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:** _____

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

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

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 OTHER

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.

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

Referring Doctor:_____
Primary Care Doctor: _____
Whom may we thank for your referral (if not provider)_____

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

___Chiropractic Care ___ TENS UNIT
___Brace Other MD work-up
Past Spine Surgeries _____
__ Physical Therapy __ Injections

_____

Past Medical History

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

Past Surgical History

_____

_____

Social History

__ single __married __ divorced __ widowed
# of children ___ Ages _____
Hobbies: _____
Smoke: ___ Yes ___ No
# of Cigarettes 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.

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?_____

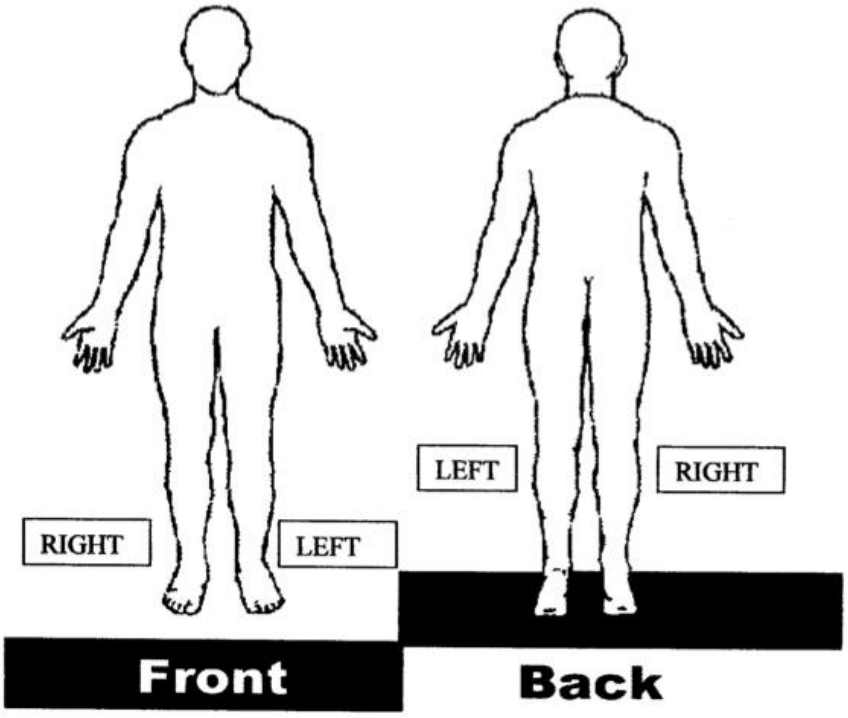
Name: _____ Date: _____

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.

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



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:

General/Constitutional

____Weight Loss? ___Weight Gain?

Date of last menstrual cycle:_____

Hematologic

____Ease of bruising ____Ease of Bleeding

____Taking Medication for This?

Name of Medication:_____

Eyes/Ears/Nose/Mouth/Throat

___Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury._____

___Vision, double vision, tearing, blind spots, pain.

___Nose bleeding, colds, obstruction, discharge

___Dental difficulties, gingival bleeding, dentures

___Loss of smell ___Double vision

___Loss of taste

Endocrine

___Abnormal body growth or body configuration

___Excessive sweating/loss of sweating

___Increased thirst, urination, or hunger

___Infertility or any hormonal abnormality

___Unusual sensitivity or in sensitivity to hot or cold.

Cardiovascular

___Angina ___Cold hand and/or feet

___Irregular heart rate or rhythm

___Pain in legs after walking

___Palpitations ___Shortness of breath after exercise

___Shortness of breath at night before falling asleep

___Shortness of breath at night that awakens you

___Swelling of hands and/or feet

Respiratory

___Asthma ___Coughing ___Night sweats

___Sputurn production (coughing up mucus)

___Shortness of breath at rest

___Shortness of breath after walking___blocks

___Other/lung infections

Gastrointestinal

___Nausea ___Belching ___Vomiting

___Vomiting blood ___Abdomen pain

___Gas ___Bowel/Bladder problems

___Blood in stool

Genitourinary

___Change in color of urine

___Decreased urination ___Painful urination

___Frequent urination at night

___Increased urination ___Change in menstrual cycle

___Erectile Dysfunction

Neurological

___Dizziness ___Falls ___Balance difficulty

___Difficulty chewing ___Swallowing problems

___Excessive Eye movement ___Speech problems

___Decreased facial sensation

___Generalized weakness of muscles

___Sensation of heavy eyelids or difficulty holding eyelids open

___Muscle paralysis (inability to move any particular muscle) Specify_____

___Involuntary movement (uncontrollable shaking, twitching, spasm)

___Decreased or increased sense of touch

___Loss of sensation ___Burning pain ___Numbness

___Tingling ___Muscle pain, swelling or tenderness (Specify where)_____

___Muscle cramps ___Inability to control urine or bowels

___Excess sweating ___Impotence(inability to have or sustain an erection)

___Loss of early morning erections ___Memory Loss

___Difficulty concentrating ___Depression

___Mood swings ___Sleep Disturbance

___Excessive sleeping (hyper somnolence)

___Inability to sleep (insomnia) ___Blackouts

___Fainting spells ___Seizures ___Headaches

___Light headedness

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 -Financial Policy

We are NOT participating providers with BCBC. But because there are no participating in Alaska, BCBS usually pays our claims in-network, however we highly recommend our patients contact BCBS and verify that they will pay our claims with an in-network exception, so you will have a lower balance.

Because we are not participating we can BALANCE BILL what your insurance does not pay. We can bill our patients what BCBS deems "over usual and customary". But for office visits we will write off usual and customary for all BCBS plans. You will be responsible for COPAY, DEDUCTIBLES, AND COINSURANCE. This applies to office visits only.

If you require surgery, we will also write off "over usual and customary" for all groups that are Premera Alaska BCBS EXCEPT:

1) **UNN-University (effective 7/2015)**
2) **ALL out of state BCBC including but not limited to:**
    a. **KRGAN**
    b. **UHL**
    c. **CGP**
    d. **WMW**

Please ask your surgery coordinator to provide you with procedure codes and prices. Please contact your carrier so you know what they will pay and what you will be responsible for. We will come up with a financial plan and possibly a partial write-off to help with the expenses.

Federal Blue Cross/United Health Care Insurance

I, _____ (insurance policy holder), promise to turn over all Federal Blue Cross and/or United Health Care 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 Federal Blue Cross and/or United Health Care. If all checks are not turned over, any remaining balance will be my responsibility and will be due in full within 30 day.

_____

Policy Holders 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

If you wish for Spine Care Specialists of Alaska to bill your insurance company, please provide our office with a copy of your insurance card and any additional information to file the claim. If you do not have an insurance card, it is your responsibility to contact your insurance company or your employers Human Resources department to obtain all the necessary information to file a claim for you.

If you have insurance, Spine Care Specialists of Alaska will bill your insurance company as a courtesy to you. If your insurance company does not pay the claim within 90 days of the date of service, you may be billed for the full amount. We will make every effort to contact your insurance company to find out the status of your claim and make any necessary corrections to have the claim paid within a reasonable amount of time. Please understand the ultimate responsibility for payment is yours, the patient. Should your insurance company deny payment or only cover a portion of the claim, the balance on your account will be your responsibility.

You are responsible for payment of co-pay at the time of service. If you have not met your deductible, you will be responsible for paying the remaining amount left on your deductible in addition to your co-pay.

If you are covered by Medicaid, you will be responsible for paying your $3.00 co-pay each visit. You must present a Medicaid sticker each visit.

If you are under Workman's Compensation, it is your responsibility to provide Spine Care Specialists of Alaska with the name of the insurance company, date of injury, insurance company's mailing address, insurance company's phone number and your adjuster's name. Without this information we will be unable to file your visit/claim with the insurance company. Make sure you have also notified your carrier you are being seen today. If you do not have insurance you must pay at the time of service.

We do not bill auto insurance. All payment is due at the time of service.

At any time you have questions regarding your account, you may contact our Billing Department:

Anderson and Lohr: 907-770-9600

If you have a balance on your account and need to make payment arrangements, please contact our office immediately to do so. All delinquent accounts may be turned over to Cornerstone Credit Service for collection. There will be a $35 insufficient funds charge for all returned checks.

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

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:_____

SPINE CARE SPECIALISTS OF ALASKA

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.

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.

_____

Patient's Signature Date Witness/Staff Member