Interventional Spine and Pain Associates
Dr. Ryan Whitmer
3106 Texas Ave S. College Station, TX 77845
Phone & Fax: (979) 985-5489

Patient Registration Form

First name: _____ MI: _____ Last name: _____

Date of birth: _____ Age: _____ Sex: M or F Phone number: _____

Primary Care Doctor: _____

Mailing address: _____

Email address: _____

Employer: _____ Occupation: _____

In case of emergency, name of local friend or relative: _____

Relationship to patient: _____ Phone number: _____

Patient's or authorized person's signature. I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to Interventional Spine and Pain Associates. I understand that even though I have assigned benefits to be paid directly to Interventional Spine and Pain Associates, I am still responsible for the entire bill.

_____ _____

Patient/Guardian signature **Date**

New Patient Questionnaire

In order to provide you with the most effective medical care, the providers of Interventional Spine and Pain need certain basic information about your medical, family, and social history. Please take the time to complete this questionnaire. Your responses to these questions will assist the doctor in his evaluation and is an important contribution to your overall care.

Basic Patient Information

Why are you seeking an evaluation at this time? Chief complaint:

_____

_____

_____

When did this problem start? _____

Is your injury work related? (circle one) Yes or No If yes, date of injury: _____

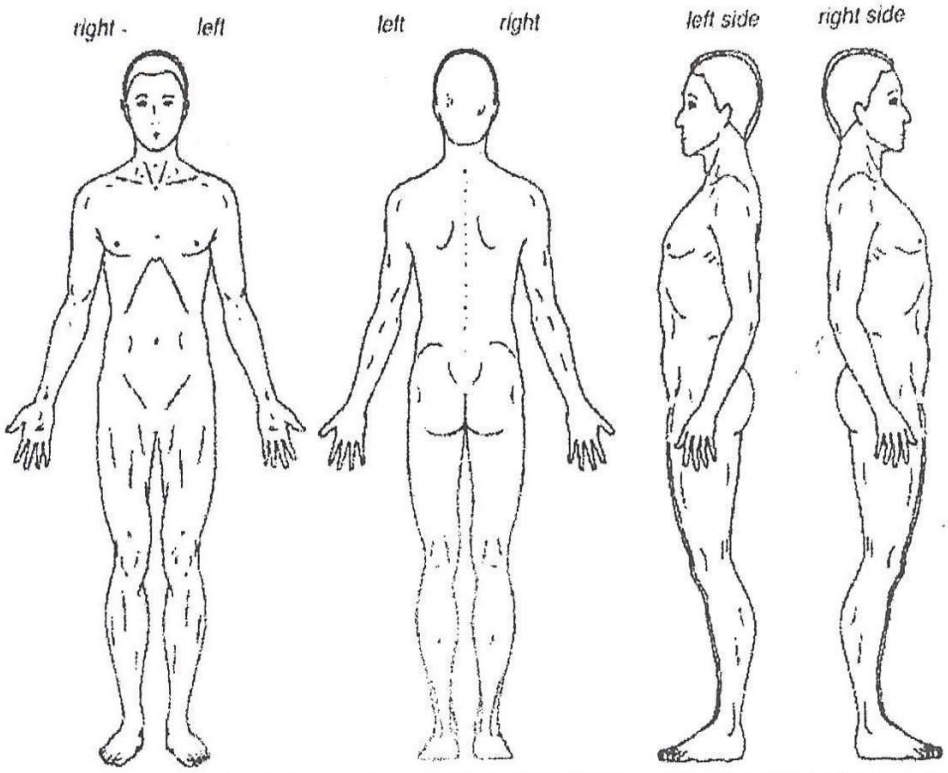
Since your pain started, has it? (circle one) Gotten better Worsened Not changed Varied

How do the following activities affect your pain? (circle all that apply)

Lifting:	Better	Worse	Unchanged
Bending:	Better	Worse	Unchanged
Twisting:	Better	Worse	Unchanged
Sitting:	Better	Worse	Unchanged
Standing:	Better	Worse	Unchanged
Walking:	Better	Worse	Unchanged
Lying down:	Better	Worse	Unchanged
Activity:	Better	Worse	Unchanged

Pain scale evaluation

On this drawing, please mark the places where you feel pain.



On these scales, rate your pain by placing an X on the lines. Zero (0) is *no* pain. Ten (10) is the *worst* pain that *you could ever imagine.* Five (5) is halfway in between these extremes. *Pain cannot be greater than 10.*

Pain right now:

0 5 10

Average pain this past week:

0 5 10

Pain when it is at its worst:

0 5 10

Pain when it is at its best:

0 5 10

My pain is (mark all that apply):

- ☐ sharp
- ☐ dull
- ☐ aching
- ☐ burning
- ☐ other _____

What have you tried for your condition? (circle all that apply)

Physical therapy:	Yes	No	Duration:_____
Injections:	Yes	No	_____
Rest:	Yes	No	
Medications:	Yes	No	_____
Chiropractic treatment:	Yes	No	
Manipulation:	Yes	No	
Exercise:	Yes	No	
Traction:	Yes	No	
Heat/Cold:	Yes	No	
TENS:	Yes	No	
Acupuncture:	Yes	No	

Other: _____

Spine Surgical History

Have you ever had spine related surgery? Yes No

If yes, please complete the following:

Surgery date: Type of surgery: Name of hospital:

_____

_____

_____

Social History

Marital status: _____

Do you live alone? Yes No

Do you exercise regularly? Yes No

Do you use assistive devices? (walker, cane, wheelchair) Yes No If yes, specify: _____

Do you smoke or use tobacco products? Yes No Quantity_____ packs/day

Do you drink alcohol? Yes No Frequency? _____

Do you use recreational drugs? Yes No If yes, please explain:

_____

_____

Medical History

Current medications:(please list ALL current prescriptions and over the counter medications)

_____

_____

_____

Past surgical history:

_____

_____

Preferred Pharmacy: (name & location)

_____

Drug Allergies: _____

Medical History

- ☐ Anemia/Blood Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Pain
- ☐ Bladder/Kidney Problems
- ☐ Blood Clots
- ☐ Bowel Problems
- ☐ Coronary Artery Disease
- ☐ Cancer Type: _____
- ☐ Claustrophobic
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Edema
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heartburn/Reflux
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Metal Implants
- ☐ Myocardial Infarction
- ☐ Peripheral Artery Disease
- ☐ Pharyngitis
- ☐ Pneumonia
- ☐ Psychological Disorder
- ☐ Pulmonary Disease
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Sleep Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Vascular Disease
- ☐ Vision Loss
- ☐ OTHER: _____

Are you under the care of a cardiologist? If yes, cardiologist name: _____

Do you take a blood thinner medication? If yes, medication name: _____

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Name of patient or patient representative

Description of patient representative's authority/relationship

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Signature of patient or patient representative

All professional fees are due at the time of service, unless previous arrangements have been made.

Assignment of Benefits & Financial Agreement

As a courtesy, Interventional Spine and Pain Associates will file an insured person's insurance if proper information is received. I hereby authorize payment of medical benefits to be paid directly to Interventional Spine and Pain Associates for services described on the claim form. I am responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by the insurance company. For unpaid claims over 45 days, it is my responsibility to notify our staff of any insurance or address changes. I will be responsible for any charges that occur if Interventional Spine and Pain Associates is not notified. Any debt to collect a debt will be at the expense of the patient/responsible party.

Consent for treatment

I hereby authorize Interventional Spine and Pain Associates to evaluate, treat and preform diagnostic tests and office procedures that the physician deems necessary. My medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. My medical information may also be disclosed to healthcare students, interns and residents.

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Consent for E-Prescribing

I have been made aware and understand that the medical practices are offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be

Right to request confidential communication

I have the right to request that Interventional Spine and Pain Associates communicate with me about medical matters in a certain way or at a certain location. To request confidential communications. I must make my request in writing. I shall not be asked the reason for my request. Interventional Spine and Pain Associates will accommodate all reasonable requests. My request must specify how or where I wish to be contacted.

Please indicate the methods and/or locations by or at which we may contact you. Circle all that apply.

Telephone Mailing Address Other_____

Right to request restrictions

I have a right to request a restriction or limitation on the medical information used or disclosed about me for treatment, payment, or health care operations. I also have the right to request a limit on the medical information disclosed about me to someone who is involved in my care or the payment for my care.

Please circle one:

No restrictions Restrictions: _____

☐ I am 18 years old or older and authorize the release of my information to:

Name: _____ Relationship: _____

_____

Print patient name

_____ _____

Signature of patient Date

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Release of information

I hereby authorize any and all physician's, surgeons, and doctors who have examined, treated, or x-rayed, and all hospitals in which I was ever a patient, to furnish to Interventional Spine and Pain Associates or the bearer hereof, all reports, records, x-rays, laboratory reports and other data or information in their possession or control, subject to my physical and mental condition, medical history, treatment, or diagnosis and to permit them to examine such records and medical information and hereby authorize them to permit the making of copies thereof or to furnish copies thereof, thereby revoking all other medical authorizations signed by me in the past. Are able to see information about medications that I am already taking, including those prescribed by other providers This authorization shall remain in effect until revoked by me in writing and may be evidenced by a photo-static or facsimile copy thereof. I give my consent to my providers to see this protected health information.

_____

Print patient name

_____ _____

Signature of patient Date

We are pleased to be your choice for your healthcare needs. Please take a moment to let us know how you were referred to us. Check all that apply.

- ☐ Newspaper
- ☐ Radio
- ☐ Billboard
- ☐ Television
- ☐ Internet
- ☐ Friend/Family
- ☐ Another Physician _____
- ☐ Other

Thank you for your time.

LATE POLICY

Please be advised that if you are more than 15 minutes late to your appointment, you will be rescheduled.

CANCELLATION POLICY

Please be advised that failure to provide a 48 hour cancellation notice will result in a fee; $50 for office visits and $100 for procedures.

PRESCRIPTION REFILLS

Please request medication refills 7 days in advance.

DISABILITY PAPERWORK

There is a $35 fee for paperwork to be filled out. This must be paid prior to the forms being picked up or submitted on your behalf. Please allow up to a week for completion of forms.

_____	_____	_____
Patient printed name	Patient signature	Date