



# Pacific Spine & Pain Center

INNOVATIVE SOLUTIONS FOR PAIN™

*A Division of Bay Area Surgical Specialists*

### PATIENT INFORMATION

Patient First Name		Middle Name		Last Name		Age	Birth Date
Mailing Address				City	State	Zip	
Street Address				City	State	Zip	
Home Phone	Cell Phone	Employer Name (for work comp only)		Employer Phone		Position	
Marital Status (Circle One) <b>M S W D P</b>	Social Security #	Doctor to Be Seen		Primary Doctor		Referring Doctor	
May we leave medical info on voicemail? Home Cell Both			Best number for reminder message? Home Cell				
May we contact you at work? Yes No			Email Address:				
Race (Optional) Check One: American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Other <input type="checkbox"/> Prefer Not To Answer <input type="checkbox"/>							
Ethnicity Hispanic or Latin <input type="checkbox"/> Not Hispanic or Latin <input type="checkbox"/> Prefer Not To Answer <input type="checkbox"/>				Preferred Language			

### EMERGENCY CONTACTS

Emergency Contact Name #1 (Spouse if married)	Relationship:	Personal Number:	Work Number:
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### PHARMACY INFORMATION

Name of Pharmacy:	Address:	Phone Number:
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### PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company		Name of Subscriber		Relationship to Patient
Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Claim #	Group #	
Subscribers mailing address if different than yours:				
Adjuster Name:	Adjuster Phone:	Adjuster Fax:	Date of Injury:	

### SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company		Name of Subscriber		Relationship to Patient
Subscribers Birth Date	Subscribers Social Sec. #	Subscriber/Member/Client ID #	Group #	
Subscribers mailing address if different than yours				

### IF PATIENT IS UNDER 18 YEARS OLD PLEASE COMPLETE THIS SECTION

Legal Guardian's Full Name	Relation to Patient	Birth Date
Guardian's Social Security #	Guardian's Phone #	
Mailing Address If Different Than Above	City State	Zip
Guardian's Employer Name	Position/Title	Employer Phone #

### Acknowledgement

I acknowledge that I have received the Notice of Privacy Practices from Pacific Spine and Pain Center.

X \_\_\_\_\_ Date \_\_\_\_\_



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Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for pain management: \_\_\_\_\_

Medications	Strength	Frequency

Please write additional medications on back of page

Medical history (other health problems): \_\_\_\_\_

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Allergies (please list ALL): \_\_\_\_\_ No known drug allergies (fill in bubble)

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Surgeries: \_\_\_\_\_

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Hospitalizations: \_\_\_\_\_

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Family history:

- Alcohol abuse (if yes, who?) \_\_\_\_\_
- Addictions problems (if yes, who?) \_\_\_\_\_
- Any pertinent health problems (if yes, who?) \_\_\_\_\_

Social history:

- Tobacco:  Never  Former – Date Stopped: \_\_\_\_\_  Current – Date Started: \_\_\_\_\_  
If current:  Some days  Everyday Quantity/Frequency: \_\_\_\_\_
- Alcohol:  Never  Former – Date Stopped: \_\_\_\_\_  Current – Date Started: \_\_\_\_\_  
If current:  Some days  Everyday Quantity/Frequency: \_\_\_\_\_
- Drug use: \_\_\_\_\_

Previous treatments for condition (injections, surgery, physical therapy, previous medications, etc. and dates):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please sign and date to verify all of the above information is correct and true

X \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to Brandon Sorensen, M.D. as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of Employee Retirement Income Security Act of 1974 ("ERISA") breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Printed Name \_\_\_\_\_

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

## FINANCIAL RESPONSIBILITY POLICIES

Pacific Spine and Pain Center participates in most insurance plans, including Medicare. Pacific Spine and Pain Center does not participate in Medicaid. I understand this office will make every effort to obtain payment from the insurance carrier, Medicare, and/or other third party payor. I acknowledge and understand services may be denied for any and all reasons, including, but not limited to pre-existing conditions, routine, experimental, not reasonable or necessary, trauma, injury or work related, etc.

I acknowledge I am financially responsible for all fees incurred for services rendered regardless of insurance. Furthermore, in the event I do not have insurance, I understand that payment in full is expected at each visit. I acknowledge that failure to comply with the financial policies of this practice will place my status at this practice in jeopardy.

All co-payment and deductibles must be paid at the time of service. I understand that this arrangement is part of the contract between Pacific Spine and Pain Center and my insurance company. I understand that failure Pacific Spine and Pain Center to collect co-payments and deductibles from me may be considered fraud.

Any unpaid balance owed on my account may be assessed at the rate of 1.5 % per month (18% per year). If bills remain unpaid for more than sixty (60) days this practice will proceed with legal action to collect the account. I understand I will be responsible to pay for any fees incurred for the collection of my bill. This includes, but is not limited to outside collection agency fees, interest charges, attorney fees, and court costs

If my insurance pays me directly, I agree to forward the payment to this office within 10 days of my receipt of payment. I further understand that failure to comply with this policy will place my status at this practice in jeopardy, as well as proceeding with legal action to collect the account. In addition to the balance due, any collection agency fees and/or attorney fees will be assessed to the account.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Printed Name \_\_\_\_\_

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

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

**Please circle all that apply regarding your most bothersome pain syndrome:**

**Location of pain:** Back Arm Neck Head Leg Other \_\_\_\_\_

**When pain began:** Days ago Weeks ago Months ago Years ago WC DOI: \_\_\_\_\_

**How would you rate your pain on a scale of 1-10 (0 for no pain, 10 for worst):** \_\_\_\_\_

**Does pain occur in a particular context? No While:** exercising working walking other

**Quality of pain:** Sharp Aching Stabbing Burning Numbness Throbbing Tingling

**Does the pain radiate (spread):** No Yes: Legs Arms Other \_\_\_\_\_ Right Left Bilateral

**The pain is:** Intermittent Constant - And lasts for: Minutes Hours Days

**What makes the pain better?** Rest Pain Meds Ice Heat Injections Nothing Other \_\_\_\_\_

**What makes the pain worse?** Sitting Standing Bending Head turning Other \_\_\_\_\_

**Is the pain:** Improving Worsening Staying the same

**Do you experience:** Weakness Tingling: Legs Arms Changes in function: Bowel Bladder

**Please circle all the symptoms you are recently experiencing, if any:**

**Constitutional:** Changes in appetite Fatigue Fever Sleeping disturbances

**Immunologic:** Frequent illnesses Sinus allergy symptoms

**Eyes:** Double vision Changes in vision Blurred vision

**Head:** Headache Vertigo

**Endocrine:** Cold intolerance Hot flashes

**Respiratory:** Cough Shortness of breath Wheezing

**Cardiovascular:** Blacking out Fainting Chest pain Irregular heartbeats

**Gastrointestinal:** Constipation Diarrhea Nausea Vomiting

**Integument:** Rash Psoriasis

**Neurologic:** Changes in alertness Seizures

**Psychiatric:** Hallucinations Anxiety Depressed mood

**Smoking status:** Never Former Current – Frequency & Amount: \_\_\_\_\_

**Alcohol status:** Never Former Current – Frequency & Amount: \_\_\_\_\_

**PLEASE REPORT ANY CHANGES IN MEDICATIONS TO THE PERSON ROOMING YOU**

**FOR OFFICE USE ONLY:** MA Name \_\_\_\_\_

**Provider:** Dr. Sorensen Dr. Deroee Erika Doria Ike Campos **Appt Type:** New patient Follow-up

**Wt** \_\_\_\_\_ **Ht** \_\_\_\_\_ **BP** \_\_\_\_\_ **P** \_\_\_\_\_ **O2** \_\_\_\_\_ **CURES** \_\_\_\_\_ **Contract** \_\_\_\_\_ **Lab** \_\_\_\_\_