Edward A. Shadid, M.D.
Interventional Pain Management

Gentian Meta M.D.
Interventional Pain Management

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

I hereby authorize ***Spine Care of Oklahoma*** to:

Receive and release photocopies of my medical records and/or health information to the following named individual(s) or organization(S): ______________________________

______________________________ or ____to myself.

I agree to pay $1.00 for the first page and $0.50 per page for each copy or copies before such are released and will also pay the actual cost of postage if the record is to be mailed.

I further release ***Spine Care of Oklahoma*** from the responsibility for any deleterious effect of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibilities for my own distribution and interpretation of medical information contained therein and holds blameless ***Spine Care of Oklahoma*** or

State law ,you must be advised that: **The information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency syndrome (AIDS).**

conclusions or opinions draw from said records without professional knowledge, assistance or review.

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

______________________________ ______________________________
Signature of patient Date

______________________________ ______________________________
Signature of person authorized to sign If other than patient Relationship to patient

508 W. 15th Street, Edmond, OK 73013
Phone 405-840-5100 www.spinecareofoklahoma.com Fax 405-840-5102

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DATE: ______________

PATIENT NAME: ______________________________

CURRENT INSURANCE COMPANY:
____
____

IN THE EVENT THAT MY INSURANCE COMPANY DOES NOT PAY I UNDERSTAND THAT I AM RESPONSIBLE TO PAY SPINE & PAIN CARE OF OKLAHOMA THE BALANCE REMAINING ON MY ACCOUNT.

____
SIGNATURE

____
PRINTED NAME

508 W. 15th Street, Edmond, OK 73013
Phone 405-840-5100 www.spinecareofoklahoma.com Fax 405-840-5102

Who referred you to our practice? ______________________________

Patient Name: ______________________________ [ ] Male [ ] Female

Address: ______________________________

City: ____________________ ST: __________ ZIP: __________

Employer: ____________________ Occupation: ____________________

Home #: __________ Work: __________ Ext: _____ Cell/Pager: __________

Date of Birth: ________ Age: ______ SS# ______ - ____ - ______ Marital Status __________

Height: ________ Weight: ________

Emergency Contact Name: ____________________ Phone # : __________

Email Address: ____________________ May We Text You? ____________________

NOTICE ON HEALTH INFORMATION PRACTICES
Acknowledgement Form

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires Providers and Health Plans to educate patients concerning the use, disclosure and access of their health information. Spine Care of Oklahoma has developed a "Notice of Privacy Practices for Protected Health Information" and is presented for your review and education.

My signature below indicated I have received a copy of Spine Care of Oklahoma's Notice of Privacy Practices for Protected Health Information. I have had the opportunity to review the notice prior to signing.

I also acknowledge I have received a copy of the medication/refill policy of Spine Care of Oklahoma.

______________________________ ______________________________
Printed Name Signature

______________________________ ______________________________
Date of Birth and Social Security # Today's Date

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the physicians of Spine Care of Oklahoma to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Spine Care of Oklahoma all payments for medical services rendered to myself or my dependents. I understand that the information authorized for release may include information, which may be considered a communicable, or venereal disease. I further understand that I am responsible for any amount not covered by my insurance.

Patient Signature: ______________________________ **Date:** __________

Parent Signature if minor: ______________________________ **Date:** __________

A photocopy of the authorization and assignment shall be considered as valid as the original.

NAME: ______________________ DATE: ____________

SPINE CARE OF OKLAHOMA

MEDICATION REQUEST/REFILL POLICY

INITIAL MEDICATION REQUEST:

Requests for medication and requests for additional medication from patients are to be discussed with the doctor at the time of visit. Telephone requests for additional prescriptions will not be honored.

HOW TO REQUEST A REFILL

Allow two (2) business days for your request to be processed.

Contact your pharmacy for a refill. The pharmacy will fax your refill request to Fax#: 405-840-5102.

The doctor must approve the refill before the request is completed.

ALL REFILL REQUESTS after 11:00 am on Friday will not be refilled until the following Monday.

MEDICATIONS WILL NOT BE REFILLED ON WEEKENDS.

MEDICATIONS WILL NOT be refilled if you miss a scheduled appointment.

NARCOTIC MEDICATIONS will not be refilled if you have not been seen by the doctor in the last 60-90 days.

WE ARE NOT RESPONSBILE FOR LOST OR STOLEN MEDICATIONS AND PRESCRIPTIONS

Due to HIPAA regulations, we are not allowed to discuss any medications with family members.

Thank you for your assistance in helping to meet your medications needs.

I acknowledge that I have read the above information and understand the medication request/refill policy.

______________________________ ______________________________

Patient Signature Date

NAME: ______________________________ DATE: ______________

Location of your pain

____

When did your pain start and what caused it?

____

Current symptoms are?
O Worsening
O Unchanging
O Getting better

Severity of pain
O Minimal
O Slight
O Moderate
O Severe

Duration of pain
O Occasional
O Intermittent
O Frequent
O Constant

Please mark any of the following symptoms you have experienced recently:
O Leg/arm weakness
O Sleeping difficulties
O Bowel incontinence/retention
O Bladder incontinence/retention
O Weight loss
O Fever chills or night sweats

What is the nature of the pain?
O Aching
O Numbness
O Pins and Needles
O Burning
O Stabbing

What makes your pain worse?

____

What makes your pain better?

____

Please circle the ONE number which best describes your current pain level.
0 represents no pain and 10 represents worst possible pain.

0 1 2 3 4 5 6 7 8 9 10

Mark the effect of each of the following on you pain

	Increases	Decreases	No change
Sitting	O	O	O
Standing	O	O	O
Rising from sitting	O	O	O
Bending forward	O	O	O
Bending backward	O	O	O
Walking	O	O	O
Lying on your back	O	O	O
Lying on you stomach	O	O	O
Driving	O	O	O
Coughing/Sneezing	O	O	O

NAME: ______________________ **DATE:** __________

List any allergies to medications.

____

Please list all medications and doses that you are CURRENTLY taking:

Medication	Dosage	How many times a day taken
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

Have you have any prior diagnostic tests?

O MRI Where ______________ When ______________
O X-Rays Where ______________ When ______________
O CT Scan Where ______________ When ______________
O Discogram Where ______________ When ______________

Have you had previous neck or back surgery? O YES/O NO

Date of spine surgery	Type of surgery	% Improvement	How long did improvement last?

Have you had previous spinal injections (epidural steroids, facet blocks, neurotomies)? O YES/O NO

Date of injection	Type of injection	% Improvement	How long did improvement last?

Additional prior treatments:

O Physical therapy Year _____ about how many visits? _____ did it help? Yes/No/Some
O Chiropractor Year _____ about how many visits? _____ did it help? Yes/No/Some
O Acupuncture
O Bracing
O TENS
O Medications

NAME: ______________________________ DATE: _______________

Past Medical History

Please mark any of the following medical problems you have had in the past.

O Arthritis
O Psoriasis
O Arthritis (not spine related)
O Tuberculosis
O Cancer
O HIV positive
O Hepatitis
O Seizure
O Anesthetic difficulties
O High blood pressure
O Abnormal bleeding tendencies
O Kidney/bladder infections
O Kidney stones
O Prostate problems
O Diabetes
O Heart disease/Heart attack
O Stroke
O Asthma
O Depression
O Other __________________________

Past Surgical History: ____

____

Family History

Please mark conditions in your immediate family

O Arthritis
O Psoriasis
O Arthritis (not spine related)
O Tuberculosis
O Cancer
O HIV positive
O Hepatitis
O Seizure
O Anesthetic difficulties
O High blood pressure
O Abnormal bleeding tendencies
O Kidney/bladder infections
O Kidney stones
O Prostate problems
O Diabetes
O Heart disease/Heart attack
O Stroke
O Asthma
O Depression
O Other __________________________

Social History:

Do you currently smoke cigarettes?

O Yes
O No, I have never smoked
O No, I quit in the last 6 months
O No, I quit more than 6 months ago

Do you use alcoholic beverages?

O No
O Yes, once in awhile
O Yes, often; how often _________

Work status

O Currently working
O On paid leave
O Unemployed
O Homemaker
O Student
O Retired (not due to health)
O Disabled and/or retired because of health problems
O Other _____________________________________

Marriage status

O Married
O Divorced
O Widowed
O Single

NAME: ______________________ DATE: ____________

Review of systems
Please check next to all your current symptoms.

Constitutional Symptoms:
O Good general health lately
O Recent weight change
O Fever
O Fatigue

Ear/Nose/Mouth/Throat:
O Hearing loss or ringing
O Earaches or drainage
O Chronic sinus/rhinitis

Cardiovascular:
O Heart trouble
O Chest pain
O Palpitations
O Swelling of feet, ankles, hands

Respiratory:
O Chronic or frequent coughs
O Shortness of breath
O Asthma or wheezing

Gastrointestinal:
O Loss of appetite
O Nausea or vomiting
O Abdominal pain

Genitourinary:

O Frequent urination
O Frequent diarrhea
O Bowel or bladder incontinence
O Kidney stones

Hematologic/Lymphatic:
O Easy bleeding or bruising
O Anemia
O Slow to heal after cuts

Musculoskeletal:
O Joint pain
O Joint stiffness/swelling
O Weakness of muscles/joints
O Difficulty in walking

Neurological:
O Headaches
O Seizures
O Paralysis
O Stroke

Psychiatric:
O Memory loss or confusion
O Anxiety
O Depression
O Insomnia

Hematologic/Lymphatic:
O Slow to heal after cuts
O Easy bleeding or bruising
O Anemia

______________________________ ______________________
Patient Signature **Date**