Academic Pain & Spine

Today's Date:

Please complete this form in order to ensure proper billing of your services. **Please Print**.

Patient's Last Name	Patient's First Name	MI
DOB / /	Sex ☐ M ☐ F ☐	Social Security Number - -	Language ☐ English ☐Other
Race ☐ African American or Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Caucasian or White ☐ Hispanic ☐		
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other		
Address Line 1	Address Line 2	
City	State	Zip
Home Phone	Work Phone	Cell Phone
Email		
Employment Status ☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Disabled ☐ Homemaker ☐ Student ☐ Retired		
Employer	Occupation	
Employer's Address Line 1	Employers Address Line 2	
City	State	Zip

Please Complete if guarantor is other than self.

Guarantor's Last Name	Guarantor's First Name		
DOB / /	Sex ☐ M ☐ F	Social Security Number - -	Patient's Relationship to the Guarantor	Phone

Emergency Contact Information.

Emergency Contact's Last Name	Emergency Contact's First Name
Patient's relationship to the Emergency Contact	Phone

Insurance Information. *A separate form is required for worker's compensation or automobile liability*.

Please bring insurance cards & ID to your appointment and you can ***skip*** this field.

Primary Insurance Company Name			
ID#		Group#	
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	
Secondary Insurance Company Name			
ID#		Group #	
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	

How did you hear about our practice?_____

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Patient's Name: _____ **Date of Birth:** _____

Today's date: _____ Height: _____ Weight: _____

Please state in your own words as to why you are here today: _____

_____

_____

Past Medical History (*check all that apply*): ☐ **No Past Medical History**

☐ Acute Myocardial Infraction (Heart Attack)	☐ Heart Disease	☐ Peripheral Vascular Disease (Poor Circulation)
☐ Anemia (Low Blood Count)	☐ Heartburn	☐ Pneumonia
☐ Anxiety / Panic Disorder	☐ Hepatic (Liver) Disorder	☐ Pulmonary Disease (Lung Disease)
☐ Arthritis	☐ Hepatitis, Type:	☐ Recent Methicillin-resistant Staph aureus (MRSA)
☐ Asthma	☐ HIV Infection	☐ Rheumatic Fever
☐ Autoimmune Disorder (Lupus/Scleroderma/RA)	☐ Hyperlipidemia (Cholesterol) Type:	☐ Seizure Disorder
☐ Cancer – list type (s):	☐ Hypertension	☐ Sinusitis
	☐ Irritable Bowel Syndrome	☐ Stroke Syndrome
	☐ Kidney Disease	☐ Thromboembolic Disease (Blood Clot Disorder)
☐ Chest Pain (Angina)	☐ Lower Back Pain	☐ Thrombophlebitis
☐ Chronic Liver Disease	☐ Mitral Valve Disorder	☐ Thyroid Disorder – (○HYPO / ○HYPER)
☐ COPD (Chronic Obstructive Pulmonary Disease)	☐ Murmurs	☐ Transient Ischemic Attack (Mini Stroke)
☐ Depression / OCD / PTSD	☐ Obesity	☐ Tuberculosis
☐ Diabetes, Type:	☐ Obstructive Sleep Apnea	☐ Other (specify):
☐ Gastric/Duodenal Ulcer	☐ Osteoporosis	

Surgery: ☐ **No Surgical History**

Surgery	Date	Surgery	Date

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Family History (check all that apply): ☐ **No Family History**

	Family Member		Family Member
☐ Anemia (Low Blood Count)		☐ Hypercholesterolemia	
☐ Cancer – list type(s):		☐ Hypertension	
		☐ Osteoporosis	
		☐ Pulmonary Disease	
☐ COPD		☐ Renal Disease	
☐ Diabetes Mellitus		☐ Stroke Syndrome	
☐ Emphysema		☐ Thromboembolic Disease	
☐ Heart Disease		☐ Unattainable – Patient Adopted	
☐ Hepatic (Liver) Disorder		☐ Other:	

Family Health Status of Father – Deceased. Age: Cause: _____

Family Health Status of Mother – Deceased. Age: Cause: _____

Social History:

☐ Alcohol Use	Weekly:
☐ Drug Use (Recreational)	Explain:
☐ Using Intravenous Drugs	Explain:
☐ Previous History of Smoking Date Quit: _____ Packs Per Day: _____ Attempts to Quit: _____ Years of Smoking: _____	
☐ No history of Smoking	☐ Wishing to Stop Smoking
☐ Smoking/Nicotine Substances	☐ Cigarettes: Packs/Times per Day: _____ Years: _____ ☐ Cigars ☐ Chewing Tobacco ☐ Pipe ☐ Vape
☐ Medical Marijuana	☐ CBD ☐ THC ☐ Cannabis ☐ CBN ☐ Hemp
☐ Special Diet	Explain:
☐ Exercise Habits	Times per Week: ☐ Being Sedentary (Do not exercise)

Immunizations/Vaccines	Most Recent Date	Immunizations/Vaccines	Most Recent Date	Immunizations/Vaccines	Most Recent Date
Tetanus		Measles		Other (specify):	
Flu		Chicken Pox			
Pneumonia		Hepatitis B			

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Describe the onset and/or cause of your problem: **Date of onset:** _____

_____

_____

_____

Does this problem keep you from working? ☐ Yes ☐ No (if yes; date last worked: _____)

How long have you had the pain? _____ Years _____ Months _____ Weeks

How far can you walk? _____ Blocks (number_____) _____ Around the house

_____ (Unlimited) _____ Other: _____

Have you ever had pain like this before? ☐ Yes ☐ No

Explain: _____

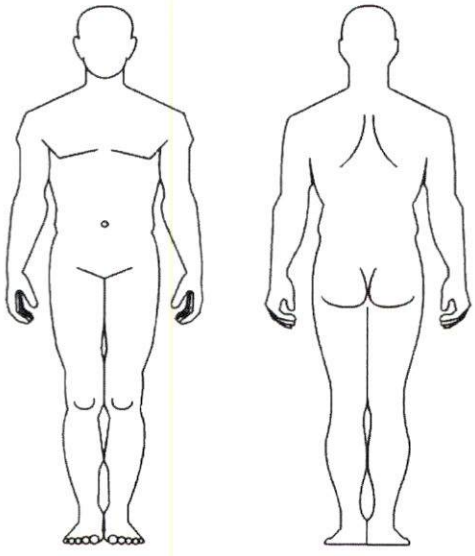
How did you treat the pain or problem? _____

How often does your pain occur? ☐ Hourly ☐ Daily ☐ Weekly ☐ Occasionally ☐ Constant

Has the pain changed over time? ☐ Yes ☐ No Explain: _____

_____

_____



Please mark where you are on the pain scales (on average):

Pain

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Ability to do things

I can do anything I can do absolutely nothing

0 1 2 3 4 5 6 7 8 9 10

Pain level needed to return to work

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Describe the character/quality of the pain (check all that apply):

☐ Cold	☐ Hot	☐ Aching	☐ Throbbing	☐ Burning	☐ Dull	☐ Shooting	☐ Exhausting
☐ Electric	☐ Spasms	☐ Sharp	☐ Pinching	☐ Squeezing	☐ Punishing	☐ Tearing	☐ Pressure
☐ Tingling	☐ Lacerating	☐ Stabbing	☐ Pounding	☐ Vicious	☐ Penetrating	☐ Cramping	

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Do you have any of the following physical changes associated with your pain/symptoms (check all that apply):

☐ Hair Growth ☐ Swelling ☐ Nail bed changes ☐ Vision changes ☐ Sweating ☐ Loss of consciousness

☐ Muscle Spasms ☐ Weakness ☐ Skin color changes ☐ Temperature Changes ☐ Loss of bladder or bowel control

☐ Inability to do fine movement with hands ☐ Changes in the way you walk

What makes your pain better?

☐ Lying down ☐ Manipulation ☐ Physical Therapy ☐ Sitting ☐ Exercise

☐ Aspirin ☐ Standing ☐ Prescription Pain pills ☐ Tylenol ☐ Walking

☐ Over the counter medications ☐ Muscle Relaxers

☐ Other: _____

What makes your pain worse?

☐ Lying Down ☐ Sneezing ☐ Coughing ☐ Sitting ☐Standing

☐ Walking ☐ Exercise ☐ Bending Forward ☐ Bending Backward

☐ Other: _____

Have you had (check all that apply):

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ EMG ☐ Myelogram ☐ MMPI-2 ☐ Discogram

What treatments have you tried for pain relief (check all that apply):

	Did it help?			Did it help?	
☐ Physical Therapy	Yes	No	☐ Taken time off work	Yes	No
☐ Aqua Therapy	Yes	No	☐ Altered daily activities	Yes	No
☐ Traction	Yes	No	☐ Rested	Yes	No
☐ Massage	Yes	No	☐ Used ice	Yes	No
☐ TENS	Yes	No	☐ Used heat	Yes	No
☐ Acupuncture	Yes	No	☐ Nerve Block	Yes	No
☐ Biofeedback	Yes	No	☐ Facet Block	Yes	No
☐ Anti-inflammatory meds	Yes	No	☐ Oral Steroids	Yes	No
☐ Pain Medications	Yes	No	☐ Epidural Steroid Injections	Yes	No
☐ Worn a brace	Yes	No	☐ Other: _____	Yes	No

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Who have you seen for treatment of pain/symptoms in the past? (please list names also)

O Primary Care Doctor_____

O Orthopaedic Spine Surgeon_____

O Neurosurgeon_____

O Rehab Doctor_____

O Neurologist_____

O Emergency room_____ How many times?_____

O Pain Clinic_____

O Chiropractor_____Adjustments done? Yes No

O Psychologist_____

O Psychiatrist_____

O Naturopath_____

O Other_____

Please circle which medicines you have tried for pain relief:

NSAIDS:	Celebrex, Vioxx, Bextra, Motrin/Ibuprofen, Aleve, Naprosyn, Tylenol, Aspirin
Narcotics:	Morphine, Oxycontin, Methadone, Duragesic Patch, Vicodin, Lorcet, Norco, Hydrocodone, Darvocet, Percocet, Oxycodone, Ultram
Antidepressants:	Paxil, Prozac, Celexa, Elavil/Amitriptyline, Zoloft, Lexapro, Effexor, Desyrel/Trazadone, Pamelor/Nortriptyline, Sinequan/Doxepin
Anticonvulsants:	Neurontin, Lamotrigine, Dilantin, Tegretol
Muscle Relaxers:	Soma, Flexeril, Skelaxin, Diazepam/Valium, Klonopin/Clonazepam, Zanaflex, Baclofen
Other Medicines:	Lidoderm Patch, Capsaicin, Catapress Patch

Name of person completing this form: _____

_____ _____

Signature of patient or Personal Representative Date

_____ _____

Relationship of Personal Representative to Patient Reason for signature by Personal Representative

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Current Medical Symptoms (Please check any that apply):

Constitution

- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue
- ☐ Excessive sweating, night sweats
- ☐ Weakness

Skin

- ☐ Rash/Hives
- ☐ Itching
- ☐ Blisters
- ☐ Changes in skin (moles, other)

Head/ENT

- ☐ Headaches
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nose Bleeds
- ☐ Sinus pain/congestion
- ☐ Sore throat
- ☐ Use a hearing aid

Eyes

- ☐ Blurred vision
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations/ irregular heart beat
- ☐ Shortness of breath, wheezing
- ☐ Leg discomfort in walking
- ☐ Ankle swelling
- ☐ Breathing difficulty while lying down

Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Excessive phlegm/ mucus
- ☐ Difficulty breathing
- ☐ Use Oxygen

Gastrointestinal

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black stool

Genitourinary

- ☐ Painful urination
- ☐ Loss of bladder control
- ☐ Blood in urine
- ☐ Frequency
- ☐ Difficulty urinating

Musculoskeletal

- ☐ Muscle ache/pain
- ☐ Joint pain/swelling
- ☐ Back or neck pain
- ☐ Pain or tiredness in legs while walking
- ☐ Leg or foot cramps at night
- ☐ Falls

Endo/Herme/Allergy

- ☐ Easy bruise/bleed
- ☐ Environmental allergies
- ☐ Excessive thirst
- ☐ Swollen glands/lumps

Neurological

- ☐ Problems with balance/dizziness
- ☐ Numbness/tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech/memory change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Loss of consciousness

Psychiatric

- ☐ Depression
- ☐ Suicidal ideas
- ☐ Nervous/Anxious
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Memory loss

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Medication Form

Please list the **medications** you are taking and include the dose if possible.

Please include vitamins, herbs and any other supplements you are taking.

Medications	Dosage	Frequency	Prescribing Physician

Allergies: ☐ **No Known Allergies**

Allergen	Reaction	Allergen	Reaction

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In order to assure that your care is coordinated with all of your physicians, please provide us with the names addresses and/or phone numbers of those physicians.

Referring Doctor:

Name: _____

Address: _____

Phone: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____

Cardiologist:

Name: _____

Address: _____

Phone: _____

Orthopedist:

Name: _____

Address: _____

Phone: _____

Other:

Name: _____

Address: _____

Phone: _____

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Pharmacy Information

Pharmacy Plan/Benefit Information:

_____

_____

Pharmacy Name/Location: (i.e. CVS, Walgreens, etc.)

_____

_____

Laboratory/Radiology Information

Are your Laboratory and Radiology studies capitated to specific performing location? ☐ Y ☐ N

Radiology/Imaging Center: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Laboratory: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

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HIPAA COMPLIANCE PRIVACY LAWS

Due to HIPAA Compliance Privacy Laws of the Federal Government,it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers:

Home Phone Yes / No

Cell Phone Yes / No

May we contact you at your place of employment? Yes / No If yes: Work Phone: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information , surgical and billing)? Yes / No

If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Is this person your Power of Attorney for medical purposes? Yes / No

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Is this person your Power of Attorney for medical purposes? Yes / No

I hereby authorize Academic Pain & Spine to obtain or release any and all pertinent information regarding my medical care as needed, to assist in my ongoing treatment to or from other healthcare providers, laboratories, radiology facilities or other institutions. THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues stated above. I have reviewed the Academic Pain & Spine Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Witnessed By: _____

Academic Pain & Spine

3070 Bristol Pike Bldg. 2-130 Bensalem, PA 19020. P:267-282-6680 F: 267-282-6677

ALL patients must complete the "Patient Information" form before seeing any physician in this office.

YOU are responsible for obtaining any necessary referrals from your PCP. Anyone who does NOT have their necessary referral will be responsible for payment in full at the time of service or will be rescheduled. Co-payments MUST be paid upon arrival in the office.

AUTO ACCIDENTS/WORKMAN'S COMPENSATION: ALL information regarding the insurance company, policy or claim numbers and the agent/case worker MUST be received in this office 48 hours prior to your visit so that we can confirm coverage.

REGARDING INSURANCE: In most cases, insurance is a contract between YOU and the INSURANCE CARRIER. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges etc, other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR TIMELY PAYMENT OF YOUR ACCOUNT.**

PAYMENTS FOR SERVICE PERFORMED: Our office accepts cash, check, Visa, MasterCard and American Express. All payments are expected at the time of service and any outstanding balances are due within 30 DAYS, unless prior arrangements have been made with the Billing Department. All balances that reach 121 DAYS past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance. Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future service.

MISSED APPOINTMENTS: We require 24-hour notice for cancellations. **You will be charged $35.00 for any missed (without 24-hour notice) appointments.** Three occurrences will result in dismissal from the office. Please help us to serve you better by keeping your scheduled appointments.

RETURNED CHECKS: A fee of **$35.00** will be charged for any checks returned to our office.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for charges to my account for ALL professional services rendered to me. I have read ALL of the information given to me and have completed all answers. I certify that this information is true and correct to the best of my knowledge. I will notify BAC Medical, PLLC of any and all changes in my health status or personal information.

Signed:_____

Date:_____

Academic Pain & Spine

PATIENT INFORMATION PACKET

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____
Street City State Zip

TELEPHONE: CELL:_____ OTHER:_____

SSN: XXX-XX-_____ E-Mail ADDRESS_____

CONSENT FOR EVALUATION AND TREATMENT

Consent is hereby voluntarily given for medical evaluation and treatment as may be necessary for the opinion of the examining physician.

Signature: _____ Date: _____

AUTHORIZATION FOR DIRECT PAYMENT

The undersigned hereby authorizes payment directly to Academic Pain & Spine upon receipt of the itemized statement for services rendered to the patient benefits herein specified and otherwise payable to the undersigned, but is not to exceed the physician's regular charge for this service. (**In layman's terms, this says that you are giving the insurance company permission to pay us directly**.)

Signature:_____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION, MEDICAL AND PHARMACEUTICAL

I hereby authorize Academic Pain & Spine to release and/or obtain any necessary information related to my health insurance, medical or pharmaceutical record as to be determined by the treating Medical Staff.

Signature:_____ Date: _____
