*MSJ Physician:*_____

Monterey Spine & Joint

12 Upper Ragsdale
Ryan Ranch, Monterey, CA 93940

Tel: 831.648.7200 Fax: 831.648.7204
montereyspineandjoint.com

220 San Jose Street
Salinas, CA 93901

Patient Information:

First Name: _____

Middle: _____

Last Name: _____

DOB _____ Suffix: _____(Jr, Sr, etc)

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____

Work #: _____

Cell #: _____

Soc Sec #: _____

Email: _____

Emergency Contact: _____

Relationship: _____

Phone #: _____

Pharmacy / Location: _____

Primary Care Physician: _____

Demographics:

✓ Ethnicity:
- ○ Caucasian
- ○ Hispanic
- ○ Asian
- ○ African American
- ○ Other _____

✓ Gender:
- ○ male
- ○ female

✓ Marital status:
- ○ single
- ○ married
- ○ domestic partner
- ○ divorced
- ○ widowed

Referral Information:

✓How did you hear about us?

- ○ My physician referred me:
  (Name: _____)
- ○ Friend:
  (Name: _____)
- ○ Internet
- ○ no one (self-referred)
- ○ Other: _____

Guarantor Information: (person responsible for medical charges)

* if patient is *not* guarantor, please fill out this section *

First Name: _____

Middle: _____ Gender: M F

Last Name: _____

DOB _____ Suffix: _____(Jr, Sr, etc)

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____

Work #: _____

Cell #: _____

Soc Sec #: _____

Relationship to patient: _____

Insurance Information:

○ None (self-pay)

	✓ Primary	✓ Secondary
Aetna	○	○
AARP	○	○
Anthem Blue Cross	○	○
Aspire	○	○
Blue Cross MCSIG	○	○
Blue Shield of California	○	○
Blue Shield Federal	○	○
CCAH	○	○
Cigna	○	○
Coastal TPA	○	○
Covered California	○	○
First Health	○	○
Health Net	○	○
Medi-cal	○	○
Medicare	○	○
Pinnacle	○	○
Tricare	○	○
Triwest	○	○
United ABT	○	○
United Healthcare	○	○
Western Growers	○	○
Worker's Compensation	○	○
Other:	_____	_____
ID#:	_____	_____
Group#:	_____	_____

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Medical History:

Current Medications: ○ none ○ see attached

Type Dose Amount

Prior Surgeries: ○ none ○ see attached

Type Month/yr Surgeon

Allergies to medication? ○ no ○ yes

Name of medication Reaction

Allergies to food? ○ no ○ yes

(if applicable, list food & reaction)

Allergies to latex? ○ no ○ yes

(if applicable, list reaction)

Please ✓ all that apply to you:

	No	Yes	Comments:
Alzheimer's disease	○	○	
Arthritis – osteo	○	○	
Arthritis – rheumatoid	○	○	
Artificial Heart Valve	○	○	
Asthma	○	○	
Atrial fibrillation	○	○	
Blood clot disorder	○	○	
Bleeding disorder	○	○	
Cancer	○	○	
Cardiovascular disease	○	○	
Carotid artery surgery	○	○	
Congestive Heart Failure	○	○	
COPD / emphysema	○	○	
Deep venous thrombosis	○	○	
Diabetes type I	○	○	
Diabetes type II	○	○	
Fibromyalgia	○	○	
GERD	○	○	
Gout	○	○	
High blood pressure	○	○	
High Cholesterol	○	○	
HIV / AIDS	○	○	
Heart murmur	○	○	
Heart attack	○	○	
Heart surgery	○	○	
Hepatitis	○	○	
Hypothyroidism	○	○	
Liver disease	○	○	
Multiple sclerosis	○	○	
Parkinson's disease	○	○	
Pain medicine addiction	○	○	
Peripheral neuropathy	○	○	
Pneumonia	○	○	
Pulmonary embolism	○	○	
Sciatica	○	○	
Sleep apnea	○	○	
Sexually transmitted dz	○	○	
Stomach ulcers	○	○	
Stroke / CVA	○	○	
Tuberculosis	○	○	

Other medical conditions:

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Social History:

Smoking history:	No	Yes	Used to
Do you smoke?	○	○	○
	Day	Week	Month
_____ # of packs per	○	○	○

How many years? _____
When did you quit? _____

Drinking history:	No	Yes	Used to
Do you drink alcohol?	○	○	○
	Day	Week	Month
_____ # of drinks per	○	○	○

How many years? _____
When did you quit? _____

Substance abuse history: Do you use …	No	Yes	Used to
Marijuana	○	○	○
Cocaine	○	○	○
Methamphetamines	○	○	○
Heroin	○	○	○
Intravenous drugs	○	○	○
Other _____			

Living situation:	No	Yes
I live alone	○	○

Please check ✓ below who lives with you:

Husband		○
Wife		○
Son	# _____	○
Daughter	# _____	○
Brother	# _____	○
Sister	# _____	○
Father		○
Mother		○
Boyfriend		○
Girlfriend		○
Domestic partner		○
Other _____		

Work / School history:

	No	Retired	Yes
Are you employed?	○	○	○

If so, what is your job? _____
Who is your employer? _____
If attending school, where? _____

	No	Possibly	Yes
If female, are you pregnant?	○	○	○

Please ✓ if you enjoy these hobbies / activities:

Baseball	○	Sailing	○
Basketball	○	Scuba diving	○
Biking	○	Skateboarding	○
Crossfit	○	Soccer	○
Football	○	Softball	○
Golf	○	Swimming	○
Hiking	○	Surfing	○
Hockey	○	Tennis	○
Hunting	○	Track & Field	○
Knitting	○	Wakeboarding	○
Lacrosse	○	Working out	○
Running	○	Yoga	○
Pilates	○		
Racquetball	○		
Rock climbing	○		

Other : _____
_____

Family History:

Please list any medical conditions for the following family members:

Father: _____
Mother: _____
Siblings: _____
Other: _____
_____

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Review of systems: please ✓ all that apply (feel free to comment on lines below)

General:
- O none
- O fevers
- O chills
- O fatigue
- O poor appetite
- O night sweats
- O weight loss
- O weight gain
- O insomnia

Eyes:
- O none
- O eye pain
- O eye discharge
- O blurry vision
- O double vision
- O decreased vision
- O dry eyes
- O red eyes

ENT:
- O none
- O sore throat
- O hoarseness
- O nose bleeds
- O sinus problem
- O ear pain
- O ear discharge
- O hearing loss

Heart:
- O none
- O chest pain
- O palpitations
- O rapid heart rate
- O heart murmur
- O bad circulation
- O leg swelling

Lungs:
- O none
- O shortness of breath
- O chronic cough
- O coughing up blood
- O excess sputum
- O wheezing

Stomach:
- O none
- O nausea
- O vomiting
- O heartburn
- O diarrhea
- O constipation
- O blood in stool

Urinary:
- O none
- O incontinence
- O urinary frequency
- O painful urination
- O frequent urinary tract infections
- O blood in urine

Skin:
- O none
- O rash
- O hives
- O hair loss
- O skin sores
- O skin ulcers
- O itching
- O mole changes

Bones/Joints:
- O none
- O joint pain
- O joint swelling
- O muscle aches
- O muscle weakness

Psychiatric:
- O none
- O anxiety
- O depression
- O panic attacks
- O drug dependence
- O alcohol dependence
- O suicidal thoughts

Hormones:
- O none
- O increased thirst
- O excess sweating
- O heat intolerance
- O cold intolerance
- O skin color Changes

Neurologic:
- O none
- O tremors
- O migraines
- O seizures
- O stroke
- O slurred speech
- O dizziness
- O numbness
- O poor balance

Blood:
- O none
- O easy bruising
- O blood clots
- O prolonged bleeding
- O swollen lymph nodes
- O low blood counts

Immune:
- O none
- O allergic reactions
- O frequent infections

			Results normal?	
Date of last colonoscopy?	O none	_____(mo/yr)	O yes	O no
Date of last mammogram?	O none	_____(mo/yr)	O yes	O no
Date of last pneumonia vaccine?	O none	_____(mo/yr)		

Reason for Your Visit:

What is the reason for your visit today?

_____

_____

_____

If you have symptoms, how did they occur?

_____

_____

_____

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Release of Medical Information & Financial Responsibility:

We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If a copayment or deductible is part of your plan, we require that your portion be paid at the time of service. We will make every effort to provide you with an accurate amount due at the end of your visit today.

I hereby authorize the release of any needed medical information to insurance carriers to process a claim, and request that payment be sent to Monterey Spine and Joint for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. Monterey Spine and Joint may add monthly rebilling fees for overdue balances.

_____

Signature Date

***** Medicare patients only *****
Release of Medical Information & Financial Responsibility:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Monterey Spine and Joint for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable to related services.

I understand that my signature requests that payment be made and authorizes the releaseof medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is fully responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Signature Date

Notice of Privacy Practices:

I, _____ have been given the opportunity to read and review this office's Notice of Privacy Practices.

_____

Signature Date

Designation of Personal Representative

I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all of my protected health information.

_____

Name Relationship

_____

Name Relationship

Consent for Treatment if Patient is a Minor:

I grant Monterey Spine and Joint and the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the stated patient.

_____

Signature Relationship Date

Thank you for your time and cooperation!