

Desert Spine Surgeons
Dr Robert Waldrip

History & Physical

Name: _____ DOB: _____ Age: _____

Primary Care Physician/Family Doctor: _____

Height ___' ___ Weight _____ (nurse only) B/P _____ P _____

Chief Complaint (circle one)

Neck Pain Neck Pain with Arm Pain Upper Back Pain

Mid Back Pain Low Back Pain Low Back Pain with Leg Pain

History of Present Illness:

When did it start: _____

Previous Episodes: _____

Previous Treatments: _____

Past Medical History: (circle if you have or have had)

AIDS	COPD	High Blood Pressure
Alcohol/Drug Addiction	Asthma	High Cholesterol
Anxiety	Cancer:	Infections:
Arthritis:	Breast	Cellulitis
Gout	Lung	MRSA
Osteoarthritis	Prostate	TB
Rheumatoid Arthritis	Skin	Liver Problems:
Bleeding Disorders:	other _____	Hepatitis A
Deep Vein Thrombosis	Depression	Hepatitis B
Blood Transfusion	Diabetes:	Hepatitis C
Anemia	Type I	Cirrhosis
Bone Problems:	Type II	Migraine
Fractures	Eye Problems:	Obesity
Scoliosis	Cataracts	Pulmonary Embolism
Osteoporosis	Glaucoma	Seizures
Bowel Problems:	Macular Degeneration	Skin Problems:
Constipation	Fibromyalgia	Shingles
Crohn's Disease	Heart Problems:	Thyroid Problems:
IBS	Angina	Hypo/Hyperthyroid
GERD	Arrythmia	
Breathing Problems:	Coronary Artery Disease	
Sleep Apnea	Mitral Valve Prolapse	
Chronic Bronchitis	Congestive Heart Failure	
Emphysema		

Past Surgical History:

Name/ Type of Surgery _____ Year of Surgery _____

Family History:

Diabetes	Hypertension	CVA
ASHD	Cancer	High Cholesterol
Colon Polyps	Kidney Disease	Psychiatric Illness
Arthritis	Heart Disease	

Social History:

Occupation: _____
__Married __Single __Widowed

Smoker: Yes / No Packs Per Day _____ How Many Years: _____
Alcohol: Yes / No Drinks Per Day _____ Per Week _____
Caffeine: (Coffee, Iced Tea, Soda) Yes / No Drinks Per Day _____

Medications:

<u>Name:</u>	<u>Dosage:</u>	<u>Frequency:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug/Food Allergy: _____

**ROBERT WALDRIP
DESERT SPINE SURGEONS**

REVIEW OF SYSTEMS: check next to ones that are positive

HEENT

- headaches
- blurred vision
- cataracts
- glaucoma
- loss of visual fields
- ringing in the ears
- epistaxis
- glasses
- contacts
- dentures

PULMONARY

- cough
- sputum
- hemoptysis
- dyspnea
- chest pain
- wheezing
- asthma

CARDIOVASCULAR

- chest pain
- palpitations
- orthopnea
- shortness of breath
- pedal edema
- hypertension
- mitral valve prolapse
- phlebitis
- deep vein thrombosis
- vascular insufficiency

GI

- weight gain/loss
- nausea
- vomiting
- diarrhea
- constipation
- hematemesis
- BRBPR
- hepatitis
- ulcers
- dysphagia
- GERD
- abdominal pain
- change in appetite
- hernias

NEURO

- dizziness
- fainting
- seizures
- vertigo
- parasthesias
- weakness
- tremors
- memory disturbance
- tingling

DERM

- rashes
- pruritus
- lumps

PSYCH

- depression
- agitation
- panic/anxiety
- manic episodes
- personality changes
- hallucinations

RHEUM

See HPI (office notes)

HEME

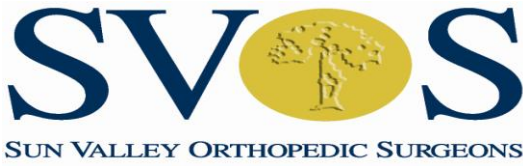
- anemia
- ease of bruising or bleeding
- prior transfusions
- lymph node enlargement
- pain
- fatigue
- fever
- chills
- night sweats

GU

- dysuria
- hematuria
- nocturia
- frequency
- decreased force of urination
- retention
- incontinence
- UTI's

ENDO

- diabetes mellitus
- hyper/hypothyroid



SUN VALLEY ORTHOPEDIC SURGEONS
AND PHYSICAL THERAPY

DESERT SPINE SURGEONS

Financial Policy

Thank you for choosing us to serve you and your family's health needs. We are committed to your care. The following is a statement of our financial policy which we require you to read and sign prior to treatment. The financial policy applies to all services provided to you by any of our providers regardless of location.

CO-PAYS AND OTHER BALANCES- UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE, ALL CO-PAYMENTS, DEDUCTIBLES AND FEES THAT ARE NOT COVERED BY YOUR INSURANCE ARE DUE AT TIME OF SERVICE. IF WE HAVE TO BILL YOU FOR YOUR CO-PAY THERE WILL BE A \$10.00 FEE ADDED TO YOUR BILL. WE ACCEPT CASH, CHECK, MASTERCARD, VISA AND DISCOVER. PLEASE NOTIFY US OF ANY CHANGE IN INSURANCE, ADDRESS OR PHONE NUMBER.

SURGERY CHARGES- SHOULD YOUR TREATMENT REQUIRE SURGERY, AS PART OF THE PRE-OPERATIVE PROCESS WE WILL MAKE AN ESTIMATE OF THE FEES. THE ACTUAL CHARGES BILLED FOR YOUR SURGERY WILL REFLECT THE PROCEDURES PERFORMED AND MAY DIFFER FROM THE ESTIMATE. **PREPAYMENT OF ANY UNMET DEDUCTIBLE AND ESTIMATED CO-PAY IS DUE PRIOR TO SURGERY. IF YOU ARE A SELF PAY PATIENT, A PREPAYMENT OF ONE HALF OF ESTIMATED COST IS REQUIRED.**

INSURANCES- IT IS YOUR RESPONSIBILITY TO UNDERSTAND AND BE AWARE OF THE TERMS AND CONDITIONS OF YOUR INSURANCE PLAN. YOUR MEDICAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE, AS A COURTESY TO OUR PATIENTS, WILL SUBMIT A CLAIM TO YOUR INSURANCE COMPANY PROVIDED WE HAVE COMPLETE AND ACCURATE INFORMATION. TO ENSURE YOUR CLAIM IS SUBMITTED IN A TIMELY FASHION A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED AT THE TIME OF SERVICE. IT IS YOUR RESPONSIBILITY TO VERIFY IF OUR PROVIDER IS PARTICIPATING IN YOUR NETWORK AND GETTING ANY REFERRALS REQUIRED FOR SERVICES RENDERED.

SELF PAY PATIENTS- PAYMENT OF A \$150 FEE IS DUE AT TIME OF SERVICE, BALANCE ON ACCOUNT MAY DIFFER ONCE SERVICES ARE RENDERED, AT WHICH POINT YOU WILL BE BILLED FOR ANY REMAINING BALANCE. IF YOU ARE UNABLE TO PAY YOUR BALANCE IN FULL, YOU WILL NEED TO MAKE PRIOR ARRANGEMENTS WITH OUR PATIENT ACCOUNTS REPRESENTATIVE.

MISSED APPOINTMENTS- IT IS A REQUIREMENT THAT YOU CANCEL OR RESCHEDULE, 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. IF YOU FAIL TO DO SO A \$25 FEE WILL BE APPLIED TO YOUR ACCOUNT.

DURABLE MEDICAL EQUIPMENT- SOME INSURANCE POLICIES DO NOT COVER DURABLE MEDICAL EQUIPMENT AND THEREFORE IS YOUR FINANCIAL RESPONSIBILITY. PAYMENT IS DUE PRIOR TO RECEIVING DURABLE MEDICAL EQUIPMENT IF YOU ARE CASH PAY. EQUIPMENT CANNOT BE RETURNED.

OUTSTANDING BALANCES- JUST AS WE MAKE EVERY EFFORT TO ACCOMMODATE YOU WHEN YOU ARE IN NEED OF MEDICAL CARE; WE EXPECT THAT YOU WILL MAKE EVERY EFFORT TO PAY YOUR BILL PROMPTLY. YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR ACCOUNT, REGARDLESS OF INSURANCE COVERAGE. IF YOU ARE UNABLE TO PAY YOUR BILL IN ITS ENTIRETY PLEASE CONTACT OUR BILLING DEPARTMENT TO DISCUSS YOUR OPTIONS.

DELINQUENT BALANCES- UNLESS WE APPROVE OTHER ARRANGEMENTS IN WRITING, THE BALANCE ON YOUR STATEMENT IS DUE UPON RECEIPT. IF PAYMENT IS NOT RECEIVED, WE RESERVE THE RIGHT TO REFUSE SERVICE ON DELINQUENT ACCOUNTS. IF YOUR ACCOUNT BECOMES DELINQUENT, WE WILL TAKE THE NECESSARY STEPS TO COLLECT THE DEBT. **IF YOUR ACCOUNT IS TURN TO AN OUTSIDE COLLECTION AGENCY A 35% FEE WILL BE ADDED TO THE BALANCE.**

These policies are subject to change without notice.

I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY **SUN VALLEY ORTHOPEDIC SURGEONS/ DESERT SPINE SURGEONS**. I UNDERSTAND THAT I AM RESPONSIBLE FOR PROMPT PAYMENT OF ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE, **INCLUDING DEDUCTIBLES AND COPAYS. I UNDERSTAND PAYMENT OF CO-PAYS IS DUE AT TIME OF SERVICE, AS WELL AS ANY PRIOR DELINQUENT BALANCE I MAY OWE.** I ALSO CONSENT THAT THE PAYMENT OF AUTHORIZED MEDICARE INSURANCE BENEFITS BE MADE ON MY BEHALF DIRECTLY TO **SUN VALLEY ORTHOPEDIC SURGEONS/ DESERT SPINE SURGEONS** FOR ANY MEDICAL OR SURGICAL SERVICES FURNISHED. I AGREE TO ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT OF MY CHARGES.

(SIGNATURE OF PATIENT/RESPONSIBLY PARTY)

(PRINTED NAME)

(DATE)

Sun Valley Orthopedic Surgeons Registration Form

New Patient Update Only

Janzer Jensen Kelly Sterusky Tsao Waldrip

ALL INFORMATION MUST BE COMPLETED - PLEASE PRINT

Today's date: _____

Patient Information

Mr. Mrs. Miss Ms. Marital Status: Single Married Divorced Separated Widowed

Patient's Last Name: _____ First: _____ Middle: _____

SS #: _____ Date of Birth: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip Code: _____

e-mail Address: _____

2nd address (out-of-state)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Race: American Indian or Alaskan Native Non-Hispanic/Latino
 Black or African American Native Hawaiian or other Pacific Islander
 Asian White
 Hispanic/Latino

Ethnicity (Ethnic Origin): Hispanic/Latino
 Non-Hispanic/Latino

Primary Language Spoken: _____

Preferred Pharmacy Information

Pharmacy Name: _____

Pharmacy Address/Cross Streets: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

Employment Information

Employer: _____ Occupation: _____

Employer Phone #: _____

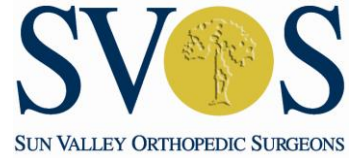
Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Emergency Contact Name: _____ Contact Phone #: _____

Relationship to Patient: Self Spouse Child Other _____



Medication Reconciliation

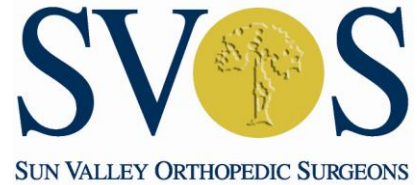
Medication Reconciliation allows the physician to efficiently reconcile your medication list, to quickly and accurately make the appropriate decision on each medication ordered and document all medications in your chart. Central to the reconciliation process should be a single source of up-to-date medications with all necessary order details.

I hereby authorize permission to Sun Valley Orthopedic Surgeons to perform a Medication Reconciliation of my medication profile with the pharmacy.

Signature _____

Date _____

Name of Patient _____



Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. to public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. to federal officials for intelligence and national security activities authorized by law.
7. to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Sun Valley Orthopedic Surgeons, Practice Administrator, 12361 W. Bola Drive, Suite 100, Surprise, AZ 85378 for further information.

I hereby acknowledge that I have been presented with a copy of Sun Valley Orthopedic Surgeons Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____