SALT LAKE SPINE & SPORTS MEDICINE

Account # _____ EMG

Patient Information

Patient's Legal Last Name	**Patient's Legal First Name**	**Patient's Legal Middle Name**

Patient's Mailing Address - Street Apt. P.O. Box	**City**	**State**	**Zip**

Race:	Ethnicity: ☐Not Hispanic or Latin ☐Hispanic or Latin	Primary Language:

Sex: ☐M ☐F	Date of Birth: (MM/DD/YYYY)	Age:	Social Security No.	Home Phone #: Cell Phone #:

Patient's Email Address: (Optional)	
Patient's Employer	Patient's Work Number

Emergency Contact	Emergency Contact's Number	Relationship to Patient

Marital Status: ☐Single ☐Married ☐Other ☐Parent	Spouse's Name	Spouse's Contact Number

Full Name of Primary Care Doctor:	Full Name of Referring Doctor:
Preferred Pharmacy	Pharmacy Phone #

☐ **Private Pay/No Insurance**

Private Insurance Information

(If not filled out completely, we are unable to bill your insurance. Your insurance card does not have all the information we need)

Primary Insurance Carrier			**Secondary Insurance Carrier**		
Primary Insurance Name	Plan Name	Telephone	Secondary Insurance Name	Plan Name	Telephone
Address			Address		
Policy Holder's Name on Card	Relationship to Patient		**Policy Holder's Name on Card**	Relationship to Patient	
Policy Holder's Date of Birth	Policy Holder's Telephone		**Policy Holder's Date of Birth**	Policy Holder's Telephone	
Group Number	Policy Number		Group Number	Policy Number	
Policy Holder's Employer and Telephone Number			Policy Holder's Employer and Telephone Number		

Auto/Industrial Insurance Information (fill out only if being seen as part of an auto claim)

Insurance Company Name	Date of Injury: (MM/DD/YY)	Industrial? ☐Yes ☐No	Auto? ☐Yes ☐No

Address – Street City State Zip	Adjuster's Name	Adjuster's Telephone

Employer at time of injury:	Employer Address Street, City, State, Zip	Employer Telephone
Claim Number:	Attorney Name (If you have one):	Attorney Telephone:

Please continue to the next page.

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Name _____ Date _____

Release of Information

The law requires us to make and keep records of each patient's medical treatment. We safeguard those records and their uses and disclose such records and the information they contain only in accordance with state and federal privacy laws.
I authorize this facility to release to my insurance company and all parties involved in my treatment any information concerning the diagnosis, treatment plan, professional opinion, and medical or surgical procedure(s) performed, as well as information contained on this form.
I also authorize any physician, medical practitioner, hospital, or any other medically related facility to release to this facility any and all information regarding my medical history to include: medical, hospital, and other facility records; as well as x-rays, scans, laboratory reports, and any other related testing results.

I have read "Release of Information" disclosure and, as the patient, or the patient's authorized representative for the purpose of signing this document, I accept these terms.

Date _____ Signature _____

Financial Responsibility

GENERAL: I understand that I am responsible for the payment of all charges incurred in connection with my treatment at Salt Lake Spine and Sports Medicine and I agree to make full payment for such charges known to not be covered by insurance. These are due in full at the time of service. I certify that the information I have provided is correct. Please note that liens on settlements are not an acceptable payment arrangement with Salt Lake Spine & Sports Medicine.
ASSIGNMENT OF BENEFITS: I hereby assign and transfer to this facility all insurance benefits payable to me by my insurance company(s), as listed on the face of this form, or which may change from time to time, for services and costs incurred in connection with my treatment. I understand that this assignment of benefits shall be exclusively for my insurance company(s) and Salt Lake Spine & Sports Medicine and/or its associated doctors.
MEDICARE/MEDICAIDE/TRICARE CERTIFICATION AND ASSIGNMENT: I certify that the information given by me in applying for payment for Medicare, Medicaid, and Tri-Care benefits or any other government program is correct. I authorize any holder of medical or other information about me to release to the Tri-Care administrator, Social Security Administration or its intermediaries, or other carriers or program administrators, to the State or any other government payer, any information needed to substantiate and process a claim for payment for this or any facility for its charges or those of its associated physicians.
OTHER AGREEMENTS: I understand that I will be responsible for any deductibles, co-insurance, or other amounts not paid by my insurance company(s). Balances remaining after insurance benefits have been paid should be paid within 30 days. I further agree to pay a service charge of $30.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union. I further agree to pay an additional 33% of my balance plus all costs and expenses including attorney's fees that are incurred in the collection of such checks or outstanding balances.

I have read the "Financial Arrangements" disclosure and, as the patient, or the patient's authorized representative for the purpose of signing this document, I accept these terms.

Date _____ Signature _____

Salt Lake Spine and Sports Medicine

5770 South 250 East Suite 235
Murray, Utah 84107
801-314-5115

Brent Bowen, M.D.P.C. Richard W. Hurst, M.D.
Stephen M. Clements, M.P.A.S., P.A.-C.

No Show and Cancellation Agreement

There is an increasing number of patients who do not come to their scheduled appointments and do not cancel with reasonable notice. This is obviously disruptive of our work and it reduces the number of patients we can assist.

Consequently, we have established a NO Show/Cancellation Policy: *If you are not able to keep a scheduled appointment, we ask that you call and give us at least 24 hour's notice.*

If you do not come to your appointment, or do not give us sufficient notice, you will be assessed a $30 charge. This charge must be paid prior to your next visit before your doctor or P.A. will see you.

If you have some extenuating circumstances that make it impossible for you to come to your appointment, or to give us notice of your cancellation, please let the staff know of your situation and we will reconsider assessing the "NO Show" charge.

Patient Name: _____ Date: _____

_____ Account: _____
Patient Signature

Please continue to the next page.

Salt Lake Spine and Sports Medicine

5770 South 250 East, Suite 235
Murray, UT 84107
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Authorization to Release Patient Information to Family Members

Patient Name: _____

Account Number: _____

For Doctor: _____

For my benefit and convenience, I hereby authorize the doctor named above, or members of the staff, to release to the following member(s) of my family any medical information regarding my care at the Salt Lake Spine and Sports Medicine. This release of information must be in person with proof of identification.

Authorized Family Member(s):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth:_____

Name: _____ Date of Birth: _____

I understand that the doctor or his staff will make a good-faith effort to assure themselves that they are releasing such information to individual(s) named above, and I release the doctor and his staff from any claim of negligence or HIPAA violation for doing so.

_____ Date: _____

Patient Signature

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Name: _____Date: _____

Birthdate: _____Age: _____ Gender: ☐M ☐F Height: _____ Weight: _____

Dominant Hand: ☐ Right ☐Left

Significant medical conditions:

☐Diabetes ☐Heart Disease ☐High blood pressure ☐Stomach Ulcers

☐Cancer ☐Asthma ☐ Other:_____

Past surgeries? _____

_____

Do you have any known Drug Allergies?_____

Medications – Please list any current medications you are taking:

_____

_____

_____

Do you smoke cigarettes or chew tobacco?☐Yes ☐No If yes, how many per day? _____

Do you drink alcoholic beverages? ☐Yes ☐No If yes, how often? _____

What is the primary pain you are experiencing:

Neck _____ (right, middle, left) Low Back _____ (right, middle, left)

Arm/Wrist _____ (right, left) Leg ____ (right, left)

When did this pain first begin? _____

Is this the result of an injury at ☐Work ☐School ☐Sports ☐Motor Vehicle ☐Unrelated

Is there or will there be legal action? ☐Yes ☐No

Is there a Workers Compensation claim pending or active? ☐Yes ☐No

Will you, or have you hired a personal attorney? ☐Yes ☐No ☐Undecided

CURRENT STATUS

Do you have weakness in the involved limb that is painful? ☐Yes ☐No

Is your pain: ☐Continuous ☐Intermittent

Does your pain travel, or shoot from one area to another area? ☐Yes ☐No

Does your pain alternate from one side of your body to the other side of your body? ☐ Yes ☐No

Do you have any tingling or numbness that occurs anywhere in your body? ☐ Yes ☐No

If so, where is it? _____

If you do have this area of tingling or numbness, is it: ☐ Continuous ☐Intermittent

Please continue to the next page.

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What is your pain like today? (none) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (severe)

Since your pain first started, is it getting: ☐Better ☐Worse ☐Stays the same

By how much? ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Have you had any of these symptoms as part of your current symptoms?

☐Yes ☐No	Weakness	☐Yes ☐No	Loss of control of your bladder or bowel
☐Yes ☐No	Fever or chills	☐Yes ☐No	Rash
☐Yes ☐No	Swelling or fluid on the joint	☐Yes ☐No	Numbness or tingling
☐Yes ☐No	Weight loss	☐Yes ☐No	Difficulty sleeping

☐Yes ☐No Giveway of your leg, falling down because of pain, locking of your joint

MOTHER:	☐Diabetes	☐Heart Disease	☐High Blood Pressure	☐Stomach Ulcers
	☐Cancer	☐Asthma	☐Other _____	
FATHER:	☐Diabetes	☐Heart Disease	☐High Blood Pressure	☐Stomach Ulcers
	☐Cancer	☐Asthma	☐Other _____	
SIBLINGS:	☐Diabetes	☐Heart Disease	☐High Blood Pressure	☐Stomach Ulcers
	☐Cancer	☐Asthma	☐Other _____	

Please continue to the diagram on the next page.

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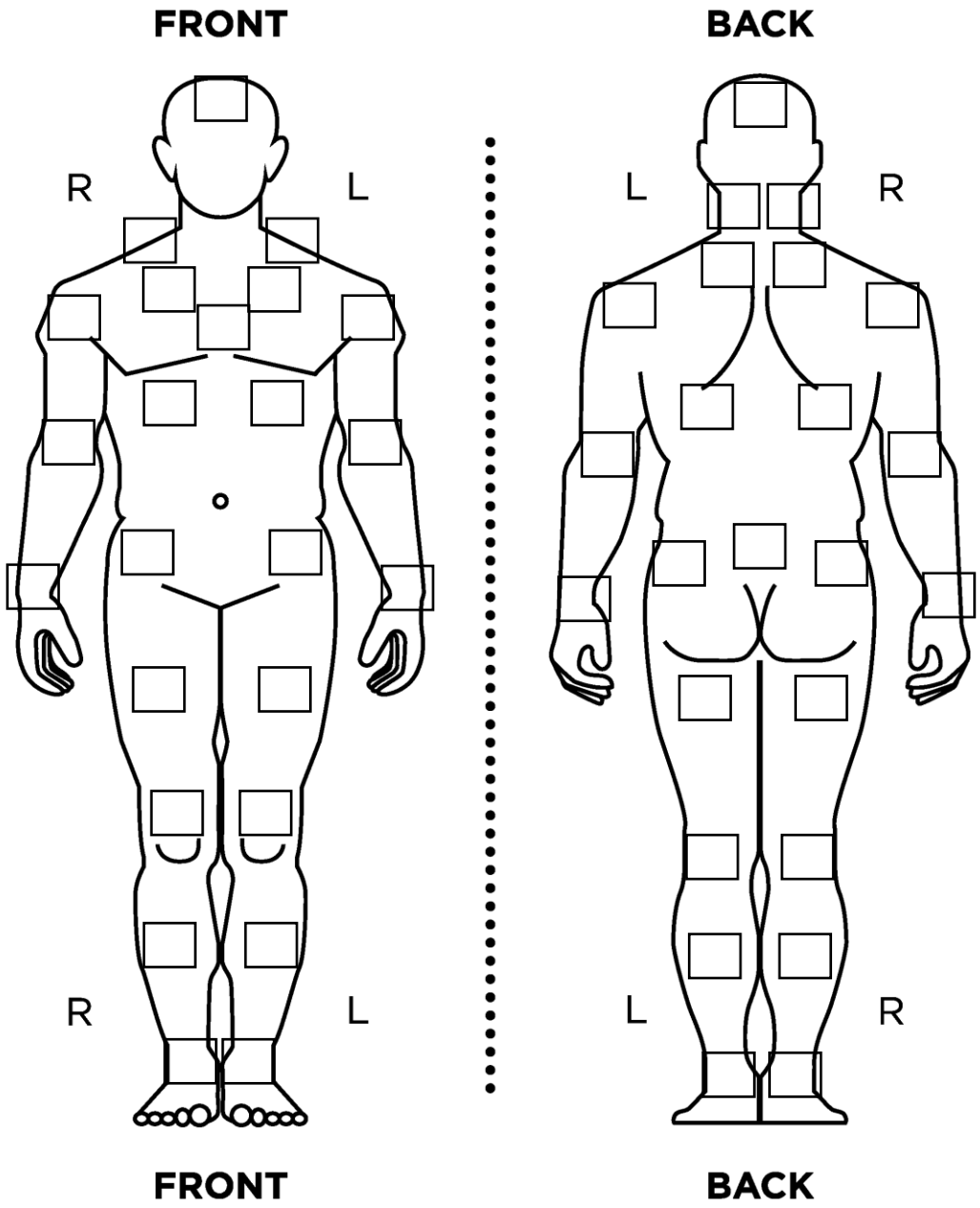
Using these symbols, use the diagram to mark where you feel your pain.

">>>>" for aching pain "XXXX" for burning pain
"////" for stabbing pain "OOOO" for numbness/tingling
"SSSS" for other. Describe other: _____

_____



Please submit this completed form by clicking "submit by email."
You may also print them for your own records.

Thank You