Southern Utah
Spine & Rehabilitation

Max Root, M.D. Bradley Root, D.O, Sean Stucki, P.A. –C Mark Udy, P.A. -C
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1424 East Foremaster Drive, Suite 120•St. George, Utah 84790
Phone (435) 656-8800 • Fax (435) 627-1809

PATIENT REGISTRATION FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST – FIRST – MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	WORK PHONE

PATIENT SSN	PATIENT BIRTH DATE	SEX ☐ Male Female	MARITAL STATUS ☐ Single Married / Other _____	AGE

PATIENT EMPLOYER NAME	PATIENT EMAIL ADDRESS (For Notification of Appointments and Medications)

INSURED/RESPONSIBLE PARTY INFORMATION

NAME (FIRST – LAST – MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET – CITY – STATE – ZIP)			DATE OF BIRTH OF INSURED
PHONE # ( )	POLICY NUMBER	ID NUMBER	NAME OF INSURED	Relationship to Patient

SECONDARY INSURANCE NAME	ADDRESS (STREET – CITY – STATE – ZIP)			DATE OF BIRTH OF INSURED
PHONE # ( )	POLICY NUMBER	ID NUMBER	NAME OF INSURED	Relationship to Patient

HOW DID THE INJURY OCCUR:	ACCIDENT RELATED? ☐ NO ☐ YES If yes, type: ☐ AUTO ☐ INDUSTRIAL ☐ OTHER DATE OF ACCIDENT: _____ ACCIDENT IN WHAT STATE: _____ IS THE ACCIDENT EMPLOYMENT RELATED? ☐ YES ☐ NO	
REFERRED BY:	YOUR EMPLOYMENT STATUS ☐ Full Time ☐ Part Time ☐ Retired ☐ Other	IF YOU ARE A STUDENT: ☐ Full Time ☐ Part Time Name of School:

NEAREST RELATIVE NOT LIVING WITH YOU	ADDRESS	PHONE NUMBER
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?		THE CO-PAY DUE TODAY IS: $_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

Date:_____ **Signature:**_____
(Patient) or, if minor (Signature of parent or guardian)

PATIENT INFORMATION & HISTORY

Last Name	First Name	Middle

Date	Age	Referring Doctor:

CHIEF COMPLAINT

What is your primary reason for being evaluated?

What happened? (How did you get your injury or illness)

Date of onset of illness: 1week, 2 weeks, 3 weeks, 1 month, other:

HISTORY OF PRESENT ILLNESS

Circle all that apply

Primary location of problem: (right arm, left arm, right leg, left leg, neck, mid back, low back)
Which side or part: (front part, back part, middle part, left side, right side, both sides)

Secondary location of problem: (right arm, left arm, right leg, left leg, neck, mid back, low back)
Which side or part: (front part, back part, middle part, left side, right side, both sides)

Quality: (sharp, dull, throbbing, burning, numbness, pins&needles, stabbing, ache)

Duration: (intermittent, constant)

Timing: (morning, evening, before meals, after meals, after exercise, after lifting)

Severity: (minor, moderate, severe)

Does strenuous activity make your problem worse? Yes_ No_

Has the problem caused you not to be able to perform your daily activities? Including work and/or homemaking. Yes_ No_

Modifying factors : (rest, heat, cold, limb elevation)

Associated signs and symptoms: (bruising, numbness, tingling, etc)

Sleep Habits: (regular, normal, poor, worse than normal)

Circle all that apply

What treatments have you had for this problem? (None, Physicians, procedures, Physical Therapy, Chiropractic)

Circle all that apply

Have you had any diagnostic studies? (X-rays, CT Scans, MRI Scans, Lab Work, or EMG's)

Are these symptoms affecting you emotionally? Yes_ No_
How have these symptoms made you feel? Angry, Anxious, Concerned, Confused, Desperate, Exasperated, Fatigued, Fearful, Frustrated, Insecure, Irritable, Preoccupied, Stressed, Trapped, Unhappy, Worried

Do you have any secondary complaints?

Last Name	First Name

REVIEW OF SYSTEMS

Do **you** have any problems in the following areas:
Constitutional: **Chills -** Yes_ No_ **Decline in Health -** Yes_ No_ **Fatigue -** Yes_ No_
Fever - Yes_ No_ **Weakness -** Yes_ No_ **Weight Gain -** Yes_ No_ **Weight Loss -** Yes_ No_
Head: **Dizziness** – Yes_ No_ **Fainting** – Yes_ No_ **Head Injury** – Yes_ No_ **Headaches** – Yes_ No_
Head Pain – Yes_ No_ **Sweats** – Yes_ No_

Eyes: **Blurry Vision** Yes_ No_ **Double Vision** – Yes_ No_ **Eye Pain** – Yes_ No_ **Eyeglass Use** – Yes_ No_
Glaucoma – Yes_ No_ **Other** _____ **Please explain**:

Ear/Nose/Throat – Yes_ No_ If Yes please explain:

Respiratory – Yes_ No_ If Yes please explain:

Cardiovascular: **Chest Pain** – Yes_ No_ **Palpitations** – Yes_ No_ **Heart Murmur** – Yes_ No_
High Blood Pressure – Yes_ No_ **History of Heart Attack** – Yes_ No_ **Short of Breath** – Yes_ No_
Other_____

Gastrointestinal: **Abdominal Pain** – Yes_ No_ **Constipation** – Yes_ No_ **Diarrhea** – Yes_ No_
Heartburn – Yes_ No_ **Liver Disease** – Yes_ No_ **Rectal Bleeding** – Yes_ No_ **Antacid Use** – Yes_ No_
Black Tarry Stools – Yes_ No_ **Hepatitis** – Yes_ No_
Other_____

Musculoskeletal: **Arthritis** – Yes_ No_ **Joint Pain** – Yes_ No_ **Gout** – Yes_ No_
Back Problems – Yes_ No_ **Deformities** – Yes_ No_ **Joint Stiffness** – Yes_ No_ **Muscle Cramps** – Yes_ No_
Muscle Stiffness – Yes_ No_ **Paralysis** – Yes_ No_ **Restricted Motion** – Yes_ No_ **Weakness** – Yes_ No_

Psychiatric: **Depression** – Yes_ No_ **Behavioral Change** – Yes_ No_ **Disorientation** – Yes_ No_
Disturbing Thoughts – Yes_ No_ **Excessive Stress** – Yes_ No_ **Hallucinations** – Yes_ No_
Memory Loss – Yes_ No_ **Mood Changes** – Yes_ No_ **Nervousness** – Yes_ No_
Psychiatric Disorders – Yes_ No_

Skin: – Yes_ No_ If Yes please explain:

Neurological: **Loss of Consciousness** – Yes_ No_ **Blackouts** – Yes_ No_ **Burning** – Yes_ No_
Dizziness – Yes_ No_ **Fainting** – Yes_ No_ **Head Injury** – Yes_ No_ **Headaches** – Yes_ No_
Memory Loss – Yes_ No_ **Numbness** – Yes_ No_ **Paralysis** – Yes_ No_ **Speech Disorders** – Yes_ No_
Strokes – Yes_ No_ **Tingling** – Yes_ No_ **Tremors** – Yes_ No_ **Unsteady Gait** – Yes_ No_

Endocrine – Yes_ No_ If Yes please explain:

Hematologic/Lymphatic – Yes_ No_ If Yes please explain:

Urinary – Yes _ No_ If yes please explain:

Last Name	First Name

Allergies

Are you allergic to any medications? Yes No	Which medications are you allergic to? Severity: Mild, Moderate, Severe Reaction:

Family History

What is your family medical history? What medical problems do your parents or siblings have? Please list Relationship, problem and if that person is alive or deceased: (example: mother-diabetes)

Do you have any new family stress or change in family structure?

Medical History

Please list your current medications:

Do <u>you</u> have any problems with:

Anemia Anxiety Arthritis Asthma Back Problems BPH Breast Cancer CAD Cancer CHF Cholesterol High COPD Dementia Depression Dermatitis Diabetes Epilepsy GERD Glaucoma Gout Headache Hepatitis HIV Hypertension MI Migraine Pneumonia Renal Stone Stroke TB Thyroid Ulcer

SOCIAL HISTORY

Do you use: Cigarettes – Yes_ No_ If yes how often? - Every day, Some days, Former smoker
Chewing Tobacco – Yes_ No_ If yes how often? – Every day, Some days, Former chewer

Do you drink: Beer – Yes_ No_ If yes how often? – Social, Occasional, Light, Heavy
:Wine – Yes_ No_ If yes how often? – Social, Occasional, Light, Heavy
:Hard Liquor – Yes_ No_ If yes how often? – Social, Occasional, Light, Heavy

Is there anything else you are taking? (Herbs, Recreational Drugs, None)

Do you see a doctor or take medication for any other problem?

Have you had any previous injuries? (Motor vehicle accidents, falls, work related injuries or other accidents of significance)

Occupation:	Hobbies:

Which town do you live in?	What is your living situation? Rent Own Home	Marital Status: Single Married Divorced Separated Widowed	How many children do you have?

SUGICAL HISTORY

Surgical Procedure & Date
AAA Repair_____ Aortic Aneurysm_____ Appendectomy_____ Breast Augment_____ CABG_____
Carotid Endartere_____ Cataract Extract_____ Cesarean Section_____ Cholecystectomy_____
Colectomy_____ Duodenal Ulcer_____ Ectopic Pregnancy_____ ESWL_____ Fracture_____
Gastric Banding_____ Heart Valve_____ Hernia Abdominal_____ Hip Fracture_____ Hip Surgery_____
Hysterectomy_____ Intestinal By-Pass_____ Knee Arthroscopy_____ Knee Surgery_____ Lasik_____
LS Spine Surgery_____ Mastectomy_____ Oophorectomy Uni_____ Pacemaker_____
Prior Surgeries_____ Prostate Biopsy_____ Prostatectomy Retro_____ PTCA_____ PVD Procedure_____
Shoulder Arthroscopy_____ Shoulder Surgery_____ Sinusectomy (Nasal)_____ Splenectomy_____
Thyroidectomy_____ Tonsillectomy_____ Tubal Ligation_____ TURP_____ Vasectomy_____
Other_____

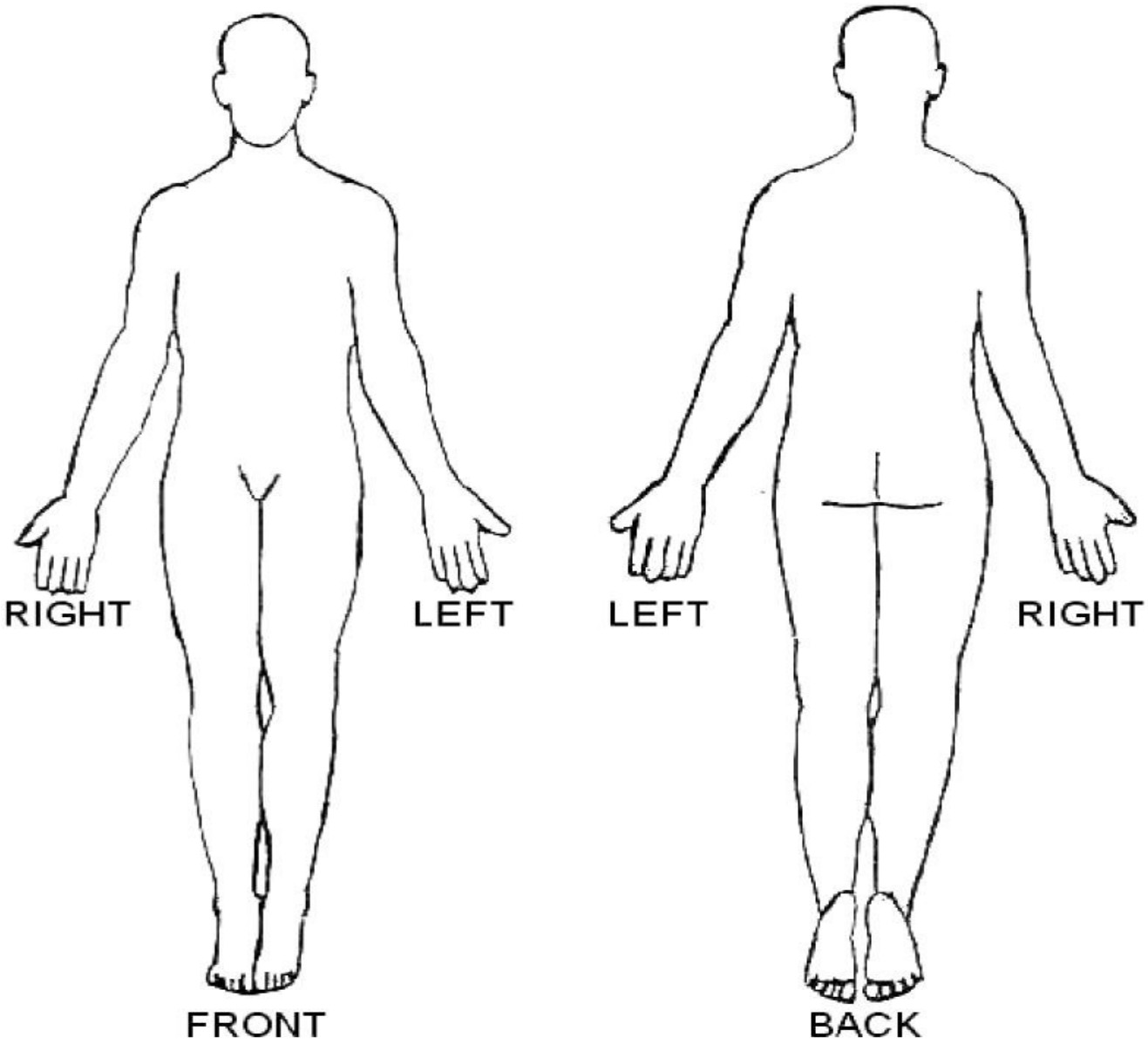
PAIN CHART

Patient Name: _____ Date: _____

PAIN DRAWING

Use the symbols below to mark the areas on your body where you feel the following sensations.
Include ALL affected areas.

BURNING	NUMBNESS	PINS & NEEDLES	STABBING	ACHE
X	**O**	**=**	**/**	**^**



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TREATMENT AND PAIN MEDICATION AGREEMENT

Patient Name:_____

The purpose of this agreement is to prevent misunderstanding about certain medications you could be taking as part of your treatment. This is to help you and your doctor to comply with state and federal laws regarding controlled pharmaceuticals.

Please initial by each line to show you understand and agree with each statement.

I understand that this Agreement is essential to the trust and confidence necessary in doctor/patient relationship and that my doctor undertakes to treat me based on this agreement._____

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines. _____

I will communicate fully with my doctor about the character and intensity of my pain, the effect of pain on my daily life, and how well the medicine is helping to relieve pain.
_____

I understand that the medications that may be prescribed to me will have benefits and potential adverse effects. As a partner in my care I will ask questions if there are concerns._____

I will not use any illegal controlled substances, including marijuana, cocaine, etc. _____

I will not use any prescription medications for which I do not have a prescription._____

I will not share, sell, or trade my medications with anyone._____

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I will not attempt to obtain any controlled medications, including opioid medications, controlled stimulants, or anti-anxiety medicines from any other doctor. If a situation arises that I will need one of these medications from a different doctor I will inform Dr. Root's office before filling the prescription._____

I will report any problems with my medication as soon as possible._____

I will communicate honestly with my doctor (or medical assistant) on how and when I am taking my medications._____

My doctor is aware of the responsibility he holds in prescribing pain medications. I am also aware of the responsibility and seriousness involved with my prescription pain medications._____

I understand that lost or stolen medications **will not be replaced**. If a police report is provided the report will be reviewed and a decision will be made on whether the medications will be replaced._____Also, excuses such as medications have fallen down the sink, been ruined by the rain, eaten by your dog, fallen out of the car, etc, will not be accepted. However; it is still your responsibility to notify your doctor of any problems with medications.

I will keep my medications in a safe and secure place to avoid any loss or theft of the medications._____

I agree to only use one pharmacy; however in the event that I will need to use a second pharmacy I will notify my doctor._____

Pharmacy name:_____Location:_____

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I agree to take my medication exactly as prescribed._____

I understand that if I exceed the directions of my medication, they **will not be refilled** until the scheduled refill date.

_____

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications._____

I authorize the doctor and my pharmacy to cooperate fully with any city state federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy of congeniality with respect to these authorizations._____

I will be seen by my doctor every 30-90 days for medications to be refilled. The time period is determined case by case, but will not exceed 90 days. If I exceed 90 days I understand my medications **will not be refilled** until I am seen my doctor. _____

The following agreements are to inform you of our office policies. Understanding the office policy will help provide you with best health care experience.

I will present state picture identification when I pick up written prescriptions and sign for my prescription each time. _____ (We will ultimately decide what identification is accepted).

I understand that I may only have **two other people**, other than myself, authorized to pick up my written prescriptions. Those two individuals will also supply state picture identification and sign for release of the prescription. If I neglect to inform my doctor's office of the individual picking up my prescription the prescription will not be released and I will have to pick it up myself. _____

First authorized individual: (first name)_____(last name)_____
Relationship:_____
Second authorized individual: (first name)_____(last name)_____
Relationship:_____

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I understand that if I miss more than three scheduled appointments, I will no longer be able to schedule any further appointments with my doctor or other doctors in the clinic. _____

I understand if I am more than 15 minutes late for my scheduled appointment, I will have to reschedule._____

I will be kind and courteous to members of doctor's staff._____

I agree that the refill of my prescriptions will be made only at the time of an office visit or during regular office hours. No refills will be available during evening or on weekends._____. I also understand that there is a **24-48 hour notice for any medication request** _____.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me._____

This Agreement is entered into on this _____day of_____, _____.

Patient Signature:_____

Physician Signature:_____

Witnessed by:_____

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Acknowledgement of Receipt "Notice of Privacy Practices"

I hereby acknowledge that I have been offered a copy of Physical Medicine, LLC's "Notice of Privacy Practices" as displayed in the front office. I also acknowledge that I can request a copy at any time during my treatment.

X_____ _____

Signature of Patient or Representative Date

[Office Use Only]

We attempted to obtain written acknowledgment of receipt of our "Notice of Privacy Practices" on the following date, _____but acknowledgment could not be obtained because:

☐ Patient/Representative Refused to Sign

☐ Emergency situation prevented us from obtaining acknowledgment at this time (will attempt again at a later date)

☐ Communication barriers prohibited obtaining acknowledgment (Explain):

_____

_____

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1. **CONSENT FOR TREATMENT**: I hereby authorize Physical Medicine, LLC to administer such medications and immunizations and to perform such diagnostic/medical/surgical procedures as may be necessary for proper health care. I am aware that any major lab work will be sent to an outside laboratory and I will receive an additional bill from that facility.

2. **PAYMENT POLICY**: All charges for medical care are due and payable at the time services are rendered unless prior payment arrangements have been specifically made. I authorize insurance benefits to be paid directly to Physical Medicine, LLC and I am financially responsible for non-covered services. I agree to pay all attorney's fees, court costs, filing fees including charges or commission that may be as much as 50% of the principle balance owing. We further agree to pay interest at the rate of 1.5% per month (18% per year.) If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

3. **WE DO NOT TAKE MEDICAID**: Medicaid will NOT be billed. You will be responsible for your bill at the time of service.

We will bill your insurance if you provide us all the information that we need. You will be responsible for any co-pay, deductible, or non-payment from insurance. Your contract is with the doctor. You need to contact your insurance company to see what benefits are covered.

X_____ _____

Signature of Patient or Representative Date