NEBRASKA SPINE + PAIN CENTER

PATIENT RESPONSIBLITIES

To fully evaluate your situation and recommend a plan of treatment, your physician needs the most complete information possible. Please obtain all of your medical records pertaining to previous spine diagnosis or treatment. These records will not be available for redistribution. Please keep copies for your own records. If these medical records and scans are not at our facility or in your possession at the time of your visit, it may be necessary to reschedule your appointment. Forms must be completed in black or blue ink. Please bring completed forms to your appointment.

It is your responsibility to bring the following to your appointment:

- Please bring in your medical records and other information related to your current condition. (This would include MRl scan reports and disc, CT scan reports and disc, nerve condition studies, operative reports, injection reports, physical therapy reports, and current medication lists, known allergies, and any other physician or other provider office notes relating to your current problem.)
- Current insurance card(s)
- A parent or guardian must accompany all patients under the age of 19.

If you have questions or concerns regarding your appointment, please call our office at (402) 496-0404.

Thank you for choosing Nebraska Spine and Pain Center!

NebraskaSpineandPain.com

Omaha
13616 California St
Suite 100
Omaha, NE 68154
402.496.0404
402.496.7766 (fax)

Lincoln
6940 Van Dorn St
Suite 201
Lincoln NE 68506
402.323.8484
402.323.8599 (fax)

Nebraska Spine + Pain Center
Patient Registration

Name: _____ Maiden Name: _____
Current Address/PO Box: _____

_____
City: _____ State: _____ Zip: _____
Telephone (Home): _____ (Work): _____ (Cell): _____
E-mail Address: _____
Birth Date: _____ Age: _____ Sex: _____ SSN#: _____
In Case of Emergency, Contact: _____ Phone: _____
Relationship to Emergency Contact: _____ *Number different from home number*
Race/Ethnicity: ☐Asian ☐Black/African American ☐Hispanic/Latino ☐ White ☐ Other

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RELEASE OF INFORMATION

I hereby authorize Nebraska Spine + Pain Center and its staff, to release any and all information to insurance companies needed to secure payment of benefits. In addition, I authorize Nebraska Spine + Pain Center to release my protected health information to myself, to my primary care or referring physician(s), and to consulting physicians any information used for treatment.

ASSIGNMENT OF BENEFITS

I authorize payment of benefits directly to Nebraska Spine Center LLP/dba Nebraska Spine + Pain Center. I understand that I am financially responsible for all charges not covered by my authorization.

HIPAA PRIVACY NOTICE

The signature below acknowledges receipt of a copy of Nebraska Spine Center's Notice of Privacy Practices.

E-MAIL / CELL PHONE COMMUNICATIONS

By providing Nebraska Spine + Pain with my cell phone number and/or email address, I hereby grant to Nebraska Spine + Pain, and its agents or independent contractors, my consent to receive communications for treatment-related purposes (such as appointment reminders, registration instructions, surveys, etc.) and billing/payment purposes on any and all cell phone numbers I list or use (even if unlisted) or via e-mail. This includes automated, artificial voice, and prerecorded calls. I understand communications by text and/or e-mail are not considered secure communications and I can opt out of receiving further communication by these methods.

CONSENT TO MEDICAL TREATMENT

I, knowing that I have (or_____has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic examination procedures and x-rays and to such medical treatment by Dr._____, his assistants, or his designees as necessary in his judgment.

FINANCIAL POLICY

I have read, understand, and agree to the financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

PHI RELEASE

This authorizes Nebraska Spine + Pain Center to disclose your medical information to family members or friends designated by you. **You only need to complete this portion if you want Nebraska Spine + Pain Center to disclose your protected health information (PHI) to another person, such as your spouse.** Please note this form does not alter our ability to communicate with family members involved in your care that are not designated below in the event of an emergency or other circumstance where you are unavailable and, in our professional judgment, we believe it is in your best interest to do so.

Person(s) authorized to receive Protected Health Information (PLEASE PRINT)

_____ _____
Name: Relationship

_____ _____
Name Relationship

_____
Signature **Date**
(Signature of patient or person legally authorized to consent/sign for patient)

NEBRASKA SPINE + PAIN CENTER

WELCOME TO NEBRASKA SPINE + PAIN CENTER

Appointments
To schedule **appointments**, please call our appointments desk. If there are no routine appointments available, **emergency** appointments **may** be approved at the discretion of your physician's assistant. If you are involved in any of our **research studies**, please mention this to our office whenever you call to schedule or reschedule an appointment.

- You may also request an appointment via our website at www.nebraskaspineandpain.com.

Telephone Calls
Your doctor's assistant will make every effort to return your calls by the end of the day. On the days when your physician is in clinic, our phone nurse will return your call in place of the assistant.

Test Results
If your physician sends you for diagnostic testing, such as an MRI or CT scan, please make an appointment to follow up with your physician in 1-2 weeks after the test has been completed to discuss results, unless otherwise instructed.

Work Status
If you need a work status form, it is in your best interest to get this filled out at the time of your appointment. As our physicians are surgeons, and are not in the office every day, it may take several days for them to get the work status form filled out and mailed back to you if it is not accomplished at the time of your appointment.

Prescriptions

- Our physicians will only provide refills for the medications that they have prescribed for you.
- Please try to remember to **ask for any refills you may need at your appointments**. If you need medication refills, and do not have any appointment, please have your pharmacy call the office **before** you are completely out of your medication, as **refills may take as long as 24 hours to be filled**. To alleviate any confusion, **do not** call the physician's assistants for refills especially if your pharmacy has already called our office.
- If you are an established portal patient, you may request a refill of your prescription via our patient portal at www.nebraskaspineandpain.com. Our policy is to handle requests within three business days.
- **Medication refill requests called to the office after 12:00 noon on Fridays will not be filled until the following business day** (usually Monday unless it is a holiday). If you are receiving narcotic pain medications from one of our physicians, you will need to sign the narcotic medication policy and comply with all the rules therein. If you are receiving a Class 2 narcotic pain medication, you will a hand-written prescription from your physician for **each** refill. Please plan in advance for this as our physicians are not in the office every day and the prescription will either need to be mailed to you or picked up by you at our office.
- You are responsible for the safekeeping of all your prescriptions, including written slips. Lost, damaged, or stolen prescriptions will not be refilled until they were due to run out as directed on the prescription.
- If you plan to be out of town and will run out of your medication while you are gone, extra medication may be prescribed to you at the discretion of the physician.

Adherence to these policies will help ensure that your care progresses as smoothly and with as much continuity as possible.

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NEBRASKA
SPINE + PAIN
CENTER

FINANCIAL POLICY AND STATEMENT OF RESPONSIBILITY

It is the patient and/or guardians who contract for our services and it is the patient and/or guardians to whom we look for payment. While we will assist you in any way we can to obtain payment of benefits from your insurance company, we will not accept responsibility for payment or denial of benefits.

FOR PATIENTS WITH INSURANCE: We will bill most insurance carriers for you when proper paperwork, including insurance cards, is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. It is the patient's responsibility to obtain any referrals that are necessary for the visit.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments, or a deductible, are due and payable at the time service is provided.

WELFARE PATIENTS: All Welfare patients must provide a current valid card before being seen.

AUTO ACCIDENTS: We will file any insurance claims for services related to an auto accident. We will accept health insurance payments after auto has paid.

WORKERS' COMPENSATION: If your injury is work-related, we will need the case number, carrier name and information prior to your visit in order to bill the Workers' Compensation insurance company. The patient is ultimately responsible for all professional fees if a Workers' Compensation claim is denied.

SELF-PAYMENT ACCOUNTS: We ask that you make payment at the time of visit. We are happy to accept payment by cash, check, or credit card. If your account reaches 90 days past due and you have not contacted us to make payment arrangements, your account may be turned over to a collection agency.

For the convenience of our patients, we do accept VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Interest at 16% APR will be charged on patient balances 60 days or older.

I have read, understand, and agree to the above financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

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NEBRASKA SPINE + PAIN CENTER

MEDICAL HISTORY FORM

DATE: _____

NAME: _____

PREFERRED NAME: _____

AGE: _____ Date of Birth: _____

REFERRED BY: _____

FAMILY DOCTOR: _____

OTHER TREATING PHYSICIANS:_____

_____

PREFERRED PHARMACY:_____

PHARMACY PHONE NUMBER:_____

PHARMACY ADDRESS:_____

HISTORY OF SYMPTOMS:

WHAT ARE YOUR GOALS & EXPECTATIONS FOR TODAY'S VISIT?_____

DATE YOUR SYMPTOMS BEGAN OR **DATE OF INJURY**? _____

IS IT A: ☐ work comp injury ☐ motor vehicle accident

Do you have an attorney for your injury? ☐ Yes ☐ No

PRIOR TO YOUR CURRENT PAIN did you have any neck or back problems? ☐ Yes ☐ No If so, when?_____

PLEASE GIVE A **BRIEF DESCRIPTION** OF HOW THE SYMPTOMS BEGAN:

_____

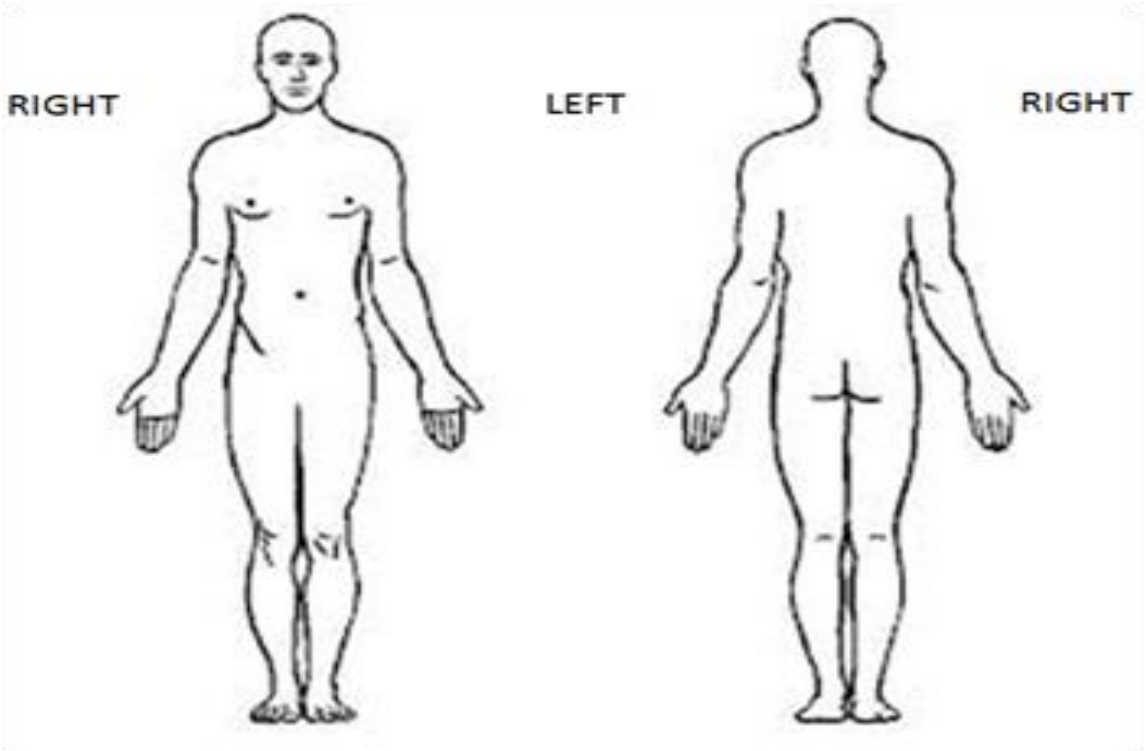
_____

DESCRIBE (circle): Dull Aching Throbbing Burning Cold Shooting Sharp Cramping Pressure Numb Tingling Pins/Needles
PAIN IS (circle): Constant Intermittent

WHAT MAKES YOUR PAIN BETTER?_____
WHAT MAKES YOUR PAIN WORSE?_____

CURRENT PAIN RATING (0-10)_____ **PAIN AT ITS BEST (0-10)**_____ **PAIN AT ITS WORST (0-10)**_____

PLEASE SHADE IN THE AREA OF PAIN THAT YOU ARE BEING TREATED FOR TODAY



PREVIOUS TREATMENT

☐ **I have had NO TESTING OR TREATMENT for my neck / back problems to date.**

☐ **NO, I have never had SURGERY on my NECK OR BACK**
☐ **YES, I have had SURGERY on my NECK OR BACK**

DATE	SPINE PROCEDURE	NAME OF SURGEON	HOSPITAL	DID SURGERY HELP?
_____	_____	_____	_____	☐Yes ☐No ☐Somewhat
_____	_____	_____	_____	☐Yes ☐No ☐Somewhat
_____	_____	_____	_____	☐Yes ☐No ☐Somewhat

ANY TESTING DONE OF THE SPINE? ☐**X-RAY** ☐**CT SCAN** ☐**MRI** ☐**EMG** ☐**DEXA/BONE DENSITY** ☐**OTHER**:_____
Dates:_____ Location:_____

WHAT TREATMENTS HAVE YOU TRIED?

☐**PHYSICAL THERAPY** ☐**AQUATIC PHYSICAL THERAPY**
Dates:_____ Location:_____
Dates:_____ Location:_____
Dates:_____ Location:_____

☐**CHIROPRACTIC CARE** Dates:_____ Name of chiropractor:_____

☐**HOME EXERCISES from PT** Dates:_____ How often?:_____times per ☐Day ☐Week

☐**ACTIVITY MODIFICATION** Dates:_____
Which activities have you stopped/changed?:_____

☐**PAIN CLINIC** Dates:_____ Name of Pain clinic: _____

☐**STEROID INJECTIONS**

DATE	TYPE OF INJECTION (OR BODY PART)	NAME OF DOCTOR	DID INJECTION HELP?
_____	_____	_____	☐Yes ☐No ☐Somewhat
_____	_____	_____	☐Yes ☐No ☐Somewhat
_____	_____	_____	☐Yes ☐No ☐Somewhat
_____	_____	_____	☐Yes ☐No ☐Somewhat

☐**OTHER TREATMENT:**_____ ☐**TRACTION** ☐**BRACE** ☐**ACUPUNCTURE** ☐**BIOFEEDBACK** ☐**MASSAGE**

DID YOU RECEIVE RELIEF FROM ANY OF THESE TREATMENTS?
Explain:_____

WHAT MEDICATIONS HAVE YOU TRIED? (Please circle)

CIRCLE meds tried:	Dates Taken:	Was it HELPFUL?		CIRCLE meds tried:	Dates Taken:	Was it HELPFUL?	
NSAIDS:				**Narcotics:**			
Advil/Motrin/Ibuprofen	_____	**Yes**	**No**	Norco/Hydrocodone	_____	**Yes**	**No**
Aleve/Naproxen	_____	**Yes**	**No**	Percocet/Oxycodone	_____	**Yes**	**No**
Celebrex/Celecoxib	_____	**Yes**	**No**	Ultram/Tramadol	_____	**Yes**	**No**
Indomethacin	_____	**Yes**	**No**	Nucynta	_____	**Yes**	**No**
Mobic /Meloxicam	_____	**Yes**	**No**	Butrans	_____	**Yes**	**No**
Diclofenac	_____	**Yes**	**No**	OxyContin	_____	**Yes**	**No**
_____	_____	**Yes**	**No**	MS Contin/Morphine	_____	**Yes**	**No**
Muscle relaxants:				Duragesic/Fentanyl	_____	**Yes**	**No**
Flexeril/Cyclobenzaprine	_____	**Yes**	**No**	Methadone	_____	**Yes**	**No**
Skelaxin/Metaxalone	_____	**Yes**	**No**	Suboxone	_____	**Yes**	**No**
Soma	_____	**Yes**	**No**	_____	_____	**Yes**	**No**
Zanaflex/Tizanidine	_____	**Yes**	**No**	**Anti-convulsants:**			
_____	_____	**Yes**	**No**	Neurontin/Gabapentin	_____	**Yes**	**No**
Antidepressants:				Lyrica	_____	**Yes**	**No**
Cymbalta/Duloxetine	_____	**Yes**	**No**	Horizant/Gralise	_____	**Yes**	**No**
Effexor/Venlafaxine	_____	**Yes**	**No**	Topamax/Topiramate	_____	**Yes**	**No**
Wellbutrin	_____	**Yes**	**No**	_____	_____	**Yes**	**No**
Savella	_____	**Yes**	**No**	**Misc:**			
Nortriptyline	_____	**Yes**	**No**	Medrol Dosepak	_____	**Yes**	**No**
Amitriptyline	_____	**Yes**	**No**	Prednisone	_____	**Yes**	**No**
_____	_____	**Yes**	**No**	Tylenol	_____	**Yes**	**No**
_____	_____	**Yes**	**No**	_____	_____	**Yes**	**No**

MEDICAL HISTORY

☐ **I have NO medical problems**

Bones and Joints:
- ☐ Arthritis/Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Spinal Deformity:_____
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other:_____

Cardiovascular:
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease: _____
- ☐ Atrial Fibrillation
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart attack
- ☐ Valvular Heart Disease
- ☐ Peripheral Vascular Disease
- ☐ Deep Venous Thrombosis
- ☐ Pulmonary Embolism
- ☐ Other:_____

Gastrointestinal:
- ☐ Gastroesophageal reflux
- ☐ Ulcers
- ☐ Other:_____

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Other:_____

Endocrine:
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Other:_____

Neurological:
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Other:_____

Pain syndromes:
- ☐ Fibromyalgia
- ☐ Headaches:_____
- ☐ Other:_____

Other diseases and infections:
- ☐ Cancer: _____
- ☐ Hepatitis
- ☐ HIV infection
- ☐ Kidney disease
- ☐ Prostate problems
- ☐ Obesity
- ☐ Wound Infection
- ☐ MRSA
- ☐ Other:_____

Psychiatric illness:
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ PTSD
- ☐ Other:_____

Substance Use:
- ☐ Alcoholism
- ☐ Nicotine dependence
- ☐ Other:_____

☐ Other Medical Problems:_____
_____
_____

Do you take blood thinners or have a bleeding disorder?
☐ Yes ☐ No Name:_____
Prescribing Physician:_____

PREVIOUS SURGERIES

☐ **I have NEVER had surgery**

- ☐ Appendectomy
- ☐ Cesarean section
- ☐ Cardiac: _____
  - ☐ Coronary Bypass
  - ☐ Pacemaker
  - ☐ Defibrillator
  - ☐ Other_____
- ☐ Carpal tunnel
  - ☐ Right ☐ Left
- ☐ Cataract
  - ☐ Right ☐ Left
- ☐ Gallbladder
- ☐ Bariatric/Weight loss surgery
- ☐ Hernia repair
  - ☐ Right ☐ Left
- ☐ Hysterectomy
  - ☐ Uterus only ☐ Uterus/ovaries
- ☐ Hip replacement
  - ☐ Right ☐ Left
- ☐ Knee arthroscopy
  - ☐ Right ☐ Left
- ☐ Knee replacement
  - ☐ Right ☐ Left
- ☐ Mastectomy
  - ☐ Right ☐ Left
- ☐ Prostatectomy
  - ☐ Partial ☐ Total
- ☐ Radiation Therapy:
- ☐ Shoulder Surgery
  - ☐ Right ☐ Left
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Vascular surgery_____
- ☐ Other:_____
  _____
  _____

Have you ever had a reaction to anesthesia?
☐ Yes ☐ No Explain:_____

Have you ever had a complication during or after surgery?
☐ Yes ☐ No Explain: _____

FAMILY HISTORY

(parents/siblings/children)

☐ **Unknown**

☐ **I have no family history of heart disease, cancer or other serious illnesses**

☐ Cancer: (what kind & who has it) _____
☐ Heart disease: (what kind & who has it) _____
☐ High Blood Pressure: (who has it) _____
☐ Arthritis: (what kind & who has it) _____
☐ Diabetes: (who has it) _____
☐ FAMILY HISTORY OF DRUG, ALCOHOL, OR SUBSTANCE ABUSE? ☐Yes (who?) _____ ☐No family with substance abuse
☐ Other: _____

SOCIAL HISTORY

OCCUPATION: _____ **EMPLOYER**: _____

ARE YOU CURRENTLY WORKING? ☐Working without restrictions ☐Working with restrictions:_____
☐Off work ☐Unemployed ☐Disabled ☐Retired Date you stopped working:_____

IF STUDENT: ☐ Current Student- Grade_____ School:_____ Sports:_____

MARITAL STATUS: ☐Single ☐Married ☐Domestic partner ☐Divorced ☐Separated ☐Widowed

NUMBER OF CHILDREN:_____

NICOTINE USE:

☐ No, I have NEVER used nicotine products.
☐ Yes, I currently do: How much? # _____ ☐ pack ☐ can ☐ cigar ☐ gum/patch/e-cigarette per day for _____ years
☐ Not anymore, I stopped on _____ How much did you use? ____ ☐ pack ☐ can ☐ cigar per day for _____ years

ALCOHOL: ☐None ☐Previous user ☐Yes, #_____ drinks per day / week / month *(circle one)*

DO YOU SMOKE MARIJUANA? ☐Yes ☐No
DO YOU USE OTHER RECREATIONAL OR STREET DRUGS? ☐Yes ☐No
DO YOU HAVE A PAST HISTORY OF DRUG, ALCOHOL, OR SUBSTANCE DEPENDENCE? ☐Yes ☐No
HAVE YOU HAD TREATMENT FOR A DRUG, ALCOHOL, OR SUBSTANCE ADDICTION? ☐Yes ☐No

REVIEW OF SYSTEMS

Do you have any of these symptoms? (check all that apply)

☐ **No further symptoms or complaints**

Allergy:
- ☐Seasonal allergies

General:
- ☐Chills
- ☐Fever
- ☐Unexpected weight loss

HEENT:
- ☐Headache
- ☐Vision problems

Cardiac:
- ☐Chest Pain
- ☐Heart Palpitations
- ☐Fast heart rate

Endocrine:
- ☐Excessive thirst
- ☐Temperature Intolerance

Urinary:
- ☐Blood in Urine
- ☐Loss of bladder control
- ☐Numbness in genital region

Gastrointestinal:
- ☐Trouble swallowing
- ☐Heartburn
- ☐Abdominal pain
- ☐Diarrhea
- ☐Constipation
- ☐Loss of bowel control

HEME/Lymph:
- ☐Easy Bleeding
- ☐Easy Bruising
- ☐Swollen glands

Musculoskeletal:
- ☐Neck pain
- ☐Back pain
- ☐Joint pain
- ☐Joint swelling
- ☐Muscle pain

Neurological:
- ☐Limb Weakness
- ☐Limb Numbness
- ☐Paralysis
- ☐Poor balance
- ☐Seizure

Psychiatric:
- ☐Trouble Sleeping
- ☐Anxiety
- ☐Depression
- ☐Suicidal Thoughts

Respiratory:
- ☐Shortness of breath
- ☐Cough
- ☐Sleep apnea
- ☐Wheezing

Skin:
- ☐Skin Lesions
- ☐Rash
- ☐Localized skin discoloration

CURRENT MEDICATIONS:

☐ **I do not take prescription or over-the-counter medications**

Drug name:	**Dose**:	
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**

Over the counter meds: _____
_____

NUTRITIONAL SUPPLEMENTS:

☐ **I do not take supplements**

Supplement name:	**Dose**:	
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**
_____	_____	**per day**

ALLERGIES:

☐ **I do not have any allergies**

I am allergic to: ☐**Latex** ☐**Betadine** ☐**Contrast Dye** ☐ **Tape/Adhesives**

List your MEDICATION allergies and the reaction you had:

Allergy:	**Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____