

Southern Utah Spine & Rehabilitation

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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 <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married / <input type="checkbox"/> Other _____	AGE
PATIENT EMPLOYER NAME		PATIENT EMAIL ADDRESS (For Notification of Appointments and Medications)		

SYMPTOMS AND COMPLAINTS:

INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian		
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? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, type: <input type="checkbox"/> AUTO <input type="checkbox"/> INDUSTRIAL <input type="checkbox"/> OTHER DATE OF ACCIDENT: _____ ACCIDENT IN WHAT STATE: _____ IS THE ACCIDENT EMPLOYMENT RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
REFERRED BY:	YOUR EMPLOYMENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Other	IF YOU ARE A STUDENT: <input type="checkbox"/> Full Time <input type="checkbox"/> 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:

HISTORY OF PRESENT ILLNESS

Location (site(s) of problem):

Quality (sharp, dull, throbbing, etc):

Severity (minor, moderate, severe):

Duration (intermittent, constant, minutes, etc):

Timing (with exercise, nightly, after meals, etc):

Context (worsening, recurrent, etc):

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

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

What treatments have you had for this problem? (Physicians, procedures, Physical Therapy, Chiropractic, etc)

Which of these has helped?

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

Do you have any secondary complaints?

PAST MEDICAL AND SOCIAL HISTORY

Do you have any problems with:

Heart disease	Lung disease	Kidney disease	Liver disease	High Blood Pressure	Diabetes	
Arthritis	Depression	Scoliosis	Osteoporosis	Cancer	OB/GYN	Other:

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)			
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?
What is your family medical history? What medical problems do your parents or siblings have? Please list relationship and problem: (example: mother-diabetes)			
Do you have any new family stress or change in family structure?			

SUGICAL HISTORY

Surgical Procedure & Date
Tonsils_____ Appendix_____ Gall Bladder_____ Heart_____ Head & Neck_____
Neck & Spine_____ OB/GYN_____ Joint (Shoulder, elbow, wrist, Carpal Tunnel, hip, knee, ankle)_____
Other:

MEDICAL HISTORY

Are you allergic to any medications? Yes No	Which medications are you allergic to?
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Please list your current medications:

Do you use Alcohol? Yes No	Do you use Tobacco? Yes No	Is there anything else you are taking? (Herbs, Recreational Drugs, None)
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REVIEW OF SYSTEMS

Do **you** have any problems in the following areas:
General Exercise Daily Activities Bowels Bladder Nutrition Swallow Eyes Skin
Ears, nose, mouth, throat Walking Numbness Weakness Sleep Pain Respiratory
Psychiatric Cardiovascular Endocrine Blood disorders Allergies Neurologic Muscle/Joins
Weight Loss/Weight Gain_____

Is there anything else you would like to talk to the doctor about?

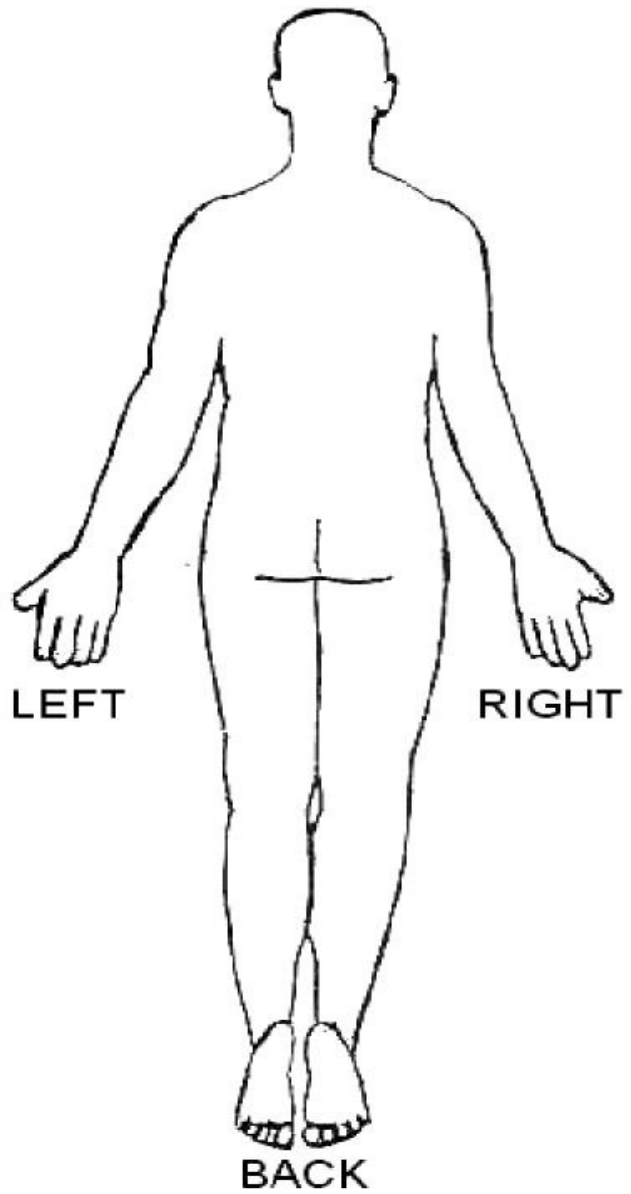
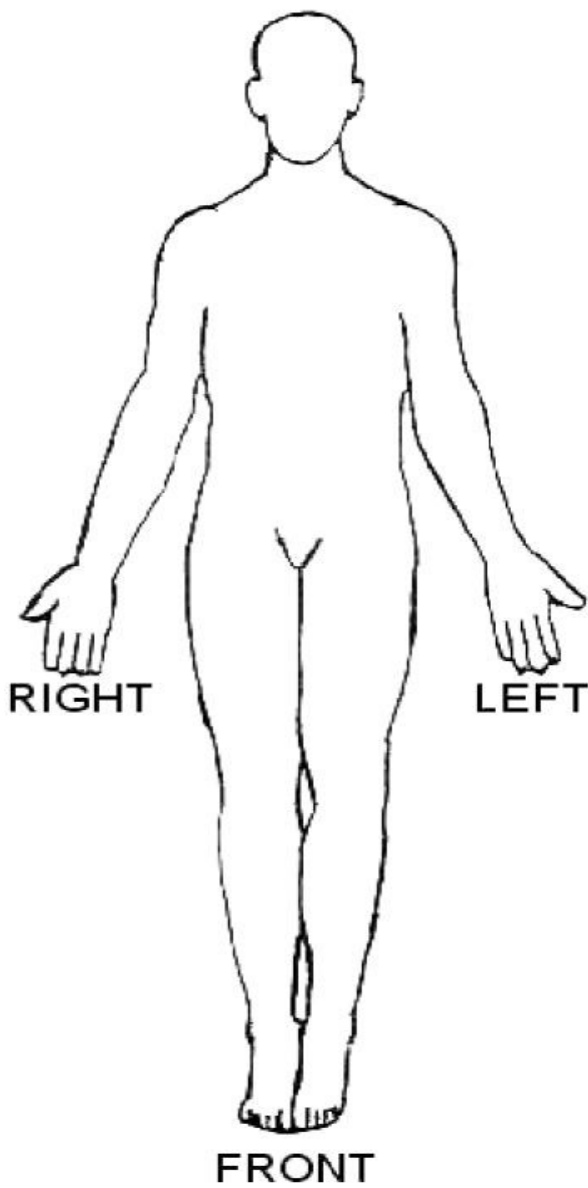
PAIN CHART

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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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you could be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a 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. _____

In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended. _____

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

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

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor. _____

I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced. _____

I agree that my refill of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. _____ . We also require a 24 hour notice to be able to refill any medicine. _____

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I agree to use _____ Pharmacy located at _____, telephone number _____, for filling prescriptions for all of my pain medicine.

I authorize the doctor and my pharmacy to cooperate fully with any city state or 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 medicine. 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 confidentiality with respect to these authorizations.

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 medicine. _____

I agree that I will use my medicine at a rate no greater than prescribed rate and that use of medicine at greater rate will result in my being without medicine for a period of time.

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: _____

