

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ Age \_\_\_\_\_

NAME AND ADDRESS OF REFERRING PHYSICIAN: \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME AND ADDRESS \_\_\_\_\_

**New Patient Information Form Related to Lumbar Spine**

Is this visit related to a recent motor vehicle accident? \_\_\_\_\_ If so, date of accident: \_\_\_\_\_

Is this visit due to a work-related injury? \_\_\_\_\_ If so, date of injury: \_\_\_\_\_

**Note: You may use the back of this paper if you need additional space.**

When did you first notice any back and/or leg pain? \_\_\_\_\_.

Describe how the problem began: \_\_\_\_\_

When did you first go to a doctor or chiropractor for this problem? What kinds of tests or treatment were ordered? \_\_\_\_\_

Were you referred to any other physicians for further tests or treatment? ( ) Yes ( ) No

If so, who were you referred to and what was recommended? \_\_\_\_\_

What things do you do that make the problem better (sitting, lying down, etc.)? \_\_\_\_\_

What things do you do that makes the problem worse (standing, walking, bending, etc.)? \_\_\_\_\_

What type of treatment has helped? \_\_\_\_\_

Has your condition changed since the pain began? ( ) Improved ( ) Became worse ( ) No change

Has any Doctor recommended surgery for this condition?  Yes  No

I have had the following tests for my back pain:

\_\_\_\_\_ MRI      \_\_\_\_\_ Myelogram      \_\_\_\_\_ CT Scan      \_\_\_\_\_ Bone Scan  
\_\_\_\_\_ EMG      \_\_\_\_\_ Discogram      \_\_\_\_\_ Regular X-rays      \_\_\_\_\_ Date of Testing  
\_\_\_\_\_ Nerve Conduction Studies

**Current Symptoms:**

\_\_\_\_\_ I have only back pain.  
\_\_\_\_\_ I have only leg pain.  
\_\_\_\_\_ I have back and leg pain; which one is worse? ( ) Back ( ) Leg ( ) Both about equal.  
\_\_\_\_\_ Have you totally lost control of your bladder? ( ) Yes ( ) No Explain: \_\_\_\_\_

**Limitations (Check one):**

**Sitting:** I can sit as long as I like with without pain \_\_\_\_\_  
Pain prevents me from sitting for more than one hour \_\_\_\_\_  
Pain prevents me from sitting for more than thirty minutes \_\_\_\_\_  
Pain prevents me from sitting for more than 10 minutes \_\_\_\_\_

**Standing:** I can stand as long as I like without extra pain \_\_\_\_\_  
Pain prevents me from standing for more than one hour \_\_\_\_\_  
Pain prevents me from standing for more than thirty minutes \_\_\_\_\_  
Pain prevents me from standing for more than 10 minutes \_\_\_\_\_  
Pain prevents me from standing at all \_\_\_\_\_

**Walking:** I can walk any distance without limitation \_\_\_\_\_  
Pain prevents me from walking for more than one mile \_\_\_\_\_  
Pain prevents me from walking for more than 1/2 mile \_\_\_\_\_  
Pain prevents me from walking for more than 1/4 mile \_\_\_\_\_  
I can only use a cane or walker \_\_\_\_\_  
I am in bed most of the time and have to crawl to the bathroom \_\_\_\_\_

**Lying:** Does lying down in bed increase your back pain? \_\_\_\_\_  
Does lying down in bed decrease your back pain? \_\_\_\_\_  
Do you wake up at night with pain while changing positions? \_\_\_\_\_

**Social:** My social life is normal \_\_\_\_\_  
My social life is affected because of pain \_\_\_\_\_  
I have no social life because of pain \_\_\_\_\_

**Medical History**

- ( ) AIDS/HIV
- ( ) Anxiety
- ( ) Arthritis ( ) Degenerative ( ) Rheumatoid ( ) Gout ( ) Other: \_\_\_\_\_
- ( ) Bladder Disorder
- ( ) Blood Disorder ( ) Anemia ( ) Leukemia ( ) Bleeding Tendency ( ) Other: \_\_\_\_\_
- ( ) Blood clots in legs
- ( ) Cancer Type and Sites: \_\_\_\_\_
- ( ) Depression
- ( ) Diabetes
- ( ) Headaches
- ( ) Head injury
- ( ) Hearing disorder
- ( ) Heart Disease ( ) Angina ( ) Heart Attack ( ) Heart Failure
- ( ) Hepatitis
- ( ) High Blood Pressure
- ( ) Joint Disease
- ( ) Kidney Disease ( ) Stones ( ) Infections ( ) Other: \_\_\_\_\_
- ( ) Liver Disease ( ) Hepatitis ( ) Type A ( ) Type B ( ) Other: \_\_\_\_\_
- ( ) Lung Disease ( ) Emphysema ( ) TB ( ) Chronic Bronchitis ( ) Cancer ( ) Asthma
- ( ) Seizure Disorder

**Medical History continued,**

- Stomach Disorder
- Thyroid Disease
- Tinnitus (ringing in ears)
- Ulcers
- Vascular Disease
- Weight changes : \_\_\_\_\_
- Psychological Difficulties:  Depression  Psychosis  Other: \_\_\_\_\_

**Previous Surgeries:**  No previous surgeries

**Year**

- |   |   |
|---|---|
| _____ <input type="checkbox"/> Tonsillectomy      | _____ <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Total <input type="checkbox"/> Partial |
| _____ <input type="checkbox"/> Appendectomy       | _____ <input type="checkbox"/> Prostate Operation   |
| _____ <input type="checkbox"/> Gallbladder        | _____ <input type="checkbox"/> Biopsy (Type – Result) _____   |
| _____ <input type="checkbox"/> Hernia Repair      | _____ <input type="checkbox"/> Fractures (Explain) _____  |
| _____ <input type="checkbox"/> Vasectomy ( Males) | _____ <input type="checkbox"/> Other: _____   |

**Allergies:** (Circle the reaction that applies)

- |                                     |       |                    |              |                          |
|-------------------------------------|-------|--------------------|--------------|--------------------------|
| <input type="checkbox"/> Penicillin | Rash  | Breathing Problems | Nausea/Vomit | Required Hospitalization |
| <input type="checkbox"/> Sulfe      | Rash  | Breathing Problems | Nausea/Vomit | Required Hospitalization |
| <input type="checkbox"/> Keflex     | Rash  | Breathing Problems | Nausea/Vomit | Required Hospitalization |
| <input type="checkbox"/> Codeine    | Rash  | Breathing Problems | Nausea/Vomit | Required Hospitalization |
| <input type="checkbox"/> Latex      | Rash  | Breathing Problems | Nausea/Vomit | Required Hospitalization |
| <input type="checkbox"/> Other:     | _____ |                    |              |                          |
| <input type="checkbox"/> None       |       |                    |              |                          |

List all current medication, including vitamins and herbs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Current tobacco use  Yes  No. If cigarettes, \_\_\_\_\_ # of packs daily (cigarettes, Cigars, Pipe, Chew tobacco)

Alcohol use  Yes  No \_\_\_\_\_ # drinks daily # of drinks every week \_\_\_\_\_

Living situation/marital status:  Married  Single  Widow(er)  Divorced  Live alone  Have roommate

**Work Status:**

Occupation: \_\_\_\_\_  
 Work full-time  Work part-time  Work but with restrictions

Job requirements are:

- Heavy      Lifting over 60 lbs and frequent bending and stooping
- Medium      Lifting 30-50 lbs
- Light      Lifting 10-20 lbs
- Sedentary      Sit most of the time and very little lifting

Not working due to pain     Not working for other reasons. Explain: \_\_\_\_\_  
\_\_\_\_\_

Do you live in a one story or two story home or apartment? \_\_\_\_\_

**Medications**

- Aspirin                       Tylenol                       Sleeping Meds: \_\_\_\_\_
- Muscle Relaxors       Anti-Inflammatories: \_\_\_\_\_
- Codeine
- Anti-Depressants       Anti-psychotics
- Others: \_\_\_\_\_

**Dr. B. Christoph Meyer, P.A.**  
**8200 Wednesbury, Suite 360**  
**Houston, Texas 77074**

**Back Pain Questionnaire**

Patient Name: \_\_\_\_\_

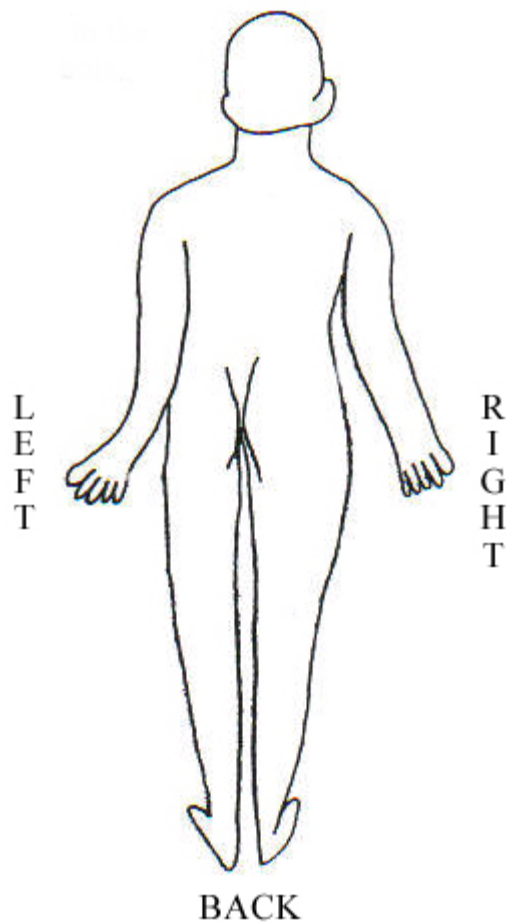
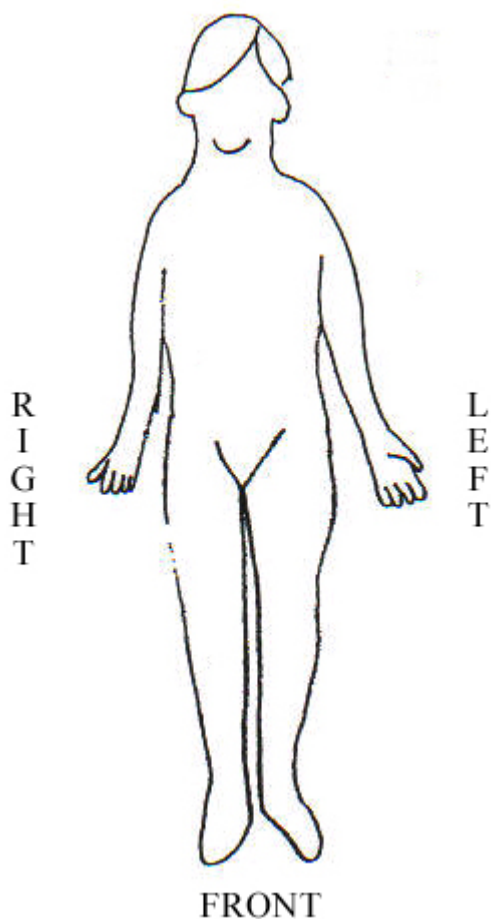
Date: \_\_\_\_\_

No Pain		Low		Moderate		Intense		Unbearable		
0	1	2	3	4	5	6	7	8	9	10

Pain level now \_\_\_\_\_ Least pain in the last month \_\_\_\_\_ Most pain in the last year \_\_\_\_\_

Indicate the location and type of your pain in the drawing below using the following symbols:

- OO Pins and Needles
- XX Burning
- // Stabbing
- = Numbness
- '''' Aching



Office Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Welcome to the **Houston Center for Spinal Reconstruction and Disc Replacement**. In order for us to be able to deliver the quality of care that you are accustomed to, we have established these financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible. **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.**

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. Further it is the patient's responsibility to verify with your insurance that Dr. Meyer is a provider within your network.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist and we will give you a form to update.
3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, MasterCard, and Discover.
4. If your insurance does not pay within 45 days, you will be billed for any unpaid balance. If your insurance denies our charges, or does not pay us in a timely manner, you will be responsible for the balance owed.
5. If you do not pay your unpaid balance within 45 days from the date of the bill your account may be referred to a collection agency, and reported to the credit bureau.
6. **MEDICARE PATIENTS:** We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of the amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
7. **HMO/PPO PATIENTS:** If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service—no exceptions. If your plan requires you to have an authorization to see a specialist, it is your responsibility to make sure your primary care physician gets the proper referral from your insurance company to see Dr. Meyer. If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
8. **SELF PAY PATIENTS:** Patient with no insurance will be expected to pay at the time services are rendered.
9. **No show or missed appointments-** When an appointment is scheduled with Dr. Meyer or the physician assistant, time is specifically allocated for you. When an appointment is not canceled in advance, and the patient 'no shows', another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be time when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If you miss your appointment without 24 hour cancellation notice, you will be charged a \$25.00 fee.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of the charges for services rendered to you. If you have any questions regarding our financial policy, please contact our billing department at 713-484-6200 ext 106.

I have read and have a full understanding of the financial policy of Houston Center Spinal Reconstruction and Disc Replacement.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_