**Southern Utah**

**Spine & Rehabilitation**

**Max Root M.D. | Bradley Root D.O. | Matthew Irvin D.O. | Sean Stucki PA-C**

**2825 East Mall Drive St. George, Utah 84790**

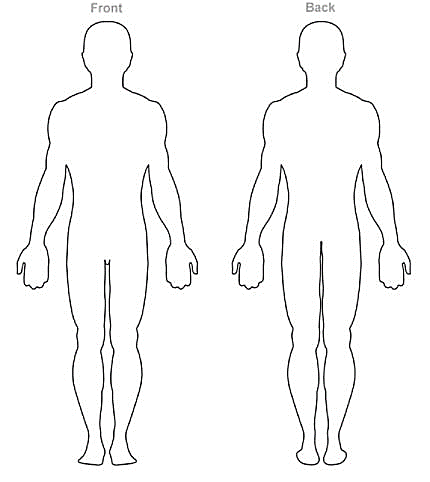
**Phone: 435-656-8800 | Fax: 435-627-1809**

**New Patient Paperwork**

|  |  |
| --- | --- |
| Patient Information | |
| Full Name: | |
| DOB: | **Phone #:** |
| Address: | **Email:** |
| Primary Care Physician: | **Referring Physician:** |
| Billing Information | |
| Primary Insurance Company: | |
| Policy/Member ID: | **Group #:** |
| Policy Holder Name: | **Relationship:** |
| Will your visit be billed to Worker’s Compensation or a Motor Vehicle Accident?  Yes  No | |
| History of Present Illness | |
| What your primary reason for being evaluated? | |
| How long have you had this pain? | |
| What is your pain level on a pain scale 1-10 (with 10 being severe pain)? | |

**Using the symbols in the table below, please mark on the body where you feel the following sensations:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Key | | |
| Burning | |  |
| Numbness | |  |
| Pins & Needles | |  |
| Stabbing | |  |
| Ache | |  |



|  |
| --- |
| **Personal Medical History** |

|  |  |  |  |
| --- | --- | --- | --- |
| Disease/Condition | Current | Past | Comments |
| Anemia |  |  |  |
| Asthma |  |  |  |
| Arthritis |  |  |  |
| Back problems |  |  |  |
| Cancer/Type |  |  |  |
| Depression/Anxiety/Bipolar/Suicidal |  |  |  |
| Diabetes/Type |  |  |  |
| Dementia |  |  |  |
| Dermatitis |  |  |  |
| Epilepsy |  |  |  |
| Emphysema (COPD) |  |  |  |
| Gout |  |  |  |
| GERD |  |  |  |
| Hepatitis |  |  |  |
| HIV |  |  |  |
| Heart Disease |  |  |  |
| High Blood Pressure |  |  |  |
| High Cholesterol |  |  |  |
| Hypothyroidism/Thyroid Disease |  |  |  |
| Renal (kidney) Disease |  |  |  |
| Migraine Headaches |  |  |  |
| Pneumonia |  |  |  |
| Stroke |  |  |  |
| Other: |  |  |  |

|  |  |  |
| --- | --- | --- |
| Surgical history | | |
| Surgical Procedure | **Date or Year** | **Comments** |
|  |  |  |
|  |  |  |
|  |  |  |
| I have not had any surgical procedures done. | | |

|  |  |
| --- | --- |
| **Allergies** | |
| **Please list any known drug, food, or environmental allergies and indicate the adverse effect/reaction:** | |
| **allergic to** | **reaction** |
|  |  |
|  |  |
|  |  |
| **I have no known drug allergies** | |

|  |
| --- |
| Family Medical History |
| What medical problems do your parents or siblings have? Please list the family member and problem (ex: Mother- Diabetes) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Relationship | Living | Deceased | No known illness | Medical History |
| Parent(s) |  |  |  |  |
| Sibling(s) |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Social History | | | | | | | | | | | | |
| Occupation ( or prior occupation): | | | | | | | **Retired** | | | **Unemployed** | **L.O.A** | **Disabled** |
| Marital Status: Single Married Divorced Widowed Separated | | | | | **Do you have children?** YesNo  **If so, how many?** | | | | | | | |
| What is your living situation? Rent Own Living with roommate(s) | | | | | **Hobbies:** | | | | | | | |
| Substance Use | **Current** | **Former** | **Social** | **Occasional** | | **Light** | | **Heavy** | **Comments** | | | |
| Cigarettes #How many daily? |  |  |  |  | |  | |  |  | | | |
| Chewing Tobacco |  |  |  |  | |  | |  |  | | | |
| Beer |  |  |  |  | |  | |  |  | | | |
| Wine |  |  |  |  | |  | |  |  | | | |
| Hard liquor |  |  |  |  | |  | |  |  | | | |
| Is there anything else you are taking or using? (recreational drugs, herbs, etc.) Yes No | | | | | | | | | | | | |
| Do you see a doctor or take medication for any other problem? Yes No | | | | | | | | | | | | |
| Review of Systems | | | | | | | | | | | | |
| Do you have any problems in the following areas: | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| General | Fatigue  Fever | Decline in health  Weight loss/gain | Weakness  Chills |
| HEENT | Cataract  Glaucoma  Headaches  Nausea | Hearing loss  Dizziness  Eyeglass use  Sweats | Double vision  Fainting  Head injury  Head pain |
| Cardiovascular | Chest pain  Palpitations  AICD/Pacemaker | Claudication  Heart attack  High blood pressure | Heart failure  Heart murmur  Hypertension |
| Respiratory | Asthma  Bronchitis  Shortness of breath | Cough  Emphysema  Wheezing | Pulmonary embolus  Sleep Apnea  Pain with breathing |
| Gastrointestinal | Cirrhosis  Diverticulitis  Peptic Ulcer | GERD  Hepatitis  Liver disease | Hyperlipidemia  Irritable bowel  Rectal bleeding |
| Genitourinary | Dialysis  Renal Failure | Transplant  Incontinence | Nocturia  Hematuria |
| Musculoskeletal | Back pain  Joint pain  Restricted motion  Joint stiffness | Neck pain  Rheumatoid Arthritis  Paralysis  Muscle stiffness | Arthritis  Gout  Muscle cramps  Deformities: |
| Neurological | Dizziness  Burning  Episodes of black out | Speech disorders  Unsteady gait  Stroke | Numbness/Tingling  Headaches  Tremors |
| Psychiatric | Anxiety  Stress  Depression | Disorientation  Mood changes  Disturbing thoughts | Hallucinations  Nervousness  Memory loss |
| Endocrine/Metabolic | Diabetes  Lupus | Thyroid Disease  Auto-Immune Disease | Increased appetite  Excessive sweating |
| Hematologic/Lymphatic | Anemia  Past transfusions | Excessive bleeding  Clotting problems | DVT  Slow to heal after cuts/wounds |

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**Treatment and Pain Medication Agreement**

The purpose of this agreement is to prevent any misunderstandings about medications you could be taking as part of your treatment and to help you and your provider comply with federal and state regulations.

**\*Initial the line at the beginning of each term to indicate that you have read and agree with our policies. If the line is left blank or filled with anything other than the initials of your name, that indicates you do not agree with the terms of this agreement.**

**Office Policies and Procedures**

1. **\_\_\_\_\_\_**I understand that my copay is required at the time of service; If I do not have the funds to pay my copay, I may still be able to see the provider, however my prescriptions will not be given to myself or my pharmacy until my copay has been paid.
2. **\_\_\_\_\_\_**I understand that if I miss more than three scheduled appointments, I will no longer be able to schedule any further appointments with my doctor or any other provider in our clinic.
3. **\_\_\_\_\_\_**I understand that if I am more than 10 minutes late for my schedule appointment, I will have to reschedule. It is important that you are prompt to your visits.
4. **\_\_\_\_\_\_**I understand that if I miss my scheduled appointment without at least a 24hr notice, I will be charged an $85 no-show fee that is required to be paid before rescheduling.
5. **\_\_\_\_\_\_**I agree that if I do not have a voicemail, a message cannot be left for me and I would be jeopardizing assistance in my health care needs.
6. **\_\_\_\_\_\_**I agree that the reminder call that I may receive the day before my appointment is a courtesy call, and it is my responsibility to remember my appointment.
7. **\_\_\_\_\_\_**Because of HIPPA guidelines, we are not able to provide or receive information from a spouse, child, family member, etc., unless you have signed a patient information release form for that individual.
8. **\_\_\_\_\_\_**I will be kind and respectful to the clinical staff.

**Pain Medication Policies and Procedures**

1. **\_\_\_\_\_\_**I understand that I must be seen every 30-60 days for medication refills. The time period is determined case by case, but will not exceed 60 days. If I exceed 60 days, I understand that my medications will not be refilled until I am seen by my doctor.
2. **\_\_\_\_\_\_**I understand that I must give a 48-hour notice for any medication requests.
3. **\_\_\_\_\_\_**I understand that no refills will be given outside of regular office hours, during the evening, on Friday’s, or during any holidays. To avoid lapse in medication, plan ahead, and schedule your appointment in advance with consideration of these factors.
4. **\_\_\_\_\_\_**I will communicate fully with my provider about the character and intensity of my pain, the effect of my pain on my daily life, and how well the medicine is helping to relieve my pain.
5. **\_\_\_\_\_\_**I understand that the medications that may be prescribed to me will have benefits and potential adverse effects. As a partner in my care, I will ask questions if there are concerns.
6. **\_\_\_\_\_\_**I will not use any illegal illicit drugs (heroin, cocaine, marijuana, amphetamines) or controlled substances. The use of these substances may be reasonable cause for an automatic discharge of care.
7. **\_\_\_\_\_\_**I will not use any prescription medications for which I do not have a prescription for.
8. **\_\_\_\_\_\_**I will not share, sell, or trade my medications with anyone.
9. **\_\_\_\_\_\_**I will report any problems with my medication as soon as possible.
10. **\_\_\_\_\_\_**I will communicate honestly with my provider and medical assistant on how and when I am taking my medications.
11. **\_\_\_\_\_\_**My doctor is aware of the responsibility he holds in prescribing pain medications. I am also aware of the responsibility and seriousness involved with my prescription pain medication.
12. **\_\_\_\_\_\_**I will not attempt to obtain any medications including: opioids, controlled stimulants, or anti-anxiety medicines from any other doctor or provider. If a situation arises where I will need one of these medications from a different doctor (dentist, surgeon, therapist, etc.), I will inform SUSR before filling the prescription.
13. **\_\_\_\_\_\_**A post-dated Rx for a future fill day may be provided to you. This is a courtesy refill. DO NOT ask to change this appointed date to an earlier time. You will have 30 days to arrange your plans to match the appropriate fill date.
14. **\_\_\_\_\_\_**I will keep my medications in a safe and secure place to avoid any loss or theft of my medications.
15. **\_\_\_\_\_\_**I agree to only use one pharmacy. However, in the event that I will need to use a second pharmacy, I will notify my doctor.
16. **\_\_\_\_\_\_**I agree to take my medication exactly as prescribed by my doctor.
17. **\_\_\_\_\_\_**I understand that if I exceed the directions of my medications, they will not be refilled until the scheduled refill date.
18. **\_\_\_\_\_\_**I agree that I will submit a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications. This is a law governing pain management, and will be done by an outside unaffiliated lab source. Lab cost may/will apply.
19. **\_\_\_\_\_\_**I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state’s Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medication.
20. **\_\_\_\_\_\_**I authorize my doctor to provide a copy of this agreement to my pharmacy.
21. **\_\_\_\_\_\_**I agree to waive any applicable privilege or right of privacy of congeniality with respect to these authorizations.
22. **\_\_\_\_\_\_**I will present a state picture identification when picking up prescriptions.
23. **\_\_\_\_\_\_**I understand that I may only have two other individuals authorized to pick up my written prescriptions. Those two individuals will also need to provide required identification. If I neglect to inform SUSR clinical staff of the individual picking up my prescriptions, the prescription will not be released, and I will be required to pick it up myself.

**Medical Treatment Authorization**

1. **\_\_\_\_\_\_**I understand that my treatment plan may consist of medications, or procedures such as injections or physical manipulation. I understand that I will be given a verbal explanation of the nature and purpose of the procedure, the risks of the procedure, the possibilities of complications or side effects that could occur, and that no guarantee has been given to me by anyone as to the results that may be obtained.
2. **\_\_\_\_\_\_**I understand that I am encouraged and invited to ask any further questions I may have and that all of my instructions and all of my questions have been answered to my satisfaction.

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1st authorized individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2nd authorized individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Having read the entirety of this agreement, my signature below acknowledges that I hereby agree with the terms above:**

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

**Patient Signature**

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

**Physician Signature**