# TIER ORTHOPEDICS SPINE PATIENT INFORMATION PACKET

We know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you the best medical care possible.

Please help us and you, by taking the time required to answer the questions accurately.
Thank you for your cooperation!

Please print

Patient name: ______________________________________________ Date: ____________

Date of birth: ______________________________ Age: _________ Gender: Male Female

Height: __________________ Weight: ________________

Allergies: ______________________________________________________________

Primary Care Doctor: ____________________________________________________

Which is your dominant hand? RIGHT HANDED LEFT HANDED

Current Occupation? __________________________________________________________

Please indicate your current work status (circle one answer):

- Working full time
- Working part time
- Seeking employment
- Not working by choice (homemaker, retired, student, etc.)
- Physically unable to work due to back/neck problem
- Physically unable to work *not* due to back/neck problem

Is your spine problem the result of an on the job injury (worker's compensation)? YES NO

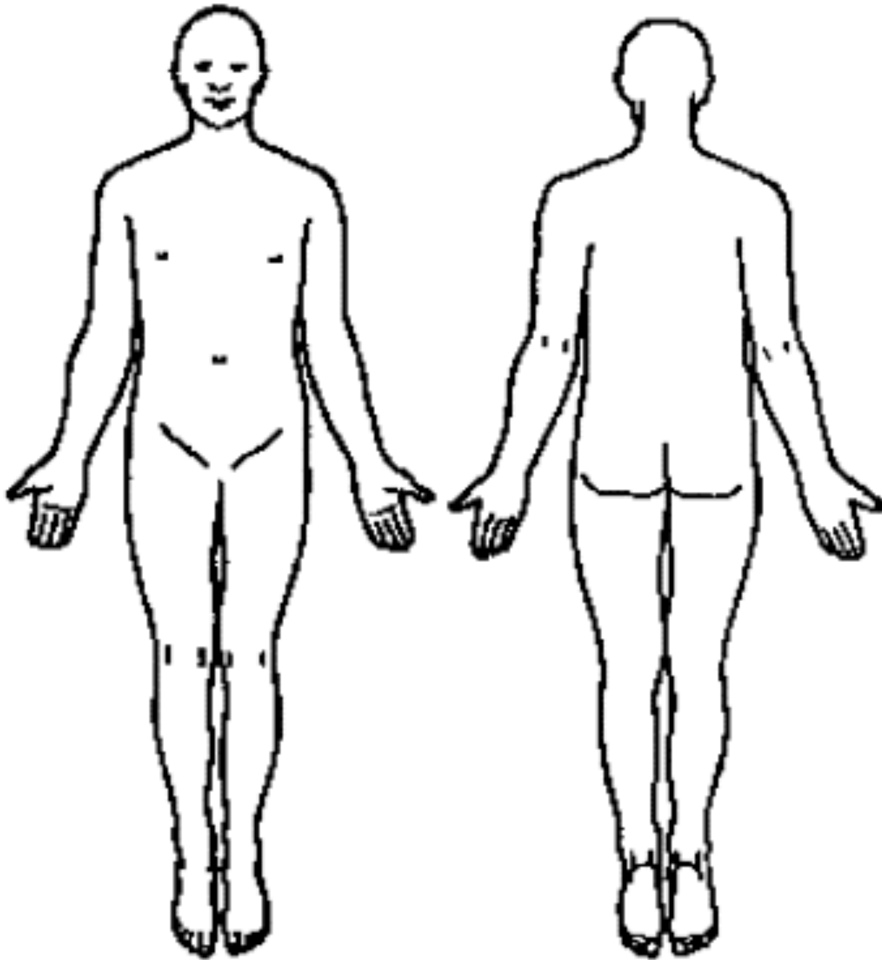
Is your spine problem the result of a Motor Vehicle Accident? YES NO

# PAIN DIAGRAM

Please mark the areas where you experience the following sensations:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | ^^^ | | 000 | | = = = | | XXX | | /// |
| Ache | ^^^ | Numbness | 000 | Pins & | = = = | Burning | XXX | Stabbing | /// |
| | ^^^ | | 000 | Needles | = = = | | XXX | | /// |

FRONT BACK



RIGHT LEFT LEFT RIGHT

# FACTORS OF COMPLAINT

What do you want to happen as a result of this visit? ____________________________________________
______________________________________________________________________________________

**How and when did your problem begin** (please mark each answer that applies to you back/neck pain):

☐ I don't know how it began

☐ It comes and goes

☐ I've had it a long time (about _____ years)

☐ Injury (date of injury: _____________ )

☐ On the job injury (date: ___________ Place of employment: _________________________________ )

Explain how the injury happened: ______________________________________________________

**How bad is your pain?** Place an "X" (----X----) on each of the lines below to indicate your current pain.

**Low back**?

No pain ------------------------------------------------------------------ Worst possible

**Leg**?

No pain ------------------------------------------------------------------ Worst possible

**Middle back**?

No pain ------------------------------------------------------------------ Worst possible

**Neck**?

No pain ------------------------------------------------------------------ Worst possible

**Arm**?

No pain ------------------------------------------------------------------ Worst possible

**Do you have the following problems? Please circle an answer for each question.**

| | | | |
|---|---|---|---|
| Weakness | arms/hands | legs/feet | none |
| Numbness (loss of feeling) | arms/hands | legs/feet | none |
| Tingling (falling asleep) | arms/hands | legs/feet | none |
| Does coughing effect your pain? | Yes | No | |
| Does you pain awaken you from sleep? | Yes | No | |

Do your legs tire/hurt if you walk too far? Yes No

*If yes*, *answer the following*:

| | | | |
|---|---|---|---|
| How far can you walk? | Less than 1 block | 1-3 blocks | More than 3 blocks |
| Is this relieved by resting your legs? | Yes | No | |
| Is this relieved by bending forward? | Yes | No | |

| | | | |
|---|---|---|---|
| Bladder control (urine): | No problem | Can't empty bladder | Loss of urine (accidents) |
| Bowel control: | No problem | Constipation | Loss of control (accidents) |

**How does each of the following affect your pain? Please circle your answer.**

| | | | | |
|---|---|---|---|---|
| Sitting | Better | Worse | No Change | |
| Standing | Better | Worse | No Change | |
| Walking | Better | Worse | No Change | |
| Lying Down | Better | Worse | No Change | |
| Rising from a chair | Better | Worse | No Change | |
| Heat | Better | Worse | No Change | Haven't tried |
| Cold | Better | Worse | No Change | Haven't tried |
| Massage | Better | Worse | No Change | Haven't tried |
| Physical activity | Better | Worse | No Change | Haven't tried |

**Have you had any of the following tests?**

| | | | |
|---|---|---|---|
| X-rays | Yes | No | Date:________________________ |
| MRI scan | Yes | No | Date:________________________ |
| CT scan | Yes | No | Date:________________________ |
| Myelogram | Yes | No | Date:________________________ |
| Discogram | Yes | No | Date:________________________ |
| Nerve test (EMG) | Yes | No | Date:________________________ |

**Have you had any of the following treatments for you current back/neck pain? Please circle.**

| | | | |
|---|---|---|---|
| Physical therapy | Yes | No | Date of last treatment: _______________ |
| Chiropractic care | Yes | No | Date of last treatment: _______________ |
| Osteopathic manipulation | Yes | No | Date of last treatment: _______________ |
| Pain management | Yes | No | Date of last treatment: _______________ |
| Psychological consultation | Yes | No | Date of last treatment: _______________ |
| Spinal injections | Yes | No | Date of last treatment: _______________ |

Do you know what type of injection? ________________________________________

Previous spine surgery Yes No

If so, When was your surgery or surgeries? ____________________________________

What surgery was performed? ___________________________________________

Who was your surgeon? ________________________________________________

Did it help your pain? _________________________________________________

If so, for how long? ___________________________________________________

## MEDICATIONS

**Please list the medications and doses that you regularly take** (include over the counter medications).

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

# GENERAL MEDICAL HISTORY

Circle all the conditions below that you have been diagnosed with.

Heart attack
Heart murmur
Angina
High blood pressure
Stroke
Varicose veins
Stomach ulcer
Duodenal problems
Colon problems
Diabetes
Hepatitis
Cirrhosis
Kidney stones
Kidney infection

Degenerative arthritis
Rheumatoid arthritis
Gout
Anxiety
Depression
Emphysema
Tuberculosis
Chronic bronchitis
Frequent pneumonia
Asthma
Anemia (low blood count)
Bleeding tendency
Sexual difficulty
Enlarged prostate
Menstrual problems

Cancer, type? ________________________________________________ Currently active? Yes No
Other diagnosis not listed above: ___________________________________________________________

**List any major surgery that you have had, <u>other than</u> on your back or neck.**

| Type of surgery | Year |
|---|---|
| 1.______________________________________________ | _____________ |
| 2.______________________________________________ | _____________ |
| 3.______________________________________________ | _____________ |
| 4.______________________________________________ | _____________ |
| 5.______________________________________________ | _____________ |

# FAMILY MEDICAL HISTORY

\□ I do not know the medical history of my biological parents or other family members.

**Mother:** □ She is alive and is _____ yrs old
□ She is in good health
□ She suffers with ___________________
□ She is deceased, cause ______________

**Father:** □ He is alive and is _____ yrs old
□ He is in good health
□ He suffers with ___________________
□ He is deceased, cause ______________

I have ____ living brothers/sisters
I have ____ deceased brothers/sisters, cause(s) __________________________________________________
Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following: (Circle)

Stroke Back problems Arthritis Diabetes Lung disease Osteoporosis
Scoliosis Heart trouble Cancer High blood pressure
None of these

# PERSONAL AND SOCIAL HISTORY

**Marital Status** (circle one answer)

Married/Domestic Partner Single Separated Divorced Widow/Widower

**Habits** (circle)

Do you, or have you ever smoked? Yes No If yes, complete the following:

I smoke __________ packs per day and I have smoked for ______ years

I did smoke _______ packs per day, but I quit smoking _________ years ago

Do you us any smokeless tobacco products? Yes No

How often do you drink alcohol?

| | | | | | |
|---|---|---|---|---|---|
| **Beer** | Daily | Often | Socially | Rarely | Never |
| **Wine** | Daily | Often | Socially | Rarely | Never |
| **Liquor** | Daily | Often | Socially | Rarely | Never |

Do you use recreational/street drugs? Yes No

If so, what? ____________________________________________________________

**Education** (Circle the highest level of education that you have completed)

Grammar school High school College Post-graduate

**Effect of you back/neck pain on your lifestyle** (circle)

| | | |
|---|---|---|
| Has your pain affected your ability to do you job or get a job? | Yes | No |
| Do you like your work situation? | Yes | No |
| Have you been laid off from your job? | Yes | No |
| My pain has affected my interaction with my family and friends | Yes | No |
| Are you currently involved in a law suit with regards to your back pain? | Yes | No |

What is your ability to enjoy life? Excellent Very Good Good Fair Poor

Is there anything that we have failed to ask that you believe is important for us to know? ________________

______________________________________________________________________________________

# REVIEW OF SYSTEMS

Do you have any of the following? Please circle Yes or No for *each* item.

**General**

| | | |
|---|---|---|
| Recent unintentional weight loss of more than 10 pounds | Yes | No |
| Recent weight gain of more than 10 pounds | Yes | No |
| Seen by primary care physician in the last year | Yes | No |
| Fever | Yes | No |
| Chills | Yes | No |
| Night sweats | Yes | No |
| Decreased energy level | Yes | No |
| Decreased appetite | Yes | No |

**Cardiac**

| | | |
|---|---|---|
| Chest Pain | Yes | No |
| Shortness of breath | Yes | No |

**Respiratory**

| | | |
|---|---|---|
| Wheezing | Yes | No |
| Chronic cough | Yes | No |
| Pneumonia | Yes | No |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal pain | Yes | No |
| Nausea | Yes | No |
| Vomiting | Yes | No |
| Diarrhea | Yes | No |
| Liver problems | Yes | No |

**Skin**

| | | |
|---|---|---|
| Open sores | Yes | No |
| New moles | Yes | No |
| Poor healing | Yes | No |
| Skin infection | Yes | No |

**Hematologic/Oncologic**

| | | |
|---|---|---|
| Easy bruising | Yes | No |
| Blood thinning medications | Yes | No |
| Blood transfusion | Yes | No |
| Organ transplant | Yes | No |

**Bones/ Joints**

| | | |
|---|---|---|
| Shoulder pain | Yes | No |
| Wrist/hand pain | Yes | No |
| Hip pain | Yes | No |
| Knee pain | Yes | No |
| Lupus | Yes | No |
| Muscle weakness | Yes | No |
| Fibromyalgia | Yes | No |

**Genitourinary**

| | | |
|---|---|---|
| Abnormal kidney function | Yes | No |
| Pain with urination | Yes | No |
| Frequent urinary infections | Yes | No |

**Mental Health**

| | | |
|---|---|---|
| Sleep disturbance | Yes | No |
| Feeling of hopelessness | Yes | No |

**Nervous System**

| | | |
|---|---|---|
| Headaches | Yes | No |
| Tremors | Yes | No |
| Poor speech | Yes | No |
| Changes in vision | Yes | No |

**Endocrine**

| | | |
|---|---|---|
| Thyroid problems | Yes | No |
| Diabetes | Yes | No |

**Tier Orthopedic Associates, PC**
**240 Riverside Drive**
**Johnson City, NY 13790**
**607-798-9356**

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes, treatment, payment and health care operations.

- **Treatment**: means providing, coordinating, or managing health care and related services by one or more health care providers.

- **Payment**: means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

- **Health care operations**: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information , including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office by speaking with our Privacy Official or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.

I Understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Tier Orthopedic Associates, P.C. has the right to change the Notice of Privacy Practices from time to time and that I may contact Tier Orthopedic Associates, P.C. at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

**I do herby acknowledge that I have received a copy of the Notice of Privacy Practice.**

Patient Name: ______________________________________ Date: _______________

Signature of Patient or Legal Guardian:________________________________________

Relationship to patient: ____________________________________________________

-----------------------------------------------------------------------------------------------------------

OFFICE USE ONLY

I attempted to obtain the patient's signature and acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Reason: ______________________________________________________________

Signature: ___________________________________________Date: ______________

## TIER ORTHOPEDIC ASSOCIATES, P.C.

240 Riverside Drive Johnson City, NY 13790

Telephone 798-9356

Social Security No. ____________________

### PATIENT INFORMATION

PATIENT NAME:

First Name ______________________ Middle Initial ________

Last Name ______________________

Patient's Address ______________________

City ______________________ Zip Code ______________________

Phone No. ____________ Age ______ Date of Birth ____________

Sex: Male ______________ Female ______________

Primary Care Physician/Referring Physician:

______________________

Patient's Employer ______________________

Work Phone ______________________

Spouse's Name or Nearest Relative ______________________

Address ______________________

Phone No. ______________________

Employed by ______________________

IF CHILD:

Parent's Name ______________________

Employed by ______________________

WHAT ARE YOU BEING SEEN FOR?

Right ______ Left ______ Body Part ______________________

WERE X-RAYS TAKEN? Yes __ No __ Where __________ When ______

WERE MRI'S TAKEN? Yes __ No __ Where __________ When ______

WAS EMG DONE? Yes __ No __ Where __________ When ______

INSURANCE INFORMATION:

WERE YOU INJURED AT WORK?

Yes __ No __ Date of injury ______________

Comp Carrier ______________________

WERE YOU INJURED IN AN AUTO ACCIDENT?

Yes __ No __ Date or Accident ______________

PRIMARY INSURANCE CO. ______________

ID No. ______________________

Subscriber ______________________

SECONDARY INSURANCE CO. ______________

ID No. ______________________

Subscriber ______________________

| OFFICE USE ONLY |
| --- |
| DOCTOR ______________________ |
| DATE SEEN ______________________ |
| Initial ______________________ |

### MEDICAL INSURANCE WAIVER

**I, THE UNDERSIGNED, AGREE TO THE PROVISION THAT IF MY MEDICAL INSURANCE DOES NOT COVER ANY AND ALL EXPENSES INCURRED DURING THE COURSE OF MY MEDICAL TREATMENT, I AM RESPONSIBLE FOR SAID PAYMENTS.**

______________________

**PATIENT OR GUARDIAN SIGNATURE**

**DATE** ______________

Payment Authorization to Provider ______________________

| **FOR OFFICE USE ONLY** | Account No. | X-Ray No. |
| --- | --- | --- |

*TIER ORTHOPEDIC ASSOCIATES, P.C. 240 Riverside Drive Johnson City, NY 13790 Phone 607-798-9356*

## *PATIENT/FAMILY MEDICAL HISTORY*

**Date** **Birthdate** **Age** **SSN**

**Name** **Male** **Female**

**Address** **Telephone**

**Occupation**

**Primary Care Physician/Referring Physician**

**Were x-rays brought with you?** **Where taken?**

**Nearest Relative** **Relationship** **Phone**

### *CHIEF COMPLAINT*

**Why are you seeing the doctor today?** ______________________

**Current problem is the result of a(n): Please check all that apply:**

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

| Medication | Dose | Reason for Medication | Medication | Dose | Reason for Medication |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**ALLERGIC TO:**

☐ Antibiotics, what: ______________________

☐ Aspirin ☐ Codine ☐ Other ______________________

**Are all immunizations up to date?** ☐ Yes ☐ No

**If no, which immunizations are due?** ______________________

### *REVIEW OF SYSTEMS*

**Are you currently having or have you had problems with your:**

| | Circle | | Describe all "Yes" responses |
|---|---|---|---|
| Eyes | No | Yes | |
| Ears, Nose, Throat | No | Yes | |
| Lungs, Breathing | No | Yes | |
| Chest Pain, Heart Problems | No | Yes | |
| Digestion | No | Yes | |
| Bowel movement | No | Yes | |
| Bladder problem | No | Yes | |
| Diabetes | No | Yes | |
| High blood pressure | No | Yes | |
| Bleeding problems | No | Yes | |
| Balance problems | No | Yes | |
| Numbness/tingling | No | Yes | |
| Blackout/fainting/seizure | No | Yes | |
| Psychological Problems | No | Yes | |
| AIDS | No | Yes | |
| Cancer | No | Yes | |
| Arthritis | No | Yes | |
| Polio | No | Yes | |
| TB | No | Yes | |
| Epilepsy | No | Yes | |
| Liver | No | Yes | |
| Hepatitis | No | Yes | |
| Kidney | No | Yes | |

** PLEASE SEE OTHER SIDE **

*PAST MEDICAL HISTORY*

| Surgeries/Hospitalizations | Year | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Have you ever had general anesthesia? ☐ NO ☐ YES

Have any problems with anesthesia? ☐ NO ☐ YES

Describe: ____________________________________

*FAMILY HISTORY (IMMEDIATE FAMILY ONLY):*

| Member | Alive | Deceased | Age | Health status or cause of death |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Do any diseases run in your family-Describe:

| |
|---|
| |

*SOCIAL HISTORY*

☐ Work in the home ☐Employed (occupation ______________________________ ) ☐ Student ☐ Daycare ☐ Retired

☐ Employed (occupation______________________________) Currently Working ☐ Yes ☐ No

Regular Duty ☐ Yes ☐ No Restricted Duty ☐ Yes ☐ No If Yes, please state restrictions ____________________

Who took you out of work or put you on light duty? ____________________

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes # ______________________________

Do you live alone? ☐No ☐ Yes

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise? ____________________________________________

History of substance abuse? ☐ No ☐ Yes What?

____________________________________________

Smoke currently? ☐ No ☐ Yes _______ Packs per day for _______ years.

Quit smoking? ☐ This year ☐ > 1 year ☐ > 5 years ☐ > 10 years Height:__________ Weight __________

Previously smoked _______ packs per day for _______ years.

Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

**INSURANCE MEDICAL RELEASE/ASSIGNMENT:**

I hereby authorize release of medical information necessary to process my insurance claim, and I also hereby authorize payment directly to the physician for benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization.

*Patient Signature:*______________________________ *Date:* ____________________

*Reviewed by:* ______________________________ *, M.D.* *Date:* ____________________

**TIER ORTHOPEDIC ASSOCIATES**
**240 RIVERSIDE DRIVE**
**JOHNSON CITY, NY 13790**

## Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

PATIENT NAME: ________________________________ DOB: ______

| Leave appointment and billing messages on/with: | | | Leave medical information messages on/with: | | |
|---|---|---|---|---|---|
| On Home Phone (Include Auto Call)? | ___ Yes | ___No | On Home Phone (Include Auto Call)? | ___ Yes | ___ No |
| On Cell Phone (Include Auto Call)? | ___ Yes | ___No | On Cell Phone (Include Auto Call)? | ___ Yes | ___ No |
| Mobile Text (Include Auto Call)? | ___ Yes | ___No | Mobile Text (Include Auto Call)? | ___ Yes | ___ No |
| On Office Voice Mail? | ___ Yes | ___No | On Office Voice Mail? | ___ Yes | ___ No |
| w/ Another Person? | ___ Yes | ___No | w/ Another Person? | ___ Yes | ___ No |
| Send via mail? | ___ Yes | ___No | Send via mail? | ___ Yes | ___ No |
| Send via e-mail/Portal? | ___ Yes | ___No | Send via e-mail/Portal? | ___ Yes | ___ No |

If you answered YES to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name: Relationship: Phone: Cell Phone:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Additional HIPAA Contact instructions:

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: ______________________________________

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP: _______________________ DATE:___________

*This authorization will expire one year from the date of signature, unless otherwise notified.*

# Notice to all Tier Orthopedic Patients

Tier Orthopedic Associates' professional staff is comprised of physicians, physician assistants, and nurse practitioners.

Physician assistants and nurse practitioners, also known as physician extenders or mid-level practitioners, are highly trained and skilled orthopedic providers.

***This notice is to inform patients that they may be seen, at the discretion of a physician, by physician extenders during the course of their treatment at Tier Orthopedics.***

All treatments administered by physician extenders are supervised and reviewed by physicians at Tier Orthopedics.

By signing below, I acknowledge that my treatment at Tier Orthopedics may be administered in part or entirely by a physician extender.

The decision of physicians to assign patients to physician extenders will apply to all patients, including those choosing to not sign this notice.

______________________________ ______________

Patient Signature Date