

# Atlantic Brain & Spine, PA

Dear \_\_\_\_\_, you're scheduled with our provider, \_\_\_\_\_, for an appointment on: \_\_\_\_\_ at \_\_\_\_\_: \_\_\_\_\_. Please **ARRIVE 30 minutes early**. Your appointment is at the following location:

- 2208 South 17<sup>th</sup> Street Wilmington NC 28401 (910)763-3333     2800 Ashton Dr, STE 200, Wilmington NC 28412 (910-)799-2262  
 215 Station Street Jacksonville NC 28546     512 Village Rd, STE 207, Shallotte NC 28470

### What to bring on your first visit?

1. **Bring ALL Radiology CD's** related to your condition, paperwork mailed from our office, a list of medications, Photo ID, and Insurance card. **If we do not have your films, your appointment will need to be rescheduled.**
2. All paperwork sent to you should be filled out **prior to your appointment time**, if sent to you **electronically, PLEASE PRINT OUT PAPERWORK. DO NOT MAIL BACK TO OFFICE.**

### Office Policies & Procedures

- **INSURANCE:** Currently, we participate with Blue Cross/Blue Shield, Medicare, United Healthcare, Aetna, Cigna. We do not file liability claims. If you have an attorney, you will still be required to pay for each visit in full at the time of service. It is your responsibility (or your referring provider) to contact your insurance company about authorization prior to your initial visit.
- **PAYMENT:** Co-payments are collected prior to services rendered. If you do not have payment, your appointment will be rescheduled. Payment is due from the time of service which may include deductibles, percentages, and/or co-pays. We bill your insurance for all services we provide, and other treating physicians/facilities may send separate bills for services. There will be a \$30.00 service fee for returned checks. Balances MUST be paid prior to your return appointments. We accept Cash, Check, and all major Credit Cards. A \$35.00 fee for completion of forms, including but not limited to disability.
- **MIDLEVEL PROVIDERS:** Our office consists of Physician Assistants and Nurse Practitioners who are utilized in our office to both evaluate and treat patients. They are well trained and competent in their evaluation process, available to answer questions, and will be a part of your plan of care in our office.
- **PHONE CALLS:** In the event of a question during office hours, we are available Monday through Thursday 8am-5pm and Friday 8am-1pm. If you leave a message with our office, we will make every effort to return your call within 24 hours.
- **MEDICATIONS:** Typically, medications are not prescribed unless a patient has had surgery with one of our providers. If you need pain medicine and have not had surgery within the past 90 days, please contact your primary care doctor or your pain management doctor to request medications.

\*\*\* PLEASE COMPLETE IN FULL \*\*\*

### PATIENT:

LAST NAME	FIRST NAME	MIDDLE/MAIDEN	SEX	
ADDRESS: STREET	P.O. BOX	CITY	STATE	ZIP
( ) -			-	-
HOME PHONE NUMBER	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	
( ) -				
CELL PHONE NUMBER	EMPLOYER	EMAIL ADDRESS:		

### IF PATIENT IS A MINOR, PLEASE PROVIDE PARENT INFORMATION

PARENT(S) NAME(S): \_\_\_\_\_ HOME PHONE #: \_\_\_\_\_

Under the requirements of HIPAA, we are not allowed to give any information to anyone without the consent of the patient. **I authorize Atlantic Brain & Spine to release my medical and/or billing information to the following below:**

1. \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
HIPAA / EMERGENCY CONTACT

2. \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

I have read, understand, and agree to follow all stated office policies, procedures, HIPAA, and privacy practices, and authorize photocopies of this form to be valid as the original. Also, by signing, I authorize Atlantic Brain & Spine to treat me via Telemedicine through video or phone call and may revoke this consent at any time in writing.

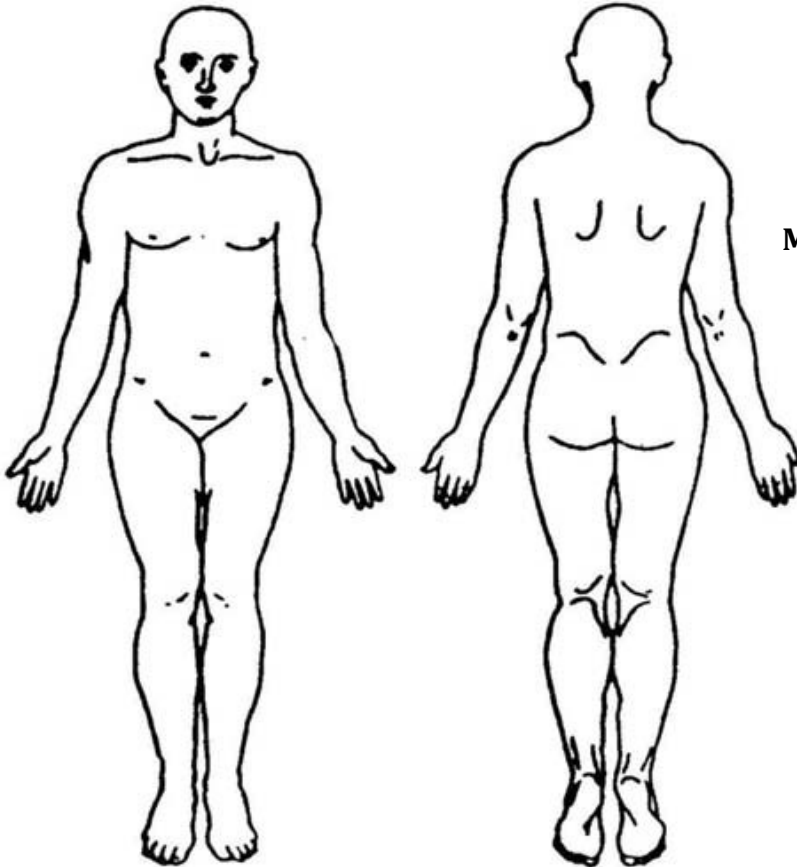
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient History Inventory

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

How bad is your pain now? (Circle ONE)

0	1	2	3	4	5	6	7	8	9	10
No pain										Excruciating pain



Mark the body diagram where you feel:

Ache

^^^^^^

Burning

XXXXXX

Numbness

000000

Pins & Needles

/////

Stabbing

=====

Please mark a check  for **symptoms** you have **RIGHT NOW**:

**CONSTITUTIONAL**

Unexpected Weight Change

Fever

**EYES**

Eye Pain/Discharge

**EAR, NOSE, THROAT**

Congestion

Sneezing

Sore Throat

**CARDIOVASCULAR**

Chest Pain

Palpitations

**RESPIRATORY**

Shortness of Breath

Cough

**GASTROINTESTINAL**

Nausea/Vomiting

Diarrhea

Abdominal Pain

**GENITOURINARY**

Frequent Urinating

Difficulty Urinating

**NEUROLOGICAL**

Seizures

Headaches

Speech Difficulty

**MUSCULOSKELETAL**

Joint Swelling

Generalized Muscle Pain

**HEMATOLOGIC/LYMPH**

Prolonged Bleeding

Easy Bruising

PLEASE CHECK HERE IF YOU HAVE NO SYMPTOMS:

# Oswestry Disability Index

Please mark the bubble next to the statement that applies to you:

## Section 1 – Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

## Section 2 – Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed, wash with difficulty, and stay in bed.

## Section 3 - Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

## Section 4 – Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

## Section 5 – Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

## Section 6 – Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

## Section 7 – Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours sleep.
- Because of pain, I have less than 4 hours sleep.
- Because of pain, I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

## Section 8 – Sex life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

## Section 9 – Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

## Section 10 – Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys of over two hours.
- Pain restricts me to short necessary journeys less than 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Patient name: \_\_\_\_\_

Today's date: \_\_\_\_\_