SPINAL CARE CENTER - PATIENT INFORMATION

Patient's Name ____________________________________ Date ___________________

Street Address _____________________________________ Phone: _________________

City, State, Zip ____

Email address ____

Date of Birth_____________________ Gender M F Marital Status S M

Spouse's Name ___________________________________ Phone: ___________________

Emergency Contact ________________________________ Phone: ___________________

Employer ____ Phone: ___________________

Referred by ____

Financial Responsibility

The office is a provider for **Anthem** (PPO), **Aetna** (PPO), **Cigna** (PPO) and **Medicare**

This office is not a provider for any HMO or Medicare Supplement Programs

I understand that my health insurance policies are arrangements between my carrier and myself, and that I am personally responsible for all payments for all services rendered to me.

Authorization to Release Information

I authorize you to release information that you find appropriate concerning my condition to any insurance company, attorney, or adjuster to receive reimbursement on any charges incurred by me for services rendered by you.

Authorization to Pay Directly to the Doctor

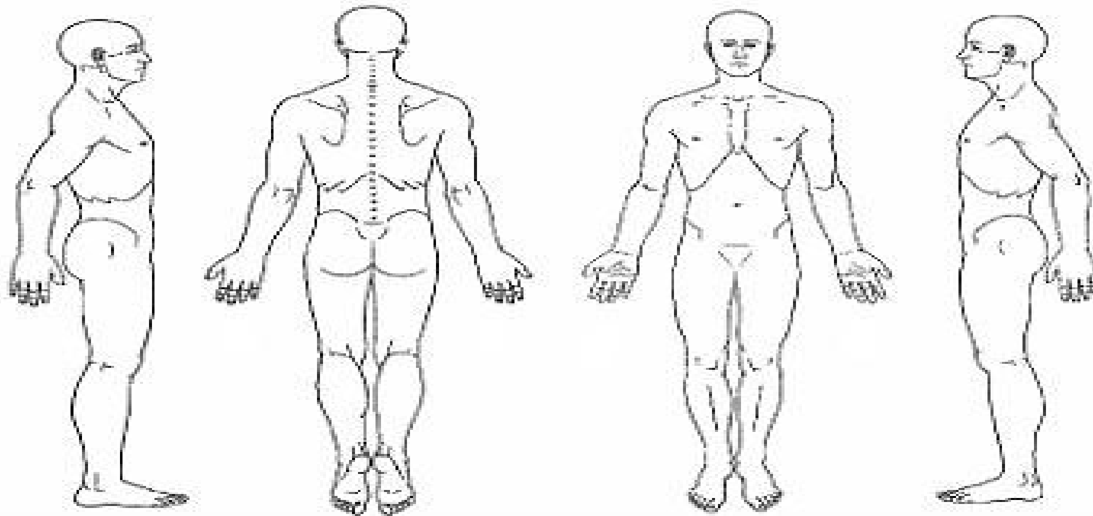
I authorize direct payment to you of any sum I owe you now or in the future from any insurance company that is obligated to reimburse me for charges incurred by me for services rendered by you.

Signature ____ Date _______________

Spinal Care Center, 2900 Peters Creek Rd, Roanoke, VA 24019 (540) 556-3914, clearthought@cox.net

Patient Name ____ **Date** ______________

WHERE IS YOUR PAIN AND HOW DOES IT FEEL TO YOU?
(Please mark the areas on the drawing you have pain and describe how each area feels to you) Pain Descriptions: A = achy, **B** = burning, **N** = numbness, **P&N** = pins & needles, S = stabbing,



FREQUENCY OF PAIN: [ ] All the time [ ] Most of the time [ ] occasionally [ ] am [ ] pm

INTENSITY OF THE PAIN (please circle the appropriate number)

0 = No pain at all	1-2 = Pain is forgotten during activities of daily living
3-4 = Pain is felt during activities of daily living	5-6 = Pain that prevents certain activities of daily living
7-8 = Pain that prevents most activities of daily living	9-10 = Pain that prevents all activities of daily living

WHAT CAUSED YOUR CONDITION? ____

____

WHEN DID IT HAPPEN? ______________ **HOW LONG HAVE YOU IT?** ______ Yrs _____ Months _____ Weeks

WHAT MAKES IT WORSE? ____

---D 0CT0R'S N0TES --

EXAMS
99202 (20 min)
99203 (30 min)

CERVICOTHORACIC REGION
M53.83 (cervicothoracic pain)
M99.01, M99.02 (seg/som. dysfunction)

SHOULDER
M25.511 (Rt) M25.512 (Lt) - M99.07

ELBOW
M25.521 (Rt) M25.522 (Lt) - M99.07

WRIST M25.531 (Rt)/…2 - M99.07

HAND M25.541 (Rt)/…2 - M99.07

HIP
M25.551 (Rt) M25.552 (Lt) - M99.06

KNEE
M25.561 (Rt) M25.562 (Lt) - M99.06

ANKLE M25.571 (Rt)/…2 - M99.06

FOOT M79.671 (Rt)/…2 - M99.06

CERVICAL REGION
M54.2 (cervicalgia)
M99.01 (seg/som. dysfunction)

LUMBAR REGION
M54.50 (lumbago)
M99.03 (seg/som. dysfunction)

THORACIC REGION
M54.6 (thoracalgia)
M99. (seg/som. dysfunction)

SACRAL REGION
M99.04 (seg/som. dysfunction)

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