ATLANTA SPINE

Demographic Information
Patient Name:
Mailing Address: City: State: Zip Code:
Home Phone: OK to Leave Message: ☐Brief ☐Extended
Cell Phone: OK to Leave Message: ☐Brief ☐Extended
Work Phone: OK to Leave Message: ☐Brief ☐Extended
Date of Birth: Marital Status:
Patient Email:
Spouse's Name: Spouse's Phone Number:
Do you authorize your spouse to receive medical information on your behalf? ☐Yes ☐No
Primary Care Provider:
Referring Provider:
Preferred Pharmacy Name: Phone Number:
Pharmacy Address:
Pharmacy City: State: Zip Code:
Race: ☐American Indian ☐Asian ☐Native Hawaiian ☐Black ☐White ☐Hispanic ☐Other
Language Spoken:
Sex: ☐Male ☐Female ☐Transgender Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Emergency Contact Information/ Release of Information other than Spouse
Emergency Contact Name:
Phone Number:
Address:
Relationship to Patient: ☐Medical information may be released
Secondary Contact Name:
Phone Number:
Relationship to Patient: ☐Medical information may be released
Guarantor/ Responsible Party (if other than self)
Guarantor Name:
Guarantor Phone Number:
Guarantor Date of Birth:
Patient Date of Birth:
Additional Information
Do you have an Advanced Directive? ☐Yes ☐No Can you provide us with a copy? ☐Yes ☐No
Power of Attorney for medical decisions ☐Yes ☐No

IF CURRENT CARD(S) ARE NOT PRESENT	
Primary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Secondary Insurance	
Insurance:	
Insured's Name:	Insured's Date of Birth:
Subscriber ID Number:	
Subscriber Address:	
Group Number:	
Insured's Relationship to Patient:	
Additional Billing Information	
Is this a Workers Compensation Case?	☐ **Yes** ☐ **No**
Workers Compensation Company/Employer:	
Is this a Motor Vehicle Accident Case?	☐ **Yes** ☐ **No**

I attest that the information provided is correct and I hereby authorize the release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Atlanta Spine to view my medication history from external sources.

_____ _____

Patient, Please sign for permission to treat **Date**

_____ _____

Guardian, Please sign for permission to treat in your absence **Date**

* Atlanta Spine includes Atlanta Spine Surgery Center, LLC and its affiliates and subsidiaries

ATLANTA SPINE

NEW PATIENT HEALTH HISTORY

Patient Name:_____ **Patient DOB:** _____

Height:_____ **Weight:**_____ **lbs.** **Dominant Hand:**☐R☐L

Reason for Visit:

_____

Past Medical History

- ☐ Acid Reflux
- ☐ Adverse reaction to anesthesia
- ☐ Alzheimer's or significant memory loss
- ☐ Anemia
- ☐ Angina or chest pain
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bladder problems
- ☐ Bleeding Ulcers
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Congestive heart failure
- ☐ Coronary Artery Disease
- ☐ Dental Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Heart Attack (MI)
- ☐ Hemophilia/Bleeding Disorder
- ☐ Hepatitis
- ☐ High Blood Pressure/ Hypertension
- ☐ High Cholesterol
- ☐ Home Oxygen ____ liters/minute
- ☐ Infections:_____
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ MRSA
- ☐ Menopause – If post-menopausal, age of menopause? _____
- ☐ No past medical problems
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other, not listed:_____ _____
- ☐ Pneumonia
- ☐ Psychiatric disorder
- ☐ Rheumatoid Arthritis
- ☐ Sickle cell
- ☐ Sleep Apnea _____ CPAP Machine
- ☐ Stroke (CVA)
- ☐ TIA
- ☐ Thyroid Disease

Past Surgical History					
	Yes	Year		Yes	Year
Appendectomy			Knee Surgery		
Gall Bladder Removal			Hip Surgery		
Tubal Ligation			Other:		
Hysterectomy					
Kidney Surgery					
Heart Surgery (Specify)_____					
Neck Surgery (Specify)_____					
Back Surgery (Specify)_____					

Who were you referred by: _____

Patient Name: _____ **Patient DOB:** _____

Are you taking any medications now? ☐ Yes ☐ No (This includes prescription, over the counter, vitamins or herbal medications)

If yes, please list below including dosages.

MEDICATIONS			
DRUG	**DOSE**	**TIMES PER DAY**	**WHY**
Example: Lortab	*5mg*	*3*	*Pain*

** PLEASE REMEMBER TO LIST ANY BLOOD THINNERS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN, COUMADIN, WARFARIN, PLAVIX, EFFIENT, PLETAL, AGGRENOX, GOODY'S POWDER, LOVENOX, AND PRADAXA **

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list them below.

ALLERGIES	
Name of Medication	**Type of Reaction (Rash, Swelling, Etc.)**

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

ATLANTA SPINE

FAMILY HISTORY									
Is your Father Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**
Is your Mother Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**
Are your siblings (sisters, brothers) Alive or Deceased?									
Alive ☐	**Deceased** ☐	**Diabetes**	**Hypertension**	**Heart Attack**	**Stroke**	**Mental Illness**	**Cancer**	**Other**	**Unknown**

Social History
Are you currently employed? ☐Yes ☐No Occupation:
Marital Status: ☐M ☐S ☐D ☐W
Alcohol Use: ☐Yes ☐No If yes: **How Often? _____** **How Many? _____**
Tobacco Use: ☐Yes ☐No If yes: **How Often? _____** **How Many? _____** **What age did you start using Tobacco? _____**
Recreational Drug Use: ☐Yes ☐No If yes:
History of Alcohol Abuse: ☐Yes ☐No
History of Prescription or Illicit Drug Abuse: ☐ Yes ☐ No
Have you ever served in the Armed Forces? ☐ Yes ☐ No
Are you able to care for yourself? ☐Yes ☐No

Briefly describe when and how your current pain started.

_____

_____

Is this a Workers Comp accident? ☐Yes ☐No If yes, what was the date of injury? _____
Is this related to an auto accident? ☐Yes ☐No If yes, what was the date of the accident? _____
If injured, is litigation ongoing? ☐Yes ☐No

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

PREVIOUS DIAGNOSTIC STUDIES – Please indicate approximate date and locations, if known.

Type	Date	Location
MRI		
CT		
X-RAYS		
EMG		

How would you describe your pain? (Choose as many as are applicable)

☐ Aching ☐ Dull ☐ Shooting ☐ Weakness

☐ Burning ☐ Intermittent ☐ Spasm

☐ Constant ☐ Pins and Needles ☐ Sore

☐ Cramping ☐ Sharp ☐ Stabbing

Circle the pain intensity with a "0" representing no pain and "10" the most severe pain imaginable.

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

What has been your average pain level for the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your lowest pain level in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

What has been your worst pain in the last 7 days?

0 1 2 3 4 5 6 7 8 9 10

How long have you been in Pain? ____Hours _____Days _____Months _____Years

ATLANTA SPINE

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

How often do you have your pain? (Please check one)

- ☐ Constantly (100% of the time)
- ☐ Waxes and Wanes
- ☐ Intermittently (50% of the time)

What activities are you unable to do well because of your pain?

- ☐ Climb Stairs
- ☐ Walk long distances
- ☐ Sleep
- ☐ Sit for long periods
- ☐ Lift greater than 5 lbs.
- ☐ Meal Preparation
- ☐ Stand for long periods
- ☐ Go shopping
- ☐ Housework
- ☐ Yard work
- ☐ Work

What activities make your pain worse?

- ☐ Sitting
- ☐ Car Rides
- ☐ Standing
- ☐ Exercise
- ☐ Walking
- ☐ Weather
- ☐ Position change
- ☐ Hot/Cold

What activities make your pain better?

- ☐ Nothing
- ☐ Sitting
- ☐ Position change
- ☐ Medications
- ☐ Standing
- ☐ Rest
- ☐ Exercise
- ☐ Walking
- ☐ Massage
- ☐ Lying down
- ☐ Heat/Ice
- ☐ Chiropractic

Patient Name: _____ Date of Birth: _____

What previous pain treatments have you tried?

Treatment	Date	How Long (1 month, 6 weeks)	Facility/ Physician	Percentage of Relief
☐ Physical Therapy				
☐ Chiropractic				
☐ Medications				
☐ Injections Type:				
☐ Surgery				
☐ Other				

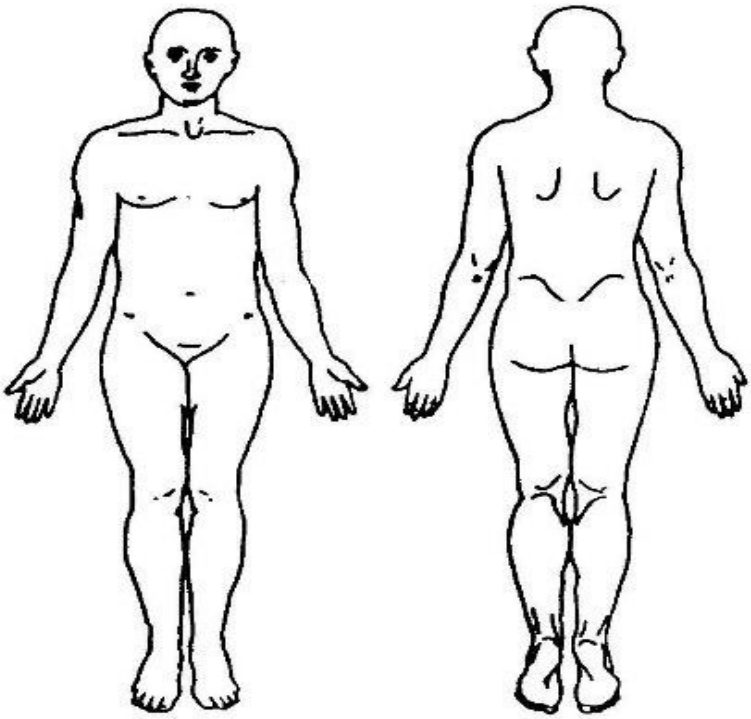
Have you previously been under contract with Pain Management? If yes, please list the following:

Facility: _____

Physician: _____

PAIN LOCATION

Please mark the locations of your pain on the diagrams below with an "X". If whole areas are painful, please shade in the painful area.



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

REVIEW OF SYSTEMS

Have you had any of the following symptoms within the last 30 days? Please check all that apply.

Constitutional
__Fever
__Weight Gain
__Weight Loss
__Night Sweats

Eyes
__Dry Eyes
__Irritation
__Vision Change

ENMT
__Difficulty Hearing
__Ear Pain
__Frequent Nosebleeds
__Nose Problems
__Sinus Problems
__Bleeding Gums
__Dry Mouth
__Mouth Ulcers
__Oral Abnormalities
__Sore Throat
__Teeth Problems

Cardiovascular
__Arm pain on exertion
__Chest Pain
__Heart Murmur
__Palpitations
__Shortness of breath when lying down
__Shortness of breath when walking

Respiratory
__Coughing
__Coughing up blood
__Shortness of Breath
__Sleep Apnea
__Wheezing

Gastrointestinal
__Abdominal Pain
__Constipation
__Diarrhea
__Dyspepsia
__GERD
__Nausea
__Vomiting
__Vomiting Blood

Genitourinary
__Difficulty Urinating
__Hematuria
__Unable to Urinate

Musculoskeletal
__Back Pain
__Extremity Swelling
__Joint Pain
__Muscle Aches
__Muscle Weakness

Integumentary
__Abnormal Mole
__Jaundice
__Sore or Lesion
__Rash

Neurologic
__Dizziness
__Migraine
__Numbness
__Loss of Consciousness
__Seizures
__ Weakness
__Tremor

Psychiatric
__Alcohol Abuse
__Anxiety
__Depression
__Feeling unsafe in a relationship
__Hallucinations
__Sleep Disturbances
__Suicidal Thoughts

Endocrine
__Cold Intolerance
__Fatigue
__Hair Loss
__Increased Thirst

Hematologic/Lymphatic
__Easy Bruising
__Excessive Bleeding
__Swollen Glands

Allergic/Immunologic
__Itching
__Frequent Sneezing
__Hives
__Runny Nose
__Sinus Pressure

_____ _____

PATIENT SIGNATURE **DATE**

Patient Name: _____

Patient DOB: _____

Financial Policy for Patient Care Services and Assignment of Benefits

We are happy that you have selected Atlanta Spine* for your healthcare needs and we look forward to working with you. At Atlanta Spine*, we are committed to meeting your healthcare needs. Our goal is to make your insurance or other financial arrangements as simple as possible.

Patients are responsible for their co-payments, coinsurances and deductibles according to their plan at the time of service. We ask that you provide us with your current insurance information so we can file an insurance claim with your carrier. If you do not have active insurance you will be considered a "Self-Pay" patient. Our "Self-Pay" financial policy is based on very reasonable rates.

We have a dedicated team of Patient Concierges that will work with you on your financial responsibilities while ensuring your healthcare needs are being met. In the rare occasion your insurance does not make a payment to Atlanta Spine on your behalf, placing the financial responsibility on you for the services provided, a member from our Patient Concierge team will contact you prior to your scheduled appointment or procedure.
In the event you are not able to maintain your scheduled appointment we ask you provide us with 24 hour notice. This will allow our practice to treat another patient. If we have not received a 24 hour notice prior to your appointment you will be charged a "No Show" fee of $25.00. Lastly, if we have not received a 24 hour notice prior to your procedure, you will be charged a "No Show" fee of $50.00.

By signing this form you are acknowledging you have read and understand you are assigning and transferring to Atlanta Spine all of the benefits due to you under Medicare, Medicaid or any insurance policy or health plan providing benefits for the services being rendered. You authorize Atlanta Spine to receive payment, file an appeal, and determine medical coverage from your health plan. You understand you are responsible for charges that are not covered by your health plan or that your health plan has assigned to you.

I have read and understood the above statements and certify that this form applies to all visits and procedures at any Atlanta Spine, PC or Atlanta Spine Surgery, LLC Center location.

_____ _____

Patient Signature Date

* Atlanta Spine includes Atlanta Spine Surgery Center, LLC and its affiliates and subsidiaries.

Atlanta Spine Notice of Privacy Practices Acknowledgement Form

Patient Acknowledgment of Understanding of Atlanta Spine Notice of Privacy Practices.

Patient's Name: _____ Date of Birth: _____

I understand that Atlanta Spine* may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, to take care of other health care operations. And for other purposes described in the document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available online and in our offices. I have been given a copy of the Notice along with this acknowledgement and I understand that I have the right to read the "Notice" before signing this acknowledgement.

Atlanta Spine* may update this acknowledgement and "The Notice of Privacy Practices". If I ask, Atlanta Spine* will provide me with the most current "Notice of Privacy Practices".)

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communications or alternative location.

Atlanta Spine* has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Atlanta Spine* by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Atlanta Spine* "Notice of Privacy Practice".

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

_____ _____ _____

Patient or legally authorized individual signature Date Time

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Disclosure to Patient

I, Harvinder S. Bhatti, M.D., own an equity share of IOM Professional Readers, LLC, a Georgia limited liability company, which provides the Professional Reading and analysis of neurophysiological data derived from intraoperative monitoring services provided during spinal surgical procedures. The purpose of this service is to provide me with data showing the status of your neurophysiology before, during, and after your surgical procedure. IOM Professional Readers, LLC has no affiliation with the hospital or ambulatory surgery center to which I have referred you for medical treatment nor is there any affiliation with the Neuromonitoring Company that is contracted with the hospital or ambulatory surgery center. If you have been referred for a surgical procedure, it is possible that I will order neuromonitoring services to provide data in connection with your procedure. You are free, however, to request that I not use neuromonitoring in connection with your procedure or to obtain such services from any other provider of your choosing (except as your choice may be limited by the companies contracted with the hospital or the ambulatory surgical center or as may be limited by the terms of your health insurance coverage). Payment for the services mentioned above are paid by most commercial insurance coverage policies.

_____ _____

Patient Signature Date

_____

Print Name