Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ _____
LAST FIRST MIDDLE INITIAL

MAILING ADDRESS: _____ CITY:_____ ST ___ZIP_____

PHYSICAL ADDRESS:_____**CITY:** _____ **ST:** ___ **ZIP:** _____

EMAIL ADDRESS:_____

HOME PHONE #: _____ ( ) **CELL#:** _____( ) **WORK PHONE #:** _____( ) check preferred

DOB : ____/_____/_____ **SOCIAL SECURITY NUMBER:** _____-_____-_____ DRIVERS LICENSE #_____

SEX: FEMALE MALE (circle one) **MARITAL STATUS**: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

IF MINOR NAME OF GUARADIAN:_____ PHONE# _____

PATIENTS EMPLOYER INFORMATION:

COMPANY: _____ **CITY:** _____ PHONE#_____

ACCIDENT INFO: please complete if this visit is due to an accident.
DATE OF ACCIDENT: _____ **WORK RELATED?**___ **AUTO ?** _____ **OTHER?**___
If worker's Comp, please furnish W/C ins info as primary insurance below and enter commercial ins as secondary.

GUARANTOR'S INFORMATION-complete if different than patient

RESP. PARTY NAME: _____ _____
_____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____ CITY: _____ ST: _____
ZIP:_____

SEX: (circle one) FEMALE MALE **DOB:** _____/_____/_____

SOCIAL SECURITY NUMBER: _____-_____-_____

HOME PHONE: _____ ( ) CELL #: _____( ) **WORK #:** _____( )check preferred

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:
COMPANY: _____ **CITY:** _____ **PHONE #:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____ PHONE#_____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SUBSCRIBER'S NAME: _____ **SUBSCRIBER'S DOB** _____ SOCIAL SECURITY:
_____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE COMPANY: _____ PHONE#_____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

SUBSCRIBER'S NAME: _____ **SUBSCRIBER'S DOB** _____ SOCIAL SECURITY:
_____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHE

MEDICATIONS

Medication	Dose	Times Taken	Reason for Medication

ALLERGIES AND SENSITIVITIES

Name of Item	Reaction (s)

Are you currently taking any blood thinners? Yes No

Are you currently taking any narcotic pain medicine? Yes No

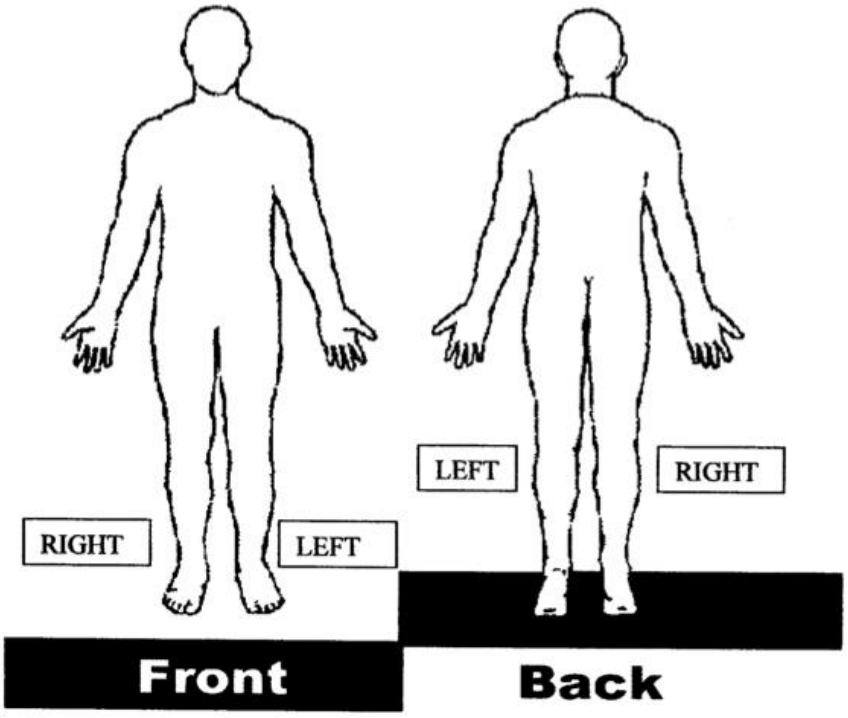
Are you currently on a pain contract with another provider? Yes No If yes, who with?_____

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Mark the areas on the body below where you feel the described sensations. Use the appropriate symbol and include all affected areas.

ACHE	BURNING	NUMBNESS	STABBING	PINS & NEEDLES
**********	##########	OOOOOOOO	//////////////	XXXXXXXX



Name:_____ **Date:**_____
Age:_____ **Hand Dominance:** _____ **DOB:**_____

Chief Complaint

__Low back pain __ with radiation to legs
__ without radiation to legs.
__ Neck pain __ with radiation to arms
__ without radiation to arms
Pain Scale: (1 to 10- 10 being worst pain)
Worst:___ Best:___ Current:___
Aggravated by: (check all that apply)
__sitting __lying __driving __bending __walking
__twisting __standing __coughing/sneezing
__pushing/pulling __flex/ extending
__other: _____
Best time of the day:_____ am / pm
Worst time of the day:_____ am / pm
Alleviated by: _____

Treatment

___Injections ___ TENS UNIT
___Brace Other MD work-up
___Other MD work-up **Where at**: _____
___ Physical Therapy **Where at**:_____
___ Chiropractic Treatment **Where at**:_____
Past Spine Surgeries _____

Past Medical History

__ Diabetic
__ Heart disease
__ Irregular Heart beat
__ Heart Attack
__ Drug Addiction
__ Kidney/Bladder
__DVT
__ Asthma
__ High Blood Pressure
__ Stroke
__ Hepatitis
__ Alcoholism
__ Bipolar disorder
__ Seizures
__ Pacemaker
__ HIV/AIDS
Other:_____

Past Surgical History

_____

_____

Referring Doctor:_____
Primary Care Doctor: _____
Cardiologist _____

Social History

__ single __married __ divorced __ widowed
# of children ___ Ages _____
Hobbies: _____
Nicotine use: __Yes ___NO
amount per day _____ # Years _____
Alcohol Consumption: _____ Yes _____ No
per day _____ # Years _____

Work History

Employer: _____
Job Title: _____
Length of Employment: ___ years _____ months
Last worked: _____ Do you enjoy work: _____
Modified work available:___ WC Litigation _____
Disability Insurance: _____ SSI: _____
Education: _____

Family History

Mother's age(or age at death)_____
Alive ___Yes ___No
Mother's Medical Problems: _____

Father's age(or age at death) _____
Alive ___Yes ___No
Father's Medical Problems: _____

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

REVIEW OF SYSTEMS:
Please Mark All That Apply To You:

Constitutional

____Altered taste/smell
____Cancer
____Change in appetite
____Excessive sleeping
____Fatigue
____Fever
____Depression
____Anxiety
____Recent sore throat
____Sleep Apnea
____Weight loss or gain

Hemilymphatic/Endocrine

____Anemia
____Blood disorder
____Circulatory problem
____Diabetes
____Dry eyes/mouth
____Endocrine disorder
____Low blood sugar
____Lymph node swelling
____Hepatitis
____HIV/AIDS
____Pituitary disorder
____Sickle cell disease
____Thyroid disease

Ears/Nose/Throat

___Hearing loss
___Trouble swallowing
___Mouth sores
___Sinus disease
___Ringing in ears

Eyes

___Blurred Vision
___Cataracts
___Double vision
___Macular degeneration
___Peripheral vision issues
___Visual impairment
___Glaucoma

Cardiovascular

___Chest pain/pressure
___Fainting
___Heart Attack
___Heart defect
___Leg Swelling
___Low blood pressure
___High blood pressure
___Heart murmur

Musculoskeletal

___ Connective tissue disorder
___ Low back pain
___Neck pain
___Joint pain
___ Joint Swelling

Gastrointestinal

___Black stool
___Constipation
___Diarrhea
___Gall bladder problems
____Ulcer
____Vomiting

Genitourinary

___Blood in urine
___Change in habits
___Infection in urine
___Kidney disease
___Kidney stones
____Loss of control
____Painful urination
____Urinary urgency
____Vaginal bleeding

Neurological

___Balance Difficulty
___Choking
___Clumsiness
___Confusion
___Concentration difficulty
___Dizziness
___Drooling
___Falls
___Hallucinations
___Headaches
___Loss of consciousness
___Memory problems
___Muscle twitching
____Nausea
____Numbness
____Personality change
____Seizure
____Shooting pain
____Smelling difficulty
____Stroke
____Tasting difficulty
____Tingling sensation
____Vertigo
____Walking difficulty

Skin

___Birth mark
___Psoriasis
___Skin rashes
____Melanoma

Respiratory

____ Asthma
____Bronchitis
____Chronic cough
____COPD
____Emphysema
____Trouble breathing
____Tuberculosis
____Wheezing
____Pneumonia
____Shortness of Breath

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

Blue Cross Blue Shield-Payment Affidavit

Although we are out of network with BCBS/FEP we will submit a prior authorization/benefit level exception on your behalf. This will allow you claims to be processed IN-NETWORK. You **will** be responsible for you IN-NETWORK COPAYS, DEDUCTIBLES, AND COINSURANCE.

Because we are a non-participating provider BCBS/FEP they may mail payment directly to you instead of to our office for your service.

By signing this affidavit, you are agreeing to immediately sign over any and all checks from BCBS/FEP for services related to Spine Care Specialist of Alaska, LLC. Failure to do so will result in legal action.

I, _____, promise to turn over all Federal Blue Cross Insurance checks to Spine Care Specialists of Alaska immediately after receiving them. I am responsible for any and all deductibles and/or copays required by Blue Cross. If all checks are not turned over, any remaining balance will be my responsibility and will be due in full within 30 days.

_____ Signature _____ Date

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

SPINE CARE SPECIALISTS OF ALASKA,LLC

Financial Policy

Welcome to Spine care Specialists of Alaska. We are pleased you have chosen us as your care provider. One important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstanding and to ensure timely payment for services.
Patents or their legal representative are ultimately responsible for all charges for services rendered. It is your responsibility to:

1. Bring your insurance card/worker's compensation information to every visit.

2. Be prepared to pay your co-pay or deductible at each visit.

3. Spine Care Specialists of Alaska is a preferred provider and "in-network" for Aetna. Our office is happy to file claims for all other out of network insurance companies

4. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent or guardian is responsible for any payment due.

5. If you have any questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (the number is usually on the back of the insurance card).

7. Our practice firmly believes that a good provider/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the management of office.

Patient's Name (PLEASE PRINT) _____

Patient's Signature: _____Date_____

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

SPINE CARE SPECIALISTS OF ALASKA,LLC

HIPAA Acknowledgement

In order to comply with the federal government regulations, Spine Care Specialists of Alaska, LLC are required to have a document available to you that explains our patient privacy information policy. There is a copy of this policy located with the Front Desk Receptionist, if you wish to review.

Please sign and date to acknowledge you have been informed of our policy.

PATIENT'S NAME (print):_____

PATIENT'S SIGNATURE: _____**DATE**:_____

Authorization to release information to the following person(s)

I authorize for Spine Care Specialists of Alaska, LLC to release all medical and financial records, including medication, surgical and appointment details to the following:

Person(s) Name	**Relationship to Patient**	**Date of Birth**	**Phone #**
1.			
2.			
3.			
4.			

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION
For Treatment, Payment or Coordination of care with other health care providers

I hereby consent to the use or disclosure of my individuality identifiable health information by Spine Care Specialists of Alaska, LLC in order to carry out treatment, payment or coordination of care with other health care providers.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Spine Care Specialists of Alaska, LLC in writing. This revocation shall be effective except in those instances that occurred prior to revocation.
By signing below, I have read and understand this information. I am the patient or the individual authorized to act on the behalf of the patient.

Patient Signature: _____**Date**:_____

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

SPINE CARE SPECIALISTS OF ALASKA

Medication Refill Policy

Spine Care Specialists of Alaska, LLC would like to make the medication refill process as easy as possible for all our patients. Spine Care Specialist of Alaska has developed a few guidelines to inform you of the process for requesting new or refills on your medication. Please read below and sign to acknowledge you do understand our policy.

- **Please allow 48-72 hours to process your medication refills. Due to our unpredictable surgery schedule, medication refills may not be approved or signed quickly.**

- **Please make sure you contact our office 7 business days in advance for medication refills. Please be aware we do not fill new prescriptions or refills of any medication on Fridays or over the weekend. If you need a refill, please have your pharmacy fax a refill request to 907-456-3877 and once approved by the provider we will fax it back to the appropriate pharmacy.**

- **Please give the office advanced notice if your medications are due to run out over a weekend/holiday and/or if you will be out of town. Again, this could take up to 48-72 hours to complete the refill process.**

- **Please notify us of any drug allergies or side effects- ALLERGIES:_____**

- **Some medications cannot be phoned-in or faxed to the pharmacy due to narcotics requiring a written prescription from the provider. Once your prescription is ready for pick up at our office will contact you to pick up during the following hours of operation: 9am to 5pm Monday through Friday.**

- **For your safety, it is important that you take all mediations as prescribed and routinely update your current medications in our records to avoid contraindications with your prescriptions. You may only receive pain mediation from one provider. We cannot replace lost, stolen, destroyed narcotics or any other type of medication. We will not refill medication until that original prescription is due to be filled.**

If you use a local pharmacy for all of your prescription needs, please complete the portion below to help us expedite your medication refills:

Pharmacy: _____ Phone: _____Fax:_____

Pharmacy Location/Address: _____

IF YOU HAVE A PAIN MANAGEMENT PROVIDER OR PAIN CONTRACT
PLEASE LIST THE INFORMATION BELOW

Provider's Name: _____Address:_____
Phone #:_____Contract Date: _____

By signing below, you have provided Spine Care Specialists of Alaska, LLC correct information and have read and clearly understand the instructions listed above.

_____

Communication Release

Please fill out all the information to the best of your knowledge and as completely as possible to assist with accurate evaluation by your health care provider. Thank You.

PATIENT AUTHORIZATION TO UTILIZE UNENCRYPTED AND UNSECURED EMAIL AND TEXT MESSAGING

I, the undersigned, a patient of Spine Care Specialists of Alaska, LLC (the "Practice"), do hereby authorize the Practice and any health care providers associated with the Practice to communicate with me or my authorized representative, using unencrypted and unsecured email and text messaging media.

I understand that the Health Insurance Portability and Accountability Act of 1996, “HIPAA” states that to comply with HIPAA, communication between health care providers and patients should be performed in a secure manner that preserves the confidentiality of the patients protected health care information. However, I have determined that it is the best interest of my health care and the most efficient way to properly communicate with me and my authorized representatives about my medical information and condition to waive the requirement that any communications with me or my authorized representatives containing any of my protected health information is transmitted in a HIPAA compliant manner.

Therefore, I hereby authorize the Practice and any health care provider associated with the Practice to communicate with me or my authorized representative, using unencrypted and hello unsecured email and text messaging media.

Patient Print:_____

Patient Sign:_____ Date:_____