DESERT INSTITUTE FOR SPINE CARE

Patient Registration

- Patient Registration
- Authorization to Discuss, Release, and/or Obtain Medical Information
- Notice to Patients
- DISC Spine Study questionnaire

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DISC
DESERT INSTITUTE FOR SPINE CARE

Patient Registration

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE HOME PHONE	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS	CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)? VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT $	
CITY, STATE ZIP	PHONE	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I hereby authorize DISC/SPSF to **release information** required in the course of my examination or treatment to any insurance carrier that may be legally responsible or liable to reimburse or indemnify me for my healthcare expenses.

I hereby **assign and authorize insurance benefits and payment** made on my behalf to be paid directly to DISC/SPSF for any surgical and medical services provided to me. I understand that I am financially responsible for the charges not covered by my insurance or this authorization.

SIGNATURE OF PATIENT/GUARDIAN:_____ DATE:_____

DISC
DESERT INSTITUTE FOR SPINE CARE
1635 E. Myrtle Avenue, #400
Phoenix, AZ 85020
Tel: 602-944-2900
Fax: 602-944-0064

Authorization to Discuss, Release and/ or Obtain Medical Information

Patient Name:_____ **Date of Birth:** _____ **Email:** _____

Address:_____ **Preferred Phone:** _____

- **I hereby authorize Desert Institute for Spine Care, PC (DISC) to call and/or leave messages on my home phone, cell phone and/or email regarding appointments, referrals, test results, medical care and financial information. I understand that each of these communications is NOT considered completely secure since someone else could access the information. If NOT, please list the exclusion(s): _____ _____.**

- **I hereby authorize DISC to discuss my medical care with the following individuals (i.e. relatives/caregiver):**
  Name:_____Relationship:_____
  Name:_____Relationship:_____

- **I hereby authorize DISC to contact the following individual in case of an emergency:**
  Name:_____ Relationship:_____ Contact Number: (_____)_____-_____

- **I hereby authorize DISC to RELEASE copies of the following medical records:**
  ❒all my medical records ❒last year's medical records ❒other records: _____

  Release my medical records to this Individual/Institution/Physician:_____

  Relationship:_____ Phone: (_____)_____-_____ Fax: (_____)_____-_____
  Address:_____City: _____ St:_____ zip: _____

***** PHYSICIAN AND CONSERVATIVE TREATMENT RECORDS ARE REQUIRED FOR SURGICAL AUTHORIZATION ******

- **I hereby authorize DISC to OBTAIN the following medical records from the physician/institution(s) listed below:**
  ❒all my medical records ❒last year's medical records ❒other records: _____

  Obtain my medical records from this Physician/P.T./Chiropractor/Institution:_____

  Relationship:_____ Phone: (_____)_____-_____ Fax: (_____)_____-_____
  Address:_____City: _____ St:_____ zip: _____

I authorize DISC to send/receive confidential information as the term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care and as authorized above. I understand DISC may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the DISC Notice Privacy Practices. I may revoke this authorization in writing, except to the extent that we have already used/disclosed your information. I understand if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. You have the right to submit a written request to inspect and copy your medical records. In certain limited circumstances this request may be denied. By signing below, I hereby release DISC from all legal responsibility/liability that may arise from the act I have authorized above.

_____ _____ _____
Name of Patient/Legal Representative **Signature** **Date**

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Notice to Patients

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A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-1401(27)(ff). We support this law, because it helps patients make reasoned financial decisions concerning their medical care. In compliance with the requirements of this law, you are being advised we have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services we prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Dr. Christopher Yeung has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, The CORE Institute Specialty Hospital, Surgical MRI, Arizona Health Associates LLC, CKY Corporation, The Recovery Shop, and Pro Sports Performance & Rehab LLC. He makes investments, receives royalties, and/or consults in Globus Medical Inc, Bonovo Orthopedics, Plasmology 4 Inc, Lattice Biologics Ltd, Electro Core LLC, Subchondral Solutions Inc, Helia Care Inc, Elliquence, Verve Medical, Arthrex, inFormed Consent, Amplify Surgical, and Spineology.

Dr. Justin Field has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, The CORE Institute Specialty Hospital, SurgCenter Camelback, Oasis Hospital, and The Recovery Shop. He makes investments, receives royalties, and/or consults in Globus Medical Inc, Precision Spine, RTI Surgical, Helia Care Inc, Lattice Biologics Ltd, Mobius Imaging LLC, Plasmology 4 Inc, NuVasive Inc, Additive Implants, Innovasive, Omnia Medical, and CoreLink Medical Device.

Dr. Nima Salari has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, Arizona Recovery Care Center LLC, Arizona Health Associates LLC, The CORE Institute Specialty Hospital, SurgCenter Pima Crossing, Excel Pharmacy, RxToME LLC, and The Recovery Shop. He makes investments, receives royalties, and/or consults in Mobius Imaging LLC, White Coat Consulting PLLC, Medacta USA Inc, Omnia Medical, Plasmology 4, Stryker Spine, Globus Medical, Helia Care Inc, DePuy Synthes, Verve Medical, Dot Technology LLC, and HOPCo.

Dr. Joshua Abrams has part ownership and/or a direct financial interest in Desert Institute for Spine Care PC, Squaw Peak Surgical Facility Inc, SurgCenter North Phoenix, The CORE Institute Specialty Hospital, and The Recovery Shop. He consults with DePuy Synthes, Omnia Medical, Orthofix-SeaSpine, and Stryker Corporation. He also receives royalties for Orthofix-SeaSpine.

Dr. Mark Wang has part ownership and/or a direct financial interest in Squaw Peak Surgical Facility Inc, SurgCenter at Pima Crossing, Excel Pharmacy, The Recovery Shop, and MJW Medical Consulting PLLC. He makes investments, receives royalties, and/or consults in NuVasive, Globus Medical Inc, Medacta USA Inc, Helia Care Inc, Amplify Medical, Verve Medical, Accelus and Xtant Medical.

ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS? _X_ Yes ___ No

Services at the above listed facilities are available on a competitive basis at other hospitals where our physicians are on staff, including Scottsdale Healthcare Shea and Scottsdale Healthcare Thompson Peak. Multiple other healthcare companies offer the same equipment that may accomplish the goals of the equipment provided by the above healthcare companies listed. You are encouraged to ask any of our physicians their reasons for choosing instruments from the above listed companies, or any other instrument, in your treatment.

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. We will keep the signed original in your patient file and you will receive a copy.

ACKNOWLEDGEMENT: I have read this "Notice to Patients" form, and I understand the disclosures that it contains.

Dated this _____Day of _____, 20_____

_____ _____

Name of Patient/Legal Representative Signature of Patient/Legal Representative

Desert Institute For Spine Care, PC

This questionnaire is designed to give us information about your health that will allow us to better understand and assist you.

Name: _____

Date Of Birth: _____

Referring Physician: _____

Family Physician: _____

Today's Date: _____

CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

☐ Back Pain ☐ Leg Pain ########☐ Neck Pain ##########☐ Arm Pain

☐ Other:_____

How long has this been a problem?

☐ Less than 2 Months ☐ 2-6 months ☐ 6-12 months ☐ Greater than 1 year

☐ Describe injury or onset of problem (Include date of injury):_____

_____

_____

Have you been treated by any other Care Giver for this condition? YES☐ NO☐

If yes, please list:_____

_____

What treatments have you had for this problem? (Check all that apply):

☐ Nothing ☐ Chiropractic Care ☐ Acupuncture ☐ Injections

Name of Physician/Institution: _____ Phone Number: _____

Type of treatment: _____

Date of last treatment: _____ Percentage of relief: _____

☐ Physical Therapy (Please check all that apply)

☐ *Stretching* ☐ *Strengthening* ☐ *Traction* ☐ *Iontophoresis/Topical Steroid* ☐ *Tens*

☐ *Massage* ☐ *Ultrasound* ☐ *Heat/ice* ☐ *Therapeutic Ball*

Name of P.T./Institution: _____ Phone Number: _____

Last date of Physical Therapy: _____

☐ Medications

☐ *Muscle Relaxants* ☐ *Pain Medications* ☐ *Ant-Inflammatory (Prescription)*

☐ *Anti-Inflammatory Over the Counter (Aspirin, Tylenol, etc)*

☐ Other: _____

Have you had any other tests for this problem? YES ☐ NO ☐

☐ X-Ray ☐ MRI ☐ Discography ☐ CT ☐ EMG ☐ CT/Myelogram ☐ Bone Scan

☐ Other (Please Specify): _____

Current problem is the result of a(n): Check all that apply:

☐ Injured at work ☐ Auto Accident ☐ Sports ☐ No apparent cause

☐ Other: _____

Desert Institute For Spine Care, PC

Current problem began:

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall

☐ Bending ☐ Pulling ☐ Other_____

What makes the pain worse?

☐ During Exercise ☐ After Exercise ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

☐ Bending Forward ☐ Bending Backward ☐ Pushing ☐ Pulling ☐ Squatting

☐ Night Pain ☐ Other:_____

What reduces your pain?

☐ Nothing ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking

☐ Medication ☐ Shifting/Changing positions

☐ Other_____

PAST MEDICAL HISTORY

SPINE Surgical History:

Date	Surgery	Complication

Other Surgical History:

Date	Surgery	Complication

Current or Past Medical Conditions (i.e. hypertension, cardiac disorders, diabetes, asthma etc.):

Date:	Illness or Hospitalization:

Desert Institute For Spine Care, PC

Are you Allergic to Latex: YES ☐ NO ☐

Medication Allergies (List and describe any allergic reaction): _____

_____

_____

List ALL prescribed and over-the-counter Medications you are currently taking:

	Medication	Strength	# of pills per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SOCIAL HISTORY

Age: _____

Occupation: _____ ☐ Right Handed ☐ Left Handed

Are you? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you working? ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Not working

What is your education level? ☐ High School ☐ College ☐ Graduate Work

What Schools attended? _____

Do you exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Type of exercise/activity? _____

Do you have children? Yes ☐ No ☐ How many?_____

Do you live alone? Yes ☐ No ☐

Do you have lots of stairs? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ Packs per day_____for_____years.

Use other nicotine products? Yes ☐ No ☐

Which product do you use? ☐ Chew ☐ Gum ☐ Patch ☐ Cigars ☐ Other:_____

Have you quit smoking? Yes ☐ No ☐ How long ago?_____

Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year ☐ Never

Is there any litigation pending? ☐ Lawsuit ☐ Workers Comp. ☐ Disability Claim ☐ Social Security Claim

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FAMILY HISTORY

Do you have a first (parents or siblings) or second degree (all other) family history of?

Arthritis	1st ☐	2nd ☐	NO ☐	Blood clots/excessive-bleeding	1st ☐	2nd ☐	NO ☐
Hypertension	1st ☐	2nd ☐	NO ☐	Diabetes	1st ☐	2nd ☐	NO ☐
Cancer	1st ☐	2nd ☐	NO ☐	Adverse Reaction to Anesthesia	1st ☐	2nd ☐	NO ☐
Mental Health Disorders	1st ☐	2nd ☐	NO ☐	Cardiac Disorders	1st ☐	2nd ☐	NO ☐

Other_____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

			Please describe all yes answers
Skin	Yes ☐	No ☐	_____
Ears, Nose, Throat	Yes ☐	No ☐	_____
Cardiac/High blood pressure	Yes ☐	No ☐	_____
Pacemaker	Yes ☐	No ☐	_____
Defibulator	Yes ☐	No ☐	_____
Lungs, (Asthma, Infection)	Yes ☐	No ☐	_____
Stomach/Digestion	Yes ☐	No ☐	_____
Bladder/Bowel problems	Yes ☐	No ☐	_____
Hematologic/Bleeding problems	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Musculoskeletal	Yes ☐	No ☐	_____
Neurological	Yes ☐	No ☐	_____
Psychiatric problems	Yes ☐	No ☐	_____
Reproductive/Sexual Problems	Yes ☐	No ☐	_____
Fever/Chills	Yes ☐	No ☐	_____
Night Sweat	Yes ☐	No ☐	_____
Night Pain	Yes ☐	No ☐	_____
Unexpected Weight loss	Yes ☐	No ☐	_____

Reviewed By:_____ Date: _____

Reviewed By:_____ Date: _____

Reviewed By:_____ Date: _____

Reviewed By:_____ Date: _____

Desert Institute For Spine Care, PC

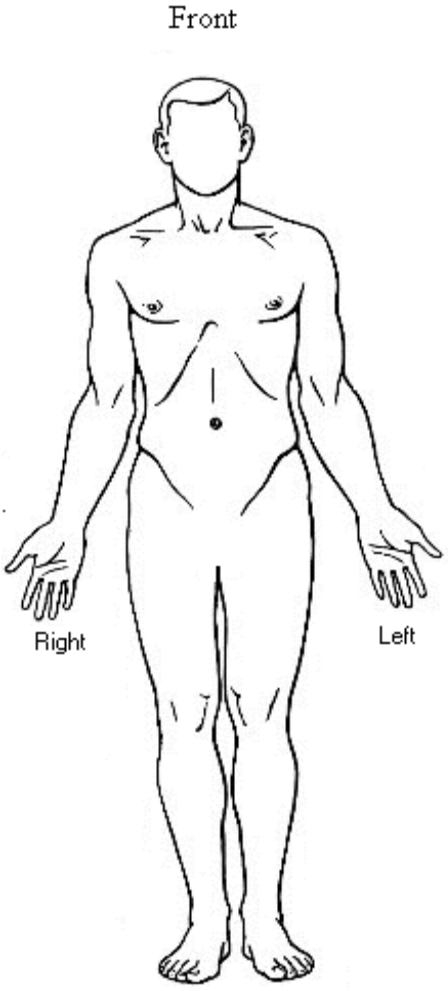
Spine Questionnaire

WHERE IS YOUR PAIN NOW? Does it go anywhere? (Describe):_____

_____

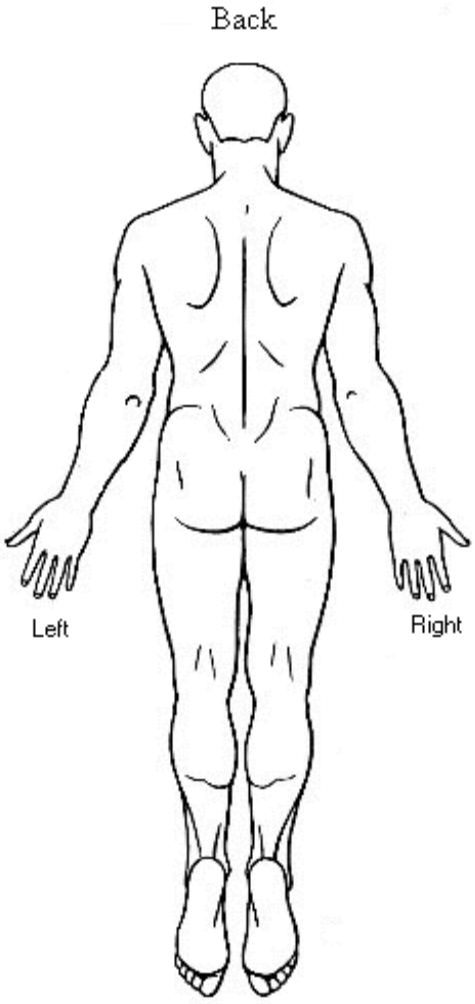
_____

_____



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.



Use the body diagrams to show where you feel the following sensations.

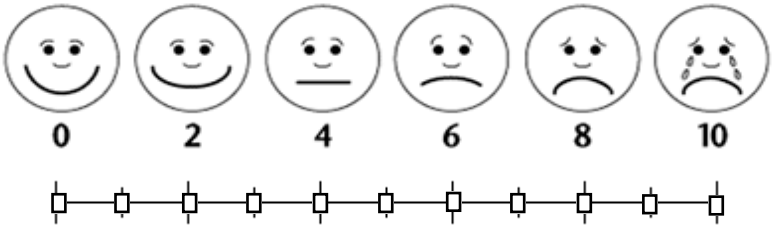
Ache	Numbness	Burning	Stabbing
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///

Pins And Needles

≡ ≡ ≡

Grade your overall Pain

Please place an X *on the hash mark* that most accurately describes your overall degree of pain now.



None Mild Moderate Seve re Very Severe Worst Possible

Desert Institute For Spine Care, PC

SF-12® Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

---

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does your health *now* limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, Limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
3. Climbing several flights of stairs	☐	☐	☐

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like	Yes ☐	No ☐
5. Were limited in the **kind** of work or other activities	Yes ☐	No ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like.	Yes ☐	No ☐
7. Didn't do work or other activities as **carefully** as usual.	Yes ☐	No ☐

---

8. During the *past 4 weeks*, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

Desert Institute For Spine Care, PC

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the *past 4 weeks*...

	All of the time	Most of the time	A good bit of time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

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12. During the *past 4 weeks*, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Desert Institute For Spine Care, PC

Oswestry Disability Index 2.0

SCORE_____

Check one of the following boxes: ☐ **Prior to Surgery** ☐ **After Surgery**

Could you please complete this questionnaire? It is designed to give us information as to how your spine trouble has affected your ability to manage in everyday life.

Please answer every section. Mark *one box only* **in each section that most closely describes you** *Today*

Section 1: Pain Intensity
1. ☐ I have no pain at the moment.
2. ☐ The pain is very mild at the moment.
3. ☐ The pain is moderate at the moment
4. ☐ The pain is fairly severe at the moment.
5. ☐ The pain is very severe at the moment.
6. ☐ The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, dressing, etc)
1. ☐ I can look after myself normally without causing extra pain.
2. ☐ I can look after myself normally but it is very painful.
3. ☐ It is painful to look after myself and I am slow and careful.
4. ☐ I need some help but manage most of my personal care
5. ☐ I need help every day in most aspects of self-care.
6. ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3: Lifting
1. ☐ I can lift heavy weights without extra pain.
2. ☐ I can lift heavy weights but it gives extra pain
3. ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table.
4. ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
5. ☐ I can lift only very light weights
6. ☐ I cannot lift or carry anything at all.

Section 4: Walking
1. ☐ Pain does not prevent me from walking any distance.
2. ☐ Pain prevents me from walking more than 1 mile.
3. ☐ Pain prevents me from walking more than a quarter of a mile.
4. ☐ Pain prevents me walking more than 100 yards.
5. ☐ I can only walk using a stick or crutches.
6. ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting
1. ☐ I can sit in any chair as long as I like.
2. ☐ I can sit in my favorite chair as long as I like.
3. ☐ Pain prevents me from sitting for more than 1 hour.
4. ☐ Pain prevents me from sitting for more than half an hour.
5. ☐ Pain prevents me from sitting for more than 10 minutes.
6. ☐ Pain prevents me from sitting at all.

Section 6: Standing
1. ☐ I can stand as long as I want without extra pain.
2. ☐ I can stand as long as I want but it gives me extra pain.
3. ☐ Pain prevents me from standing for more than 1 hour.
4. ☐ Pain prevents me from standing for more than half an hour.
5. ☐ Pain prevents me from standing for more than 10 minutes.
6. ☐ Pain prevents me from standing at all.

Section 7: Sleeping
1. ☐ My sleep is never disturbed by pain.
2. ☐ My sleep is occasionally disturbed by pain.
3. ☐ Because of pain I have less than 6 hours' sleep.
4. ☐ Because of pain I have less then 4 hours' sleep.
5. ☐ Because of pain I have less than 2 hours' sleep.
6. ☐ Pain prevents me from sleeping at all.

Section 8: Sex life (if applicable)
1. ☐ My sex life is normal and causes no extra pain.
2. ☐ My sex life is normal but causes some extra pain.
3. ☐ My sex life is nearly normal but it is very painful.
4. ☐ My sex life is severely restricted by pain.
5. ☐ My sex life is nearly absent due to pain.
6. ☐ Pain prevents any sex life at all.

Section 9: Social Life
1. ☐ My social life is normal and causes me no extra pain.
2. ☐ My social life is normal but increases the degree of pain.
3. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
4. ☐ Pain has restricted my social life and I do not go out as often.
5. ☐ Pain has restricted social life to my home.
6. ☐ I have no social life because of pain.

Section 10: Traveling
1. ☐ I can travel anywhere without pain.
2. ☐ I can travel anywhere but it gives extra pain.
3. ☐ Pain is bad but I manage journeys over 2 hours.
4. ☐ Pain restricts me to journeys less than 1 hour.
5. ☐ Pain restricts me to short necessary journeys less than 30 minutes.
6. ☐ Pain prevents me from traveling except to receive treatments