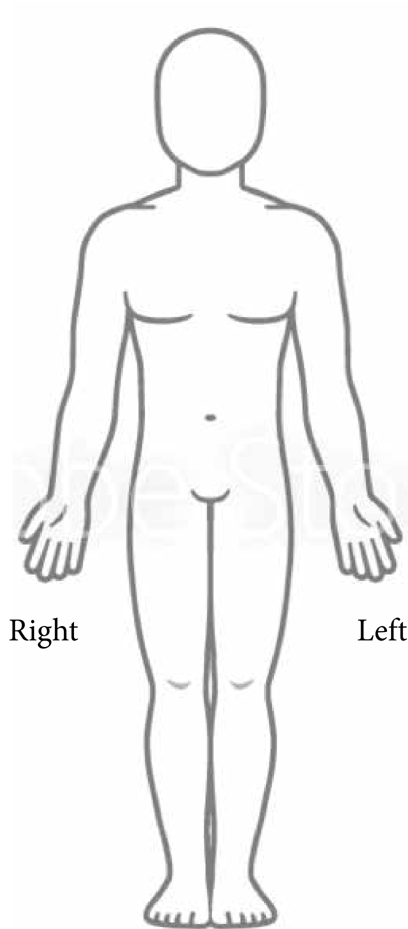
Please Print Each Page One-Sided

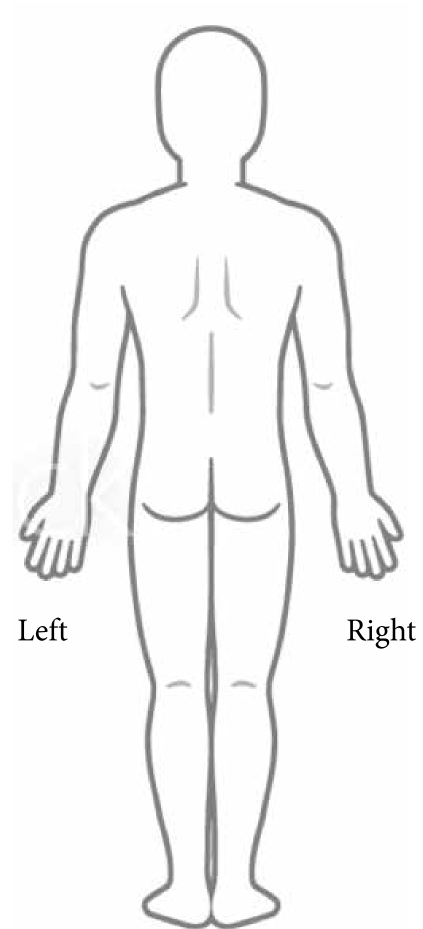
NAME ____ **DATE** ______________________

Mark the areas on the diagram below where you feel the majority of your pain. Use “Xs” (xxx) to designate each location.

FRONT



BACK



The following questions are designed to provide your physician with a thorough understanding of your medical history. Please answer every question as completely as you can.

1. Name ________________________________ Age _____ Height ________ Weight ________

2. Please circle the number below to indicate the level of pain you are having.

   Use the following scale as a rough guide:

   0 = No pain
   3 = Take Tylenol or Advil for pain
   6 = See your doctor for prescription
   10 = Worst pain you could ever have

   0 1 2 3 4 5 6 7 8 9 10

3. What position or activity makes your injury or pain worse? ________________________________

4. What position or activity reduces your pain? ________________________________

5. Have you had any of the following tests or treatments concerning your current symptoms? If so, please list date, location, and result, if known.

	Yes	No	Date/Location/Result
a. X-ray	☐	☐	________________
b. Myelogram	☐	☐	________________
c. CAT scan	☐	☐	________________
d. MRI scan	☐	☐	________________
e. Bone scan	☐	☐	________________
f. EMG or Nerve Conduction Study	☐	☐	________________
g. Physical Therapy	☐	☐	________________
h. Chiropractor	☐	☐	________________
i. TENS Unit	☐	☐	________________
j. Back Brace	☐	☐	________________
k. Trigger Point Injection	☐	☐	________________
l. Epidural Steroid Injection	☐	☐	________________
m. Facet Joint Injection	☐	☐	________________
n. Discogram	☐	☐	________________
o. Neck or Back Surgery	☐	☐	________________

6. List any drug allergies or sensitivities you have: ________________________________

   ____

7. List prescription medications you are currently taking. Include dosage and how many times per day you take it: ________________________________

   ____

8. Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No
Hepatitis	☐	☐	Kidney Disease	☐	☐
AIDS/HIV	☐	☐	Cancer	☐	☐
Arthritis	☐	☐	Heart Disease	☐	☐
Diabetes	☐	☐	Osteoporosis	☐	☐
Ulcers	☐	☐	Thyroid Problems	☐	☐
Unexplained Weight Loss	☐	☐	Migraines	☐	☐
Night Sweats / Fever	☐	☐	Lung Problems	☐	☐
Seizures	☐	☐	Bleeding Disorders	☐	☐
High Blood Pressure	☐	☐	Liver Problems	☐	☐

If you answered "Yes" to any of the above, please describe: ______________________________

____

____

8a. Have you ever had weakness/numbness in your legs or arms? If yes, please explain.

____

8b. Have you ever had any changes in bowel/bladder functions? If yes, please explain.

____

8c. List any additional medical problems or surgeries you have had: ____________________________

____

____

9. Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower ?

10. What is your current job or occupation? ____________________________________

10a. How long have you been working at this position? ____________________________

11. Have you missed any work because of your injury? ☐ Yes ☐ No ☐ N/A

If so, please list dates: ____

11a. Is your injury work-related? ☐ Yes ☐ No ☐ N/A

If so, please list date of accident: ____

12. Do you smoke? If yes, how much and for how long?

____

12a. Do you drink? If yes, how much and for how long?

____

13. Do you have any blood relatives who have had the following illnesses? Please cheek those that apply.

Illness	Yes	No	Relationship to Patient
Cancer	☐	☐	______________________
Seizures	☐	☐	______________________
Osteoporosis	☐	☐	______________________
Thyroid Problems	☐	☐	______________________
Heart Disease	☐	☐	______________________
Nerves/Depression	☐	☐	______________________
Diabetes	☐	☐	______________________
Migraine Headaches	☐	☐	______________________

In the space provided below, please list any other family illnesses your doctor should be aware of.

____

____

____

14. Review of Systems: Please circle any of the following problems which you now have or which you have had in the past six months.

Allergic/Immunologic
1. Rashes
2. Itching
3. Wheezing
4. None

Cardiovascular
1. Chest Pain, Tightness
2. Palpitations
3. None

Constitutional
1. Weight Gain
2. Weight Loss
3. Appetite Change
4. Marked Fatigue
5. Unexplained High Fever
6. Night Sweats
7. Difficulty Sleeping
8. None

Hemotology/Endocrinology
1. Swelling
2. Bruising
3. Bleeding
4. None

Gastrointestinal
1. Persistent/Recursing Belly Pain
2. Uncontrolled Loss of Stool
3. Diarrhea
4. Blood in Stool
5. Heartburn
6. Constipation
7. Yellow Jaundice
8. Pain with Bowel Movement
9. None

Integumentary
1. Discoloration of Skin
2. Pain
3. None

Musculoskeletal
1. Joint Pain
2. Joint Stiffness
3. Joint Redness
4. Joint Swelling
5. Loss of Strength
6. Weakness
7. None

Neurological
1. Headaches
2. Change in Sensation to Lower Extremities
3. Numbness in Extremities
4. None

Psychological
1. Psychological Difficulties
2. Mood Changes
3. None

Respiratory
1. Shortness of Breath with Normal Activities
2. Wheezing
3. Recurring Cough
4. None

Urological
1. Difficulty with Urination
2. Blood in Urine
3. None

______________________________ Physician Signature(s)

______________ Date(s) Reviewed

Spine and Orthopaedic Specialists of South Carolina PA
J. Robert Alexander Jr., M.D.

IF YOU HAVE HAD ANY REVISION TO YOUR INSURANCE, ADDRESS, OR PATIENT INFORMATION, PLEASE SEE THE FRONT DESK!

Name ______________________________ **Patient Email** ______________________________

Primary Care Physician ______________________________ **Referring Doctor** ______________________________

Current Medications (include dosage):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

PLEASE NOTE: All areas are required to be filled in or checked. Please write N/A for items that are not applicable.

LAST NAME ______ FIRST NAME ______ MIDDLE INITIAL ______ Male / Female (circle one)

MAILING ADDRESS ______ CITY ______ STATE ______ ZIP ______

SOCIAL SECURITY NUMBER ______ DATE OF BIRTH ______ PHONE (Home) ______ PHONE (Cell) ______

☐ Single ☐ Married ☐ Divorced ☐ Widowed (check one) MARITAL STATUS

RACE ______ ETHNICITY ______ LANGUAGE ______

EMPLOYER NAME ______ EMPLOYER PHONE ______

REFERRING PHYSICIAN ______

PHARMACY NAME ______ LOCATION ______ PHONE ______

SPOUSE FIRST NAME ______ LAST NAME (if different than above) ______

SPOUSE SOCIAL SECURITY NUMBER ______ SPOUSE DATE OF BIRTH ______ SPOUSE EMPLOYER ______

Complete this section if patient is a minor.

RESPONSIBLE PARTY/GUARDIAN LAST NAME (if other than patient) ______ FIRST NAME ______

PHONE (Daytime) ______ PHONE (Evening) ______ RELATIONSHIP TO PATIENT ☐ Parent ☐ Other ______

EMERGENCY CONTACT ______ PHONE ______

PRIMARY INSURANCE NAME ______

INSURED'S NAME ______ SOCIAL SECURITY # ______

ID # ______ GROUP # ______

RELATIONSHIP TO PATIENT: ☐ Spouse ☐ Parent ☐ Other ______

SECONDARY INSURANCE NAME ______

INSURED'S NAME ______ SOCIAL SECURITY # ______

ID # ______ GROUP # ______

RELATIONSHIP TO PATIENT: ☐ Spouse ☐ Parent ☐ Other ______

I hereby authorize Spine and Orthopaedic Specialists of South Carolina PA (J. Robert Alexander Jr.,M.D.) to release -any information acquired in my examination or treatment to any insurer or government agency providing benefits. I also authorize any insurer or government agency to release personal demographic information including my current address to Spine and Orthopaedic Specialists of South Carolina PA.

Signature ______ Date ______

PAYMENT FOR SERVICES RENDERED

I hereby assign to and authorize payment directly to Spine and Orthopaedic Specialists of South Carolina PA (J. Robert Alexander Jr., M.D.) all benefits payable under the terms of any insurance policy listed above. I agree to pay the difference or the entire bill if necessary.

Signature ______ Date ______

Complete this section only if you have a workers compensation claim.

Date of Injury: ______

Name of Employer at Time of Injury ______

Worker's Comp Claim Number ______

Employer's Address at Time of Injury ______

Worker's Comp Insurance Company ______

SPINE AND ORTHOPAEDIC SPECIALISTS OF SOUTH CAROLINA, PA
NOTICE OF PRIVACY PRACTICES SUMMARY

This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a fun copy of our Notice of Privacy Practices.

Uses and Disclosures of Health Information
We use health information about your treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask you for your written authorization before using or disclosing at any identifiable health information about you. If you choose to sign an authorization to disclose information, you can hear revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Your Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect end obtain a copy of your health record as provided for in CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Following is a statement of your rights with respect to your protected health information and brief description of how you may exercise these rights.

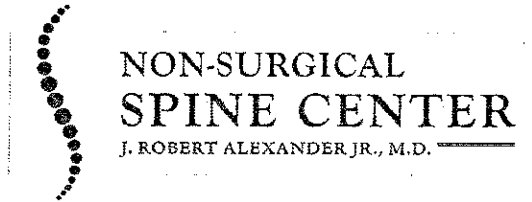
Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact our office at:
526 Johnnie Dodds Blvd, Suite 301. Mt Pleasant, South Carolina 29464. (843) 856-9669

Written Acknowledgment
I acknowledge that I have reviewed the Notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to restrictions I request.

______________________________	______________________________
Signature of Patient or Legal Representative	Witness
______________________________	______________________________
Date	Date



Spine and Orthopaedic Specialists of South Carolina PA
J. Robert Alexander Jr., M.D.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________ and assign directly to Spine & Orthopaedic Specialists, PA all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all information necessary to secure the payment of benefits. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

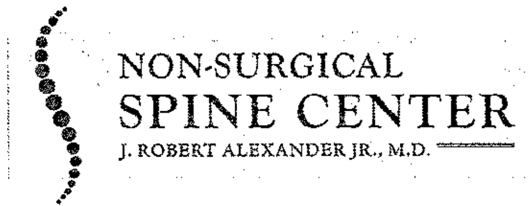
______________________________ ______________________________
Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me at on my behalf to Spine & Orthopaedic Specialists of South Carolina, PA for any services furnished me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in line 9 of the HCFA-1500 form, or elsewhere on of approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charged determinations of the Medicare carrier.

______________________________ ______________________________
Beneficiary Signature Date

Please turn over to complete.



Spine and Orthopaedic Specialists of South Carolina PA
J. Robert Alexander Jr., M.D.

FINANCIAL POLICY

To help provide efficient and reasonable health care services, it is necessary for us to have a Financial Policy. Patients are responsible for payment of all services provided. It is our policy to file for insurance reimbursement as a courtesy to you if we have accurate and complete insurance information.

If you have insurance coverage and we file with your carrier, we ask that you pay the portion that is your responsibility and any deductible amount due at the time of service. Your insurance policy is a contract between you and your insurance company. **Please keep in mind that we file insurance as a courtesy to you and we are in no way responsible for the agreement and conditions of your plan. It is also your responsibility to determine what procedures your policy will cover. Any claims unpaid after 60 days become the responsibility of the patient.**

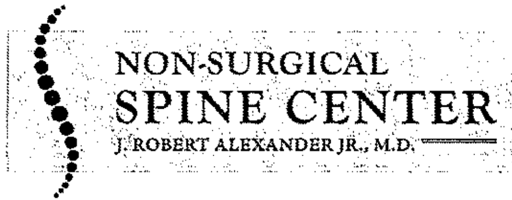
If you do not have insurance, payment is due in full at the time of service.

We require **two business days (48 hours)** notice to cancel any EMG/Nerve Conduction Study or block procedure appointments. The physician has set aside a significant amount of time for these procedures and it is very important that the appointments are kept scheduled. Patients who do not show for their scheduled appointments or do not give adequate notice of cancellation will be assessed a no-show fee of $150. We also require 24-hour notice to cancel an office visit. It is very important the staff is notified to avoid a $40 no-show fee. Payment will be required to schedule another office visit. This policy is to ensure that other patents are fairly provided the opportunity to assumed your scheduled appointment in the event of a cancellation.

I have reviewed, understand, and accept the terms and conditions of the Financial Policy as outlined above.

Patient/Guardian Signature ______________________ Date ______________________

Witness ______________________ Date ______________________



Spine and Orthopaedic Specialists of South Carolina PA
J. Robert Alexander Jr., M.D.

Consent to Obtain External Prescription

I, ________________________, whose signature appears below, authorized Spine & Orthopaedic Specialists of South Carolina and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

______________________________	______________________________
Patient	Date
______________________________	______________________________
Witness	Date