Patient information

Name:	DOB:	Age:	Sex:
Race:	Ethnicity:		Language:
Address: City, State, Zip code:			
Billing Address:	Social Security number:		
Job FT, PT, none:	Employer:		
Primary phone:	Work phone:	Cell phone:	
Email Address:			

Emergency contact information

Emergency contact name:	Emergency contact:
Relationship to patient:	Primary phone:

Attorney Information

Law Office:	Law Office Contact Name: (Example: Attorney or Paralegal)

Authorization to Release Medical Information: I hereby authorize my Provider to release any information necessary for my course of treatment. I certify that the above information is correct as of the date signed.

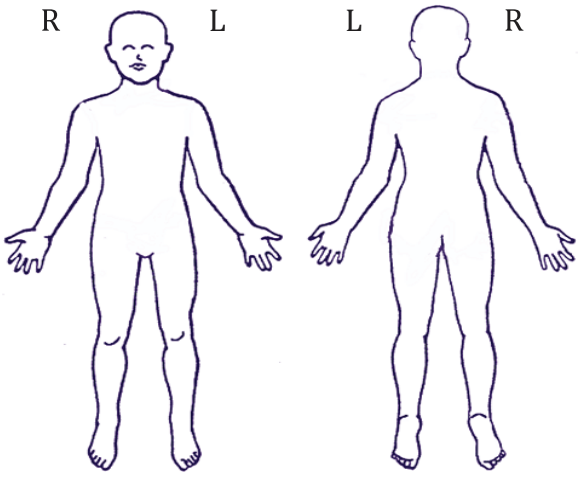
Signature _____ Date_____

Height:_____ Weight: _____

Accident/Injury

- Are you currently involved in a litigation regarding your injury? Yes/ No)
- Date of Accident/injury: _____
- Is your pain work related? Yes/No
- Workman's compensation involved? Yes/No

Circle the area of pain



Onset of pain:

Acute Sudden Gradual

Severity of Pain:

Mild Moderate Severe

Intensity of pain at best:

0 1 2 3 4 5 6 7 8 9 10

Intensity of pain at worst:

0 1 2 3 4 5 6 7 8 9 10

Intensity of pain at average:

0 1 2 3 4 5 6 7 8 9 10

Description of pain

- ○ Deep
- ○ Pins & Needles
- ○ Shooting
- ○ Cramping
- ○ Numbness
- ○ Burning
- ○ Pressure

Pain Pattern

- ○ Episodic
- ○ Persistent
- ○ Intermittent

Course of pain

- ○ Gradual
- ○ Worsening
- ○ Recurrent
- ○ No change
- ○ Gradually improving
- ○ Rapidly Improving

Duration of pain

- ○ Years, how many? _____
- ○ Months how many? _____
- ○ Weeks, how many?_____

Pain Aggravated by

- ○ Nothing
- ○ Lying down
- ○ Walking
- ○ Sneezing/Coughing
- ○ Bending/Twisting
- ○ Sitting/Standing
- ○ Bowel Movements

Pain Relieved by

- ○ Nothing
- ○ Rest
- ○ Exercise
- ○ Heat
- ○ Sitting
- ○ Physical Therapy
- ○ Ice
- ○ Change in position
- ○ Pain Medication
- ○ Standing

Daily activities impaired by

- None
- Work
- Intimacy
- Sleeping
- Exercise

Assistive Devices

- None
- Wheelchair
- Cane
- Walker

Failed treatment

- Physical Therapy
- Chiropractic
- Surgery
- Epidural Injection
- NSAID's
- Massage
- Facet Injections
- Modification of Activity

Please mark all that apply

Constitutional

- Fatigue
- Weight loss

Head

- Seasonal allergies
- Vertigo
- Hearing loss

Eyes

- Blurred vision
- Double vision
- Loss of vision
- Pain with light

Respiratory

- Shortness of breath
- Sleep apnea
- Chronic cough

Cardiovascular

- Chest pain
- Rapid heart rate
- Swelling/pain legs

Gastrointestinal

- Abdominal pain
- Constipation
- Bloody stool
- Tarry stool
- Diarrhea
- Vomiting
- Nausea

Musculoskeletal

- Joint pain
- Muscle spasm
- Back pain
- Neck pain
- Restricted motion

Psychiatric

- Depression
- Anxiety
- Mood Changes
- Panic Attacks

Skin

- Itching
- Excessive sweating
- Open Wounds
- Ulcers
- Bruising
- Rashes

Neurological

- Headaches
- Numbness
- Trouble walking
- Leg weakness
- Seizures
- Loss of bowel or bladder control

Endocrine

- Appetite change
- Thyroid problems

Hematologic/Lymph

- Nose bleeds
- Bleeds easily
- Blood clots

Throat/Neck

- Ulcers
- Swollen glands

Current Prescriptions

Medication, Dose(mg), Frequency

1._____

2._____

3._____

4._____

5._____

Allergic to any medications

_____

Are you taking any blood thinners? Yes/No

Family History:

Please specify family member

- Diabetes_____
- Cancer_____
- Alzheimer_____
- Mental Illness_____
- High blood pressure_____
- Migraines_____

Past Medical History and surgeries

1._____

2._____

3._____

4._____

5._____

Previous Imaging

- Xrays
- Bone Scan
- MRI
- CT scan

Previous evaluation

- ER visit
- Primary Doctor
- Neurology
- Urgent Care

Do you drink alcohol? Yes / No

Servings per week:_____

Do you smoke? Yes / No

How many per day or week? _____

Has anyone in your family had a history of:

- Alcohol abuse
- Drug abuse
- Prescriptions

Have you had a history of preadolescent sexual abuse?

Have you ever been diagnosed in the past with:

- Depression
- ADD
- Bipolar disorder
- Schizophrenia

ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities **("payers"),** which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future ("condition") to pay directly and exclusively in the name of **CAROLINA SPINE AND PAIN CENTERS LLC("office")** such sums as may be owing to Office for charges incurred by me at the Office relating to my condition ("charges") with such payments to be made exclusively in the name **CAROLINA SPINE AND PAIN CENTERS LLC** I further grant a lien to **Office** with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law according to South Carolina Rules of Professional Conduct Rule 1.15 (b), (d), (e), Rule 1.15 Comment 4, Ethics Advisory Opinion 94-20 and Ethics Advisory Opinion 93-14. For the purpose of this document (herein 'Assignment and Lien"), "benefits" shall include, but not limited to, proceeds from any settlement, judgement or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distribution, disability benefits, worker's compensation benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

Further, I hereby authorize **CAROLINA SPINE AND PAIN CENTERS LLC,** to file my claim with my health insurance. I understand, however, that in the event that my charges are submitted in their full amount to any other form of insurance (e.g., liability, medpay, etc.), I hereby authorize and direct **CAROLINA SPINE AND PAIN CENTERS LLC** to collect any and all write-offs or discounts, issued by my health insurance, out of the proceeds from the other insurances. This authorization cannot be revoked without the express written consent of **CAROLINA SPINE AND PAIN CENTERS LLC**.

In the event that I retain one or more attorneys to represent me in this matter who are not located in South Carolina, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the express written consent of the office.

I authorize this office to release any information regarding my treatment or pertinent to my cases(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers and/or any attorneys that I may hire to release to Office any information regarding any coverage or benefits which I may have or may be available to me including , but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims, **including but not limited to all information pertinent to obtaining coverage details such as a police report, insurance card, etc.** I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers, including, but not limited to, group health insurance, medpay, liability and/or workers compensation. I further authorize Office to apply any credit balances on charges are related to my condition.

I understand that I remain personally responsible for the total amount due to Office for their services. This Assignment and Lien does not constitute consideration for this office to wait for payment and it may demand payments from me immediately upon rendering services as its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees. This Assignment and Lien shall not be modified or revoked without the mutual written consent of Office and myself or my attorney. I hereby revoke any previously signed authorizations, whether executed in this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement and Lien.

Patient Name (please print) _____ Date _____

Patient Signature (Seal) _____ Date _____

Name of Custodial Parent or Legal Guardian (please print) _____

Parent/Guardian's Signature _____ Date _____