

Patient Name: _____ Date ____/____/____

Age _____ Birthday _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS

Check () symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of Sleep
- Loss of Weight
- Nervousness
- Sweats

EYES

- Crossed eyes
- Double vision
- Vision - Flashes
- Vision - Halos
- Blurred vision

EARS/NOSE/THROAT

- Earache
- Ear Discharge
- Ringing in ears
- Loss of hearing
- Hay fever
- Sinus problem
- Nose bleeds
- Bleeding gums
- Hoarseness
- Difficulty swallowing
- Persistent cough

RESPIRATORY

- Shortness of breath
- Cough Congestion
- Distress Sputum

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

ENDOCRINE

- Weight gain
- Wight loss
- Hoarseness
- Heat Intolerance
- Cold Intolerance
- Breast Changes
- Hair C hanges
- Extreme Thirst

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting no blood
- Vomiting bleeding

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lumps
- Extreme menstrual pain
- Hot flashes
- Nipples discharge
- Painful intercourse
- Vaginal discharge
- Other _____
- Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

MEN only

- Breast lumps
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

INTEGUMENTARY

- Bruise easy
- Hives
- Change in moles
- Sores that wont heal
- Itching
- unusual swelling
- sores/ulcers
- Rash
- Scars

NEUROLOGICAL

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensations
- Loss of facial epression
- Weak Grip
- Paralysis
- Difficulty of Speech
- Tingling
- Loss of Memory
- Numbness
- Un-coordination

MUSCLE/JOINT/BONE

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

PSYCHIATRIC

- Hyperventilation
- Insecurity
- Depression
- Trouble Sleeping
- Irritable
- Anxiousness
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependency
- Extreme Worry
- Sexual Problems
- Suicidal Thoughts

CONDITIONS

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Asthma
- Bleeding Disorders
- Breast Lumps
- Bronchitis
- Breath shortness
- Buliemia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- Other _____

MEDICATIONS

List medications you are currently taking, and dosages

ALLERGIES to medications or substances

Patient Signature _____
(or guardian)

Date ____/____/____



PATIENT INFORMATION FORM

Your patience and cooperation in supplying us with complete and accurate information is very much appreciated. We rely on this data in the event that we need to contact you regarding laboratory reports, prescription information and various other medical necessities that may occur. Please notify the Front Desk Receptionist if you require assistance in completing this form. Language Spoken:

Appointment with Dr. _____ on ____/____/____ Translator Necessary Yes No

Last Name		First		Middle initial / Maiden Name		Date of Birth		Sex Male <input type="checkbox"/> Female <input type="checkbox"/>		Home Phone # ()	
Mailing Address						Apt. / Lot		City		State/Zip	
Alternate Mailing Address						Apt. / Lot		City		State/Zip	
Material Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single		Widowed Separated		Mother's Name (If Minor Patient)				Father's Name (If Minor Patient)			
Occupation of Patient				Employer/Company Name				Employer Address			
Spouse's Name				Spouses Social Security#		Spouses Employer		Spouses Employer Address			
Allergies:						Do You Drink? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do You Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No		

INSURANCE INFORMATION

INSURANCE INFORMATION *Please write information about the patient's insurance here*

Primary Insurance Company Name				Secondary Insurance Company Name											
Insurance Company Address				Insurance Company Address											
City		State		Zip		City		State		Zip					
Insurance ID Number				Group Plan Number				Insurance ID Number				Group Plan Number			

POLICYHOLDER INFORMATION

(Complete the information below if the PATIENT is NOT the POLICYHOLDER)

*Is the secondary policyholder the: Patient Primary Policyholder Other
(Complete the information below if you checked "Other")*

Primary Policyholder's Name (Last, First, Middle Initial)				Date of Birth				Secondary Policyholder's Name (Last, First, Middle Initial)				Date of Birth			
Primary Policyholder's Address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Secondary Policyholder's Address				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female					
City		State		Zip		Telephone ()		City		State		Zip		Telephone ()	
Employer's Name or School Name				Telephone				Employers Name or Schools Name				Telephone ()			
Employer's Address				City				Employer's Address				City			
City		State		Zip		Social Security Number		Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		City		State		Zip	
Employer Plan Coverage				If Champus; <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled				Employer Plan Coverage				If Champus; <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled			
<input type="checkbox"/> Yes <input type="checkbox"/> No				Branch of Service _____				<input type="checkbox"/> Yes <input type="checkbox"/> No				Branch of Service _____			

GUARANTOR INFORMATION

Head of Household/Custodial Parent of Minor Child				Relationship to Patient				Guarantor's Social Security #							
Mailing Address				Apt/Lot		City				State/Zip		Gua rantor's Phone # ()			
Guarantor Employer				Employer's Address				City				State/Zip		Employer's Phone # ()	
Guarantor's Occupation				Drivers License #				Person Completing Form/Relationship to Patient							

(Please complete reverse side)

INSURANCE ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **SpinalAid** to release any information acquired in the course of my medical examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claim.

AUTHORIZATION TO PAY BENEFITS:

I hereby authorize my insurance carrier(s) to make payment directly to **SpinalAid** for the surgical and/or medical benefits payable for the services rendered.

PATIENT SIGNATURE

INSURED'S SIGNATURE

Date

FINANCIAL AGREEMENT

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT THE TIME SERVICE IS RENDERED.

If this account is assigned to and attorney/or outside agency for collection and/or suit, **SpinalAid** shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

PATIENT SIGNATURE

GUARANTOR'S SIGNATURE

Date

HOW DID YOU HEAR ABOUT US?

- Referral by _____
- Commercial TV/Radio
- Newspaper
- Flyer/insert
- Other _____
- Counter Display
- Telephone Directory
- Website
- Billboard

IN CASE OF AN EMERGENCY:

-- WHO SHOULD WE CONTACT --
(Please list someone living at a residence other than those listed on the reverse side.)

City: _____

State: _____

Relationship _____

Address: _____

Night () _____

Name: _____

Day () _____

Telephone _____

WELCOME TO BUKATY SPINAL AID of WNY

Date _____ DOB: _____ Patient SS#: _____
Name: _____
Address: _____ City/State/Zip: _____
Home Phone : _____ Cell Phone : _____
Single Married Widowed Spouse Name: _____
Employer: _____ Phone : _____
Occupation : _____ Email address: _____
Whom may we thank for referring you?

Primary Physician _____ Phone: _____
Other Dr.s _____ Phone _____
_____ Phone: _____

Any concerning Health Conditions? _____

Accident Information

Is condition to an accident: Yes No Type of accident: Auto Work Home Other
Date of Accident: _____ Did you report this accident:: Yes No
Reported to Whom: _____

PATIENT CONDITION

Patient Name _____ Date _____

Reason for Visit: _____

How Long: _____

How often: _____

Is it constant or random: _____

At night:: _____

Is your pain in neck or low back? _____

Is this condition getting progressively worse? Yes No

Rate the severity of your pain on a scale of 1 (least pain) to 10 (worst pain): _____

Type of pain (circle all that apply): Sharp Dull Throbbing Numbness
Aching Shooting Burning Tingling Cramps Stiffness
Swelling

Does the pain interfere with: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform (circle all that apply)
Sitting Standing Walking Bending Lying Down Stairs

Do you have any Hip/Knee replacements? _____

Do you have a Defibrillator, Pacemaker, any Hardware in spine?
Yes No

What treatment(s) have you already received for your condition?
Medications Surgery Physical Therapy Chiropractic Other

Date of Last: Physical Exam _____ Spinal X-Ray _____
Blood Test _____ Chest X-Ray _____
MRI, CT Scan, Bone Scan _____

Where did you have them taken? _____

Do you or were you diagnosed with Cancer, when? _____

Thank you for filling out our health questionnaire.