ARIZONA PRECISION SPINE PLLC

New Patient Intake Form

PERSONAL INFORMATION

Today's Date:_____ Name: _____Marital Status: **M S W D**

Mailing Address _____City _____State_____ Zip _____ Sex **M F**

DOB: _____ Age:_____ SS# (**must have to file insurance**) _____Email _____

Home Phone: _____ Cell:_____Work: _____ OK to Text and Leave a message **YES NO**

Emergency Contact: _____ Phone: _____ Relationship: _____

REASON FOR TODAY'S VISIT ? _____

Is this due to an accident? **YES NO** Type of Accident if YES: **AUTO WORK FALL ASSAULTED** Date of Injury: _____

EMPLOYMENT

Name of Employer: _____ Phone: _____

Address: _____City: _____State: _____ Zip: _____

PRIMARY INSURANCE

Insurance Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

Policy: _____ Group: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

SECONDARY INSURANCE

Insurance Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip:_____

Policy: _____ Group: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBITY

The information above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my physician here at Arizona Precision Spine PLLC. I understand that I am financially responsible for balance that is due before and after my insurance has been paid. I also authorize Arizona Precision Spine PLLC to obtain/release any of my information required to process anyclaims. If my insurance does not pay the claim within 30 days of submission, I will be responsible for payment of the claim. If the insurance company pays you directly, you will be responsible for the amount on your account.

Patient Signature: _____**Date:** _____

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

Primary Doctor:_____ **Referring Provider:** _____

Date of Onset:_____ **Work Related Injury:**_____ **Height:**_____ **Weight:** _____

PAST MEDICAL HISTORY: Circle if you have/ had any of the following conditions:

High Blood Pressure	Heart Disease	Stroke	Diabetes	High Cholesterol
Emphysema	Asthma	Cirrhosis	Hepatitis	Hypothyroidism
Ulcer	Acid Reflux	Arthritis	Blood Clots	Kidney Problems
Depression	Anxiety	HIV/AIDS	Osteoporosis	Cancer

Other:_____

Past surgeries/Illnesses/Injuries (Please include DATE and NAME OF SURGEON if possible)

_____

_____

_____

Allergies to Medications: _____

Current Medications (Including over the counter meds and supplements) with dosage:_____

_____

_____

Please circle and/or indicate the following:

Education: Elementary High School College Degree Other:_____
Occupation:_____ **Last Day Worked:** _____
Tobacco Use: Yes No **Packs per Day:**_____ **Years:**_____ **Quit Date:** _____
Alcohol Use: Yes No **Drinks per Week:**_____ **Other Substance Use:** _____

Family History: (Blood Relative Only)

High Blood Pressure	Heart Disease	Stroke	Diabetes	High Cholesterol
Emphysema	Asthma	Cirrhosis	Hepatitis	Hypothyroidism
Ulcer	Acid Reflux	Arthritis	Blood Clots	Kidney Problems
Depression	Anxiety	HIV/AIDS	Osteoporosis	Cancer

Other: _____

ARIZONA PRECISION SPINE PLLC

Release of Information (ROI)

I authorize Arizona Precision Spine PLLC to release some or all medical records, medication(s),financial and appointment information to the following persons:

Name	Relationship to Patient	DOB
• _____		
• _____		
• _____		

HIPAA ACKNOWLEDGMENT

For Arizona Precision Spine PLLC to comply with Federal government regulations, we are required to have a document available for you to review that explains our Patient Privacy Information/HIPAA policy. If youwish to review, please ask our front desk receptionist for a copy of this policy

- I hereby acknowledge that I have been offered, received or viewed a copy of Arizona Precision Spine, PLLC Noticeof Privacy Practices.
- With my consent, Arizona Precision Spine, PLLC may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations as discussed in the New Patient Paperwork.
- With my consent Arizona Precision Spine, PLLC may call my home, cell, work or other designated location and leave amessage on voicemail or in person in reference to any items that may assist the practice in providing my healthcare.
- With my consent, Arizona Precision Spine, PLLC may mail or email to my home or other designated location anyitems that assist the practice in providing my healthcare.
- I may revoke this consent in writing, except to the extent that the practice has already made disclosures relying upon my priorconsent. If I do not sign this consent Arizona Precision Spine, PLLC may decline to provide treatment to me.

I hereby consent to the use or disclosure of my individually identifiable health information by Arizona Precision Spine, PLLC in order to carry out the treatment, obtain payment from my insurance company, and continuation of care with any of my present or future healthcare providers. At any time, I have the right tovoid this consent; such void must be submitted in writing to Arizona Precision Spine, PLLC by signingbelow, I have read and understood all sections of this policy.

Patient Signature:_____Date:_____

Representative, if applicable:_____Date:_____

For Clinic Use

_____**Patient Refused to Sign** **Patient Unable to Sign Because** _____

Employee Signature:_____**Date:** _____