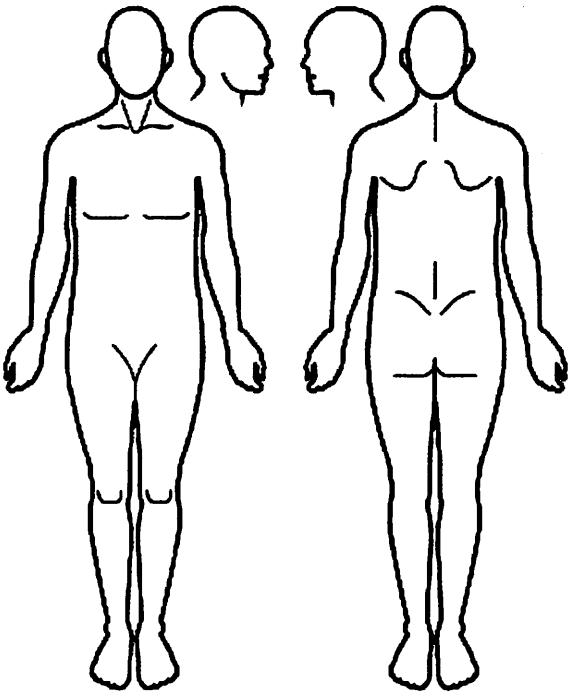
Describe what you felt The NEXT day:

_____

_____

Please indicate on diagram areas of pain:



The pain is described as:

__Sharp __Shooting

__Dull __Aching

__Throbbing __Constant

__Other: _____

_____

Do you experience any of the following?

__Numbness __Tingling __Pins/Needles

__Headaches __Nausea __Photophobia __Muscle Spasms __Other:

_____

_____

Does the pain radiate anywhere?

_____

PRIOR HISTORY:

Did you have any physical complaints BEFORE THE ACCIDENT?: ___No ___Yes

If yes, please describe in detail:_____

Have you ever been involved in a previous auto accident?: ___No ___Yes When?_____

If yes, did your previous injuries heal before the present accident? ___ No ___ Yes

Have you had any imaging studies done?: __X-ray __MRI __CT

Facility Obtained (Name and City):_____

Patient OR Legal Representative:

Print Name:_____

Signature:_____ Date:_____

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Medications

Are you currently taking any of the following? *(write Yes or No)*:

Drug	Y/N	Specific Drug(s)	Dose	Reason
Blood thinners				
Aspirin				
NSAIDs (anti-inflammatories)				
Antibiotics/Antifungals				

Please list all **OTHER** medications, including: pain medication, vitamins, and/or herbal supplements you are taking:

Medication	Dosage (mg)	Frequency (1x/day, etc)

Have you stopped any previous pain medications? ___ Yes ___ No

Please list medications stopped and why? _____

ALLERGIES

Please mark if applicable: __No Known Drug Allergies __Sulfa Drugs __Iodine __Penicillin __NSAIDS __Steroids __Latex __Anesthesia

If not listed above, please document all other known allergies:

_____

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Medical History

Do you currently have or have had any of the following medical conditions?:

Condition(s)	Y/N	Specify
Bleeding problems *(e.g. hemophilia, clotting disorders)*		
Cancer *(e.g. prostate, breast, colon)*		
Heart disease *(e.g. hypertension, CAD, hyperlipidemia)*		
Respiratory problems *(e.g. asthma, COPD, sleep apnea)*		
Gastrointestinal disorders *(e.g. GERD, IBS, Crohn's)*		
Liver disease *(e.g. hepatitis, cirrhosis)*		
Kidney disorders *(e.g. CKD, ESRD, kidney stones)*		
Endocrine disorders *(diabetes, thyroid disorder)*		
Psychiatric *(e.g. anxiety, depression, bipolar, addiction)*		
Nerve disorders *(e.g. stroke, MS, neuropathy)*		
Infections *(e.g. frequent UTIs, HIV, sinusitis, common cold)*		
Rheumatologic disorders *(e.g. Lupus, RA)*		
Headache disorder *(e.g. migraines, cluster headaches)*		

Social History

Do you currently smoke? *(circle) Y N*

Have you ever smoked? *circle: Y N* Packs/day:_____

Do you currently use illicit drugs? *(circle) Y N*

Any history of drug abuse? *(circle) Y N* Time sober:_____

Do you currently use marijuana? *(circle) Y N*

Have you ever used marijuana? *(circle) Y N*

Do you drink alcohol? *(circle) Y N*

If yes, how many drinks per week?:_____

Any history of alcohol abuse? *(circle) Y N*

Time sober:_____

Are you currently working? *(circle) Y N*

Work status: *(circle) part-time full-time modified retired*

Family History

Are there any of the following illnesses in your family?:

Condition(s)	Y/N	Relationship
Neurologic disorders *(e.g. MS, etc)*		
Diabetes		
Depression		
Heart disease		
Stroke		
Rheumatologic disorders *(e.g. lupus, RA)*		
Thyroid disease		
Blood disorders *(e.g. anemia, etc)*		
Autoimmune disorders		
Addiction		

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FOR PHYSICIAN USE ONLY

Motor Testing:

Bicep R: 4* 4+ 5 L: 4* 4+ 5
Tricep R: 4* 4+ 5 L: 4* 4+ 5
Wrist Ext. R: 4* 4+ 5 L: 4* 4+ 5
Hand Int. R: 4* 4+ 5 L: 4* 4+ 5
APB R: 4* 4+ 5 L: 4* 4+ 5
Hip Flex R: 4* 4+ 5 L: 4* 4+ 5
Hip Abd. R: 4* 4+ 5 L: 4* 4+ 5
Knee Ext. R: 4* 4+ 5 L: 4* 4+ 5
Knee Flex R: 4* 4+ 5 L: 4* 4+ 5
Dori-Flex R: 4* 4+ 5 L: 4* 4+ 5
EHL: R: 4* 4+ 5 L: 4* 4+ 5
FHL: R: 4* 4+ 5 L: 4* 4+ 5

Special Test:
SLR: (-) or (+): (B) (L) (R)
Axial Compression: (-) or (+): (B) (L) (R)
Hoffman's: (-) or (+): (B) (L) (R)
Spurling's: (-) or (+): (B) (L) (R)
Extension Loading Test: (+): (B) (L) (R)
Neer (+): (B) (L) (R)
Knee Test's: (+): (B) (L) (R)
CMC Grind (+): (B) (L) (R) Finkelstein's (+):
Faber's (+): Gaenslan (+):
Fortin's (+): Tinel's (+):
Drawer (+): Varus Stress (+):

Other:

Diagnosis: (1): Left (2): Right

__M79.18 Myalgia/Myofascial Pain __M54.12 Cervical Radiculopathy __M47.812 Cervical Spondylosis
__M48.02 Cervical Spinal Stenosis __M50.10 Cervical disc disorder with radiculopathy
__M54.16 Lumbar Radiculopathy __M51.26 Lumbar Intervertebral Disc Displacement
__M47.816 Lumbar Spondylosis __M48.061 /__M48.062 Lumbar Spinal Stenosis
__Z79.891 Long-term __M75.40/__.41/__.42 (Impingement Syndrome, unspecified shoulder
__M65.819 Tendinopathy, unspecified shoulder __M77.10/__.11/__.12 Lateral epicondylitis, unspecified elbow
__G56.03 Carpal tunnel syndrome, bilateral upper limbs __M53.3 Sacroiliac Joint Disorder
__M17.9 Knee Osteoarthritis
__Other:

Treatment Plan:

Injection:

___ SI INJ /___Ganglion Impar __SI Joint Disorder
___ C ILESI __Cervical Radiculopathy
___ C MBB __Cervical Spondylosis Levels:
___ C RFA __Cervcial Spondylosis Levels:
___ L MBB __Lumbar Spondylosis Levels:
___ L RFA __Lumbar Spondylosis Levels:
___ L ILESI __Lumbar Radiculopathy
___ L TFESI __Lumbar Radiculopathy Levels:
___ CAUDAL __Lumbrosacral Radiculopathy
___ TPI __Myalgia/Myofascial Pain Regions:
___ GON/LON
___ JOINT INJ __KNEE: __HIP: __ SHOULDER:
__Knee Osteoarthritis __ HIP OA __Shoulder OA
__Meniscus Tear __Trochanteric Bursitis __Shoulder impingemnet

___ OTHER

DIRECTIONS:
_____ PRIOR AUTHORIZATION
_____ RADIANCE or STARPOINT
_____ HOSPITAL

INNOVATIVE PAIN *and* SPINE CENTER

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Patient Financial Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, checks, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the InNetwork rate.

Worker's Compensation	Personal Injury
If your claim is denied, you may be responsible for payment in full.	We bill your attorney for charges incurred associated with personal injury cases. We require a signed Lien for all personal injury cases.

I have read the financial policies contained above, and my signature below serves as an acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party: _____ Date: _____

Name of Patient/Responsible Party: _____ Relationship: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Innovative Pain and Spine Center Privacy Act on the date indicated. If you have any questions regarding the information in Innovative Pain and Spine Center Notice of Privacy Practices, please do not hesitate to contact our office located at 4418 Vineland Ave Suite 218 North Hollywood CA 91602.

The following individuals may have access to my medical records (family/friend(s)/caregiver(s):

_____

*I understand that ONLY the above named individuals will have access to my medical information upon their request. I understand that I may update this information at any time that I am physically in your office.

Patient Name/ Responsible Party (Printed):

_____

Relationship to Patient (Printed):

_____

Signature of Patient/Responsible Party:

_____

Date Notice Received:

_____

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Authorization for Release of Medical Record Information

Patient Name:_____ D.O.B.:_____

Home/Cell Phone:_____

Email:_____

Address:_____

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

Above listed patient authorizes the following healthcare facility to send and receive record disclosures:

Facility Name:_____

Facility Address:_____

Facility Phone:_____ Facility Fax:_____

Dates and Type of Information to Disclose:

___ 2 years prior from last date seen

___ Dates Other:_____

___ Specific Information Requested:_____

_____

Purpose of Disclosure (check all that apply):

___ Change of Insurance of Physician

___ Continuation of Care

___ Referral

___ Other:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Innovative Pain and Spine Center (Matthew Root, D.O.)

Address: 4418 Vineland Ave Suite 218 North Hollywood CA 91602

Phone: (818) 621-0019 **Fax: (818) 671-5556** Please (check): ___ Mail ___ Fax Records

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient or Authorized Representative Signature:_____ Date:_____

Patient or Authorized Representative Name(printed):_____

Relationship to Patient:_____

Brief Pain Inventory (Short Form)

Date: _____ Time: _____

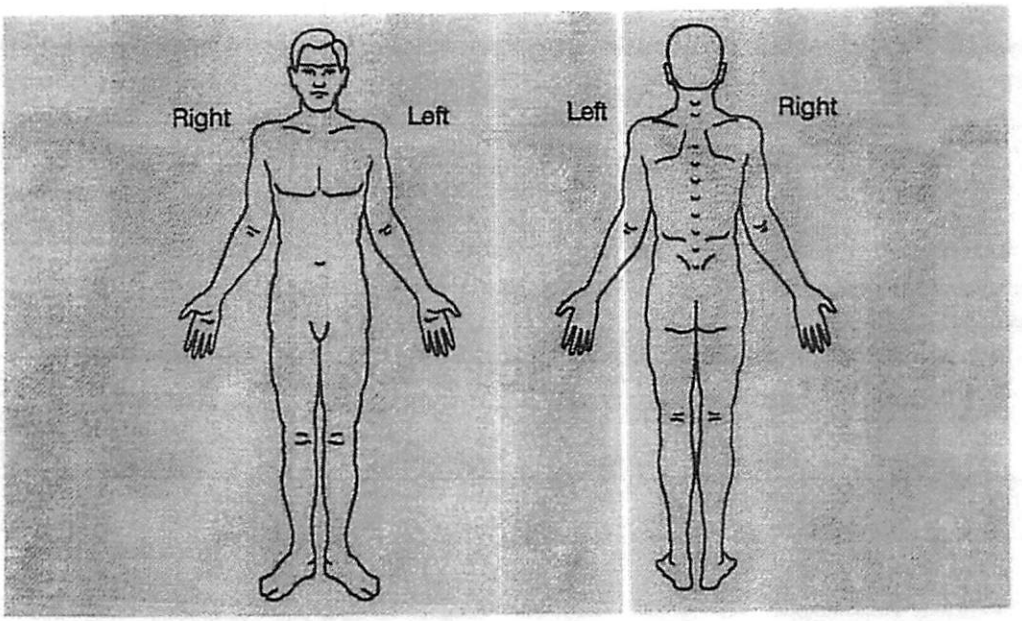
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Questionnaire

Name: _____ Date:_____

No.	Question	Answer	Score
1	Are you basically satisfied with your life?	Y / N	
2	Have you dropped many of your activities of interest?	Y / N	
3	Do you feel your life is empty?	Y / N	
4	Do you often get bored?	Y / N	
5	Are you in good spirits most of the time?	Y / N	
6	Are you afraid that something bad is going to happen to you?	Y / N	
7	Do you feel happy most of the time?	Y / N	
8	Do you often feel helpless?	Y / N	
9	Do you prefer to stay at home, rather than going out and doing new things?	Y / N	
10	Do you feel you have more problems with memory than most people?	Y / N	
11	Do you think it is wonderful to be alive?	Y / N	
12	Do you feel pretty worthless the way you are now?	Y / N	
13	Do you feel full of energy?	Y / N	
14	Do you feel that your situation is hopeless?	Y / N	
15	Do you think that most people are better off than you are?	Y / N	
	For office use	Total:	