IDAHO OCCUPATIONAL MEDICINE GROUP
CDA SPINE & SPORTS
1839 N Government Way, Coeur d Alene, ID 83814 P: 208-765-0156 F: 208-292-3177

Date:_____

Referring Physician:_____ Primary Care Physician_____

**PATIENT INFORMATION**

Name:_____ Preferred Name/Nick Name:_____
First MI Last

Mailing Address:_____
Street City State Zip

Physical Address:_____
Street City State Zip

Home Phone: (  )_____ Cell/Work: (  )_____ Email:_____

I prefer to be contacted on my ☐Home ☐Cell ☐Work ☐Email Is it OK to leave a detailed message Y / N

SSN:_____ Date of Birth:_____ Age:_____ Sex: M / F

Marital Status: Single / Married / Divorced / Widow Preferred Language:_____

Spouse's Name:_____ Phone:(  )_____ Spouse's SSN:_____

Spouse's DOB_____ Spouse's Employer_____

Emergency Contact:_____ Phone:_____ Relation:_____

**PLEASE REQUEST A RELEASE OF INFORMATION FORM TO ALLOW ANOTHER PERSON ACCESS TO YOUR HEALTH RECORD INCLUDING DISCUSSING APPOINTMENTS AND BILLING QUESTIONS.**

**EMPLOYMENT**

Employer:_____ Occupation:_____

Employer Address:_____ Phone:(  )_____
Street City State Zip

**GUARANTOR/RESPONSIBLE PARTY**

Name:_____ Phone: (  )_____
First MI Last

Address:_____
Street City State Zip

Is this visit a result of an accident or injury? Y / N Date of Injury:_____

Is this work related? Y / N Are you represented by an attorney? Y / N

Is this auto accident related? Y / N Attorney Name:_____ Phone:_____

**Medicare Patients ONLY:** I request that payment of authorized Medicare benefits be made either to me or on my behalf of Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**Signature:**_____ **Date:**_____

**Please fill in this information even if we have a copy of your insurance cards. Thank you!**

My Primary Insurance for this visit is ☐Private Medical Insurance ☐Workers Compensation ☐Medicare ☐Medicaid ☐Auto

Carrier Name:_____ ID/Claim #_____

Insurance Address:_____ Phone:_____

Subscriber Name: ☐Self ☐Other_____ DOB:_____ Relation:_____

Does your insurance require pre-authorization for specialist visits? Y / N

Claims Manager:_____ ☐N/A Phone:_____

Secondary Insurance ☐Private Medical Insurance ☐Medicare ☐Medicaid ☐**NONE**

Carrier Name:_____ ID/Claim #_____

Insurance Address:_____ Phone:_____

Subscriber Name: ☐Self ☐Other_____ DOB:_____ Relation:_____

Tertiary Insurance ☐Private Medical Insurance ☐Medicare ☐Medicaid

Carrier Name:_____ ID/Claim #_____

Insurance Address:_____ Phone:_____

Subscriber Name: ☐Self ☐Other_____ DOB:_____ Relation:_____

**Patient Financial Responsibility**

Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports appreciates the confidence you have shown in choosing us to provide for your health care needs. The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance on your behalf. However, you are ultimately responsible for payment of your bill. We are unable to provide you care if you are unwilling to sign the Patient Financial Responsibility.

**Electromyogram (EMG) and Nerve Conduction Study (NCS) Patients**

The amount collected at the time of service is based on your insurance benefits at the time of verification and is our best estimate based on the information we have at the time of benefits check. If insurance pays more you will be reimbursed within 2 weeks of our receiving payment. If insurance pays less you may receive a bill.

Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports is contracted with the following insurance(s):
**Blue Cross of Idaho | Regence Blue Shield of Idaho | First Choice Health Network | Kaiser Permanente | Medicare | Medicaid of Idaho | Cigna | IPN | PacificSource | Aetna | Mountain Health Coop | United Healthcare | SelectHealth**
If your insurance is **NOT** included on the list above your services will apply to your out of network benefits. I understand that I am ultimately responsible for any balance not covered by insurance. I authorize for Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports to release any information acquired in the course of my treatment to appropriate agencies as necessary for treatment or payment including appeals on my behalf.

**Cancellation/No Show Policy**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family, we appreciate a 24 hour cancellation notification. Patient's who "no show" without advance notice may be discharged from Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports.

**Co-Pay**

Your co-payment must be paid at the time of service and is required at each visit or follow up appoinment as determined by your contract with your insurance carrier.

**Self Pay**

Patient's that do not have health insurance will be responsible for payment of services prior to services being rendered.

**Motor Vehicle Insurance**

Patient's wishing to file claims through motor vehicle carrier are responsible for ANY bills incurred that are not covered and/or paid in full using the PIP/Med Pay benefit through the patient's motor vehicle insurance. Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports does not accept third party insurance; services will be treated as Self Pay and payment will be collected at the time of service.

**I hereby acknowledge that I have read the Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports Patient Financial Responsibility in its entirety and understand my responsibilities and options as a patient. I authorize Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports to bill my insurance on my behalf. I authorize for Coeur d Alene Spine and Brain to release any information acquired in the course of my treatment to appropriate agencies as necessary for treatment or payment including appeals on my behalf. I understand that Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports will bill my insurance as a courtesy and that I am ultimately responsible for any balance not covered by insurance.**

**Patient/Guarantor Signature:**_____ **Date:**_____

**Printed Name:**_____

**RX Prescription Refill Policy**

Refills require TWO DAYS minimum to process prescription renewal and/or pick up requests. The patient is responsible for knowing when medication(s) will need to be refilled. Hours for prescription phone-in/pick up are M-F 8am to 4pm. Prescriptions will not be filled for unauthorized "walk-in" patients. Prescription directions must be followed and early refills are not allowed. No medication/prescription will be replaced if lost, stolen, misplaced, overused etc. Medications are for the prescribed individual's use only. It is illegal to "share" your medicine. Patients must pick up his/her written prescription(s) in person, unless pre-authorized by staff.

**THESE PROTOCOLS ARE RECEOMMENDATIONS OF THE US DRUG ENFORCEMENT AGENCY**

I understand and accept the protocol listed above. Failure to comply may subject me to immediate termination of prescriptive medications.

**Patient/Guardian Signature:**_____ **Date:**_____

**Printed Name:**_____

**Consent for Treatment and Authorization to Release Information**

I am aware that by signing below, I authorize Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I also authorize Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports to release to appropriate agencies, any information acquired in the course of my or the above names patient's examination and treatment.

To help protect our patient's privacy, Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports requires patient's to sign a medical records release prior to releasing any records. We understand that there are situations where another medical provider might need pertinent information in order to expedite your medical care. To help you receive timely care, Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports will release medical information via verbal and written requests from the other physician's offices without a signed release.

By signing below, I am aware that Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sports will do their best to protect my confidential information, but I understand that it is possible for someone to misrepresent themselves by telephone and/or forgery and that my right to privacy may be compromised.

**Notice of Privacy Practices (HIPAA)**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it be contacting Dawn S Stanciu, Office Manager. Our Notice of Privacy Practices (HIPAA) describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your records you may request on from the front desk.

**Patient/Guarantor Signature:**_____ **Date:**_____

**Printed Name:**_____

**Consent to Obtain Patient Medication History**

Patient medication history is a list of prescriptions medication that our practice providers, or other providers, have prescribed to you. A variety of sources, including pharmacies and health insurers contribute to the collection of this history.

The collection information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your permission for your healthcare provider, pharmacy and health insurer to disclose information about your prescriptions that have been filled at any pharmacy or covered by and health insurance plan. This includes prescription medications to treat AIDS/HIV and medication used to treat mental health issues such as depression.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

**Patient/Guarantor Signature:**_____ **Date:**_____

**Printed Name:**_____

**Self Referral Notice (Pleasant View Surgery Center)**

Pursuant to Section 6002 of the Patient Protection and Affordable Care Act (PPACA), with respect to transparency reports and reporting of physician ownership or investment interests, Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sport would like you to be aware that Pleasant View Surgery Center is owned in part by physicians. Michael Ludwig MD is a part owner in the surgery center. Idaho Occupational Medicine Group/Coeur d' Alene Spine and Sport providers may choose to refer you to have your surgery/procedure done at Pleasant View Surgery Center and may also be performing your surgery or other services in connection with your referral. Please discuss this matter with your physician so that you may exercise your right to be treated in another health care facility if desired. Upon your request, your physician will provide names and addresses of alternative facilities where you may go to obtain services.

# New Patient History

**Name** _____ **DOB** _____

**Height** _____ **Weight** _____

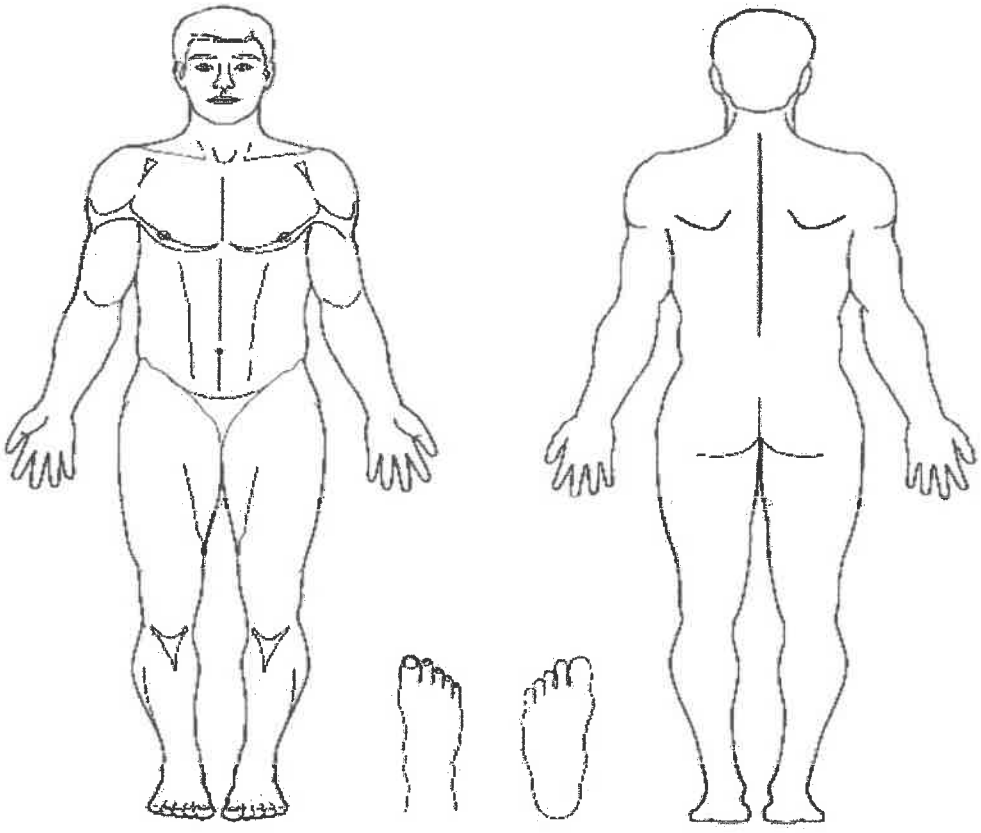
**How did you find us?** ☐ Chiropractor ☐ Therapist ☐ Friend/relative ☐ Internet
☐ Doctor referral _____ ☐ Other _____

1. **My current pain developed:** ☐ Gradually ☐ Suddenly
2. Date of onset ___/___/_____ if unsure of exact date, how long have you had pain?_____
   ☐ Motor vehicle accident Attorney: _____
   ☐ Work injury: Date of injury _____/____/_____

3. **Please make a mark on the line below to show your average pain level over the past week.**

No Pain ——————————— Worst pain Imaginable

Please use the following key to shade in the distribution of your pain on the figures:
**Numbness** ..... **Pins and Needles** 00000000 **Pain** ////////////////



4. **My pain is best described as** (check all that apply):

| | | | | |
|---|---|---|---|---|
| ☐ Dull | ☐ Sharp | ☐ Throbbing | ☐ Constant | ☐ Intermittent |
| ☐ Aching | ☐ Stabbing | ☐ Shooting | ☐ Burning | ☐ Tingling |
| | | | ☐ Electrical | |

5. **My pain is worse with** (check all that apply): ☐ Bending forward ☐ Bending backward

| | | | |
|---|---|---|---|
| ☐ Sitting | ☐ Standing | ☐ Walking | ☐ Laying down |
| ☐ Looking up | ☐ Looking down | ☐ Turning left | ☐ Turning right |
| ☐ Cough/ sneeze | ☐ Lifting | ☐ Pushing / pulling | |

6. **My pain is better with:** ☐ Laying down ☐ Sitting ☐ Standing ☐ Therapy
☐ Changing positions ☐ Pain meds ☐ Ice ☐ Heat ☐ Nothing

7. **Do you have difficulty doing the following activities?**
☐ Every Day Activities ☐ Work ☐ School ☐ Home Duties
☐ Recreational Activities ☐ None of the above

8. **Have you experienced new bowel or bladder leakage/accidents recently?** ☐ Yes ☐ No

9. **Have you had any of the following tests for the current problem in the last 2 years?**
☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ Bone scan
☐ Diagnostic Spinal Injections (e.g. epidural, facet/sacroiliac joint block, discogram)
☐ Diagnostic or Therapeutic Joint Injection

10. **Have you tried the following treatments for my pain** (Circle those that helped):
☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Massage
☐ Injections ☐ Home/gym exercises ☐ Surgery ☐ Traction
Where/when did you have treatment: _____

11. **Have tried the following medications for my pain** (Circle those that helped, X out those that didn't):
☐ Anti-inflammatories ( Ibuprofen, Aleve, Naproxen, Mobic, Celebrex, Diclofenac, Steroids)
☐ Muscle relaxants ( Soma, Flexeril, Carbamazepime, Zanaflex, Skelaxin, Robaxin, Methocarbamol)
☐ Anti seizure drugs ( Neurontin, Gabapentin, Lyrica)
☐ Anti-depressants ( Paxil, Zoloft, Nortriptyline, Amitriptyline)
☐ Narcotics ( Lortab, Hydrocodone, Oxycodone, Oxycontin, Ultram, Vicodin, Percocet, Methadone)

11. **Medication Allergies**: ☐ None ☐ Iodine ☐ Contrast dye ☐ Steroids ☐ Local Anesthetics
☐ Latex ☐ Other: _____
Allergic Reaction that occurred: _____

12. **Are you currently taking any blood thinning/anticoagulation medications?** ☐ YES ☐ NO
**(Coumadin, Warfarin, Pradaxa, Plavix, Aggrenox, Aspirin, Flax seed, Fish Oil etc.)**

13. **Medications** _____ _____ _____ _____
_____ _____ _____ _____

14. **Medical History**:
Please check the following medical problems you have now, or have had:

| | | | |
|---|---|---|---|
| ☐ Heart problems | ☐ Thyroid problems | ☐ Easy bleeding | ☐ Osteoarthritis |
| ☐ Asthma | ☐ Epilepsy | ☐ Colon disease | ☐ Ulcers |
| ☐ Diabetes | ☐ Migraines | ☐ Vascular problems | ☐ Kidney problems |
| ☐ Stroke | ☐ Depression | ☐ Hepatitis/HIV | ☐ Bladder problem |
| ☐ Anxiety | ☐ Osteoporosis | ☐ Fibromyalgia | ☐ Lung Disease |
| ☐ Anemia | ☐ High blood pressure | ☐ Rheumatoid arthritis | ☐ Cancer |

☐ Other: _____
Have you had previous back or neck problems? ☐*Yes* ☐*No*
Have your received care from a mental health professional? ☐*Yes* ☐*No* ☐*Still seeing* _____
Have you ever had an infection with MRSA? ☐*Yes* ☐*No*

15. **Surgical History**:
Spine surgery? ☐ None ☐ Neck/Cervical ☐ Mid-back/ Thoracic Spine ☐ Low back/lumbar
Orthopedic surgery? ☐ None ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot
Heart surgery or lung surgery? ☐ No ☐ Yes
Cardiac or peripheral stents? ☐ No ☐ Yes

**16. Family History**: Please check those illnesses that your family members have had

| | Hypertension | Diabetes | Neurologic Problems | Heart Disease | Cancer | Arthritis |
|---|---|---|---|---|---|---|
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Siblings | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Grandparents | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Father: ☐*Living* ☐*Deceased (Age)* ____ Mother ☐ *Living* ☐*Deceased (Age)* ____

**17. Social History**:

Do you now, or did you ever smoke? ☐ No ☐ Yes Packs per day?_____ Quit?_____

Do you drink alcohol?_____ ☐ No ☐ Yes ☐ daily ☐ rarely

Do you now, or have you ever had a drug or alcohol problem? ☐ No ☐ Yes

Please explain:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**18. Vocational History**:

☐ Employed Full Time ☐ Employed Part time ☐ Retired

☐ Regular Duty ☐ Light Duty ☐ Disability (reason)_____

Employer:_____

Job Description:_____

Years at current job: _____ Date last worked:_____

Rate your current job satisfaction: ☐ Very Satisfied ☐ Satisfied ☐ Indifferent ☐ Dissatisfied

Have you ever been on disability? ☐ No ☐ Yes: _____

How physically demanding is your job? Check one.

☐*Very heavy ( lifting > 100 pounds)* ☐*Heavy ( lifting > 60 pounds)* ☐*Moderate (lifting > 30 pounds)*

☐*Light ( lifting > 10 pounds)* ☐*White collar (no lifting)*

**19. Review of Systems**:

Please check any of the symptoms you have had during the past year.

| | | | |
|---|---|---|---|
| ☐*Fever* | ☐*Chills* | ☐*Unintentional weight loss of >10 #* | |
| ☐*Rashes* | ☐*Skin infections* | ☐*Itching of skin* | |
| ☐*Cataracts* | ☐*Glaucoma* | ☐*Double vision* | ☐*Loss of vision* |
| ☐*Ear infections* | ☐*Mouth sores* | ☐*Sore throat* | ☐*Nasal congestion* |
| ☐*Chest pain* | ☐*Leg swelling* | ☐*Irregular heart beat* | |
| ☐*Short of breath* | ☐*Cough* | ☐*Wheezing* | |
| ☐*Nausea* | ☐*Vomiting* | ☐*Abdominal pain* | |
| ☐*Blood in urine* | ☐*Painful urination* | ☐*Difficulty urinating* | |
| ☐*Dizziness* | ☐*Seizures* | ☐*Ringing in ears* | ☐*Memory loss* |
| ☐*Face numbness* | ☐*Arm numbness* | ☐*Leg numbness* | ☐*Sudden weakness* |
| ☐*Joint pain* | ☐*Muscle pain* | ☐*Difficulty walking* | |
| ☐*Depression* | ☐*Anxiety* | ☐*Hallucinations* | |
| ☐*High blood sugar* | ☐*Thyroid disorder* | ☐*Anemia* | |

**The information I have provided in this document is true and accurate to the best of my knowledge.**

_____ _____

Patient Signature Date