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SPINE AND ORTHOPEDIC PAIN CENTER, P.C.

Winifred D. Bragg, M.D., FAAPMR

6160 Kempsville Circle, Suite 303 A
Norfolk, Virginia 23502

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial) ..... Gender M ☐ F ☐

Home Address ..... Phone (Home) .....

City ..... State ..... Zip code ..... Phone (Work) .....

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐ DOB ..... Phone (Cell) .....

Date of injury, if applicable ..... Work Related Injury Yes ☐ No ☐ Email .....

SSN .....

Employer Name / Address ..... Age .....

Current Problem ..... Primary Physician .....

SPOUSE/GUARANTOR INFORMATION

Spouse / Guarantor ..... Phone (Home) .....

Home Address ..... Phone (Work) .....

Relationship to guarantor Self ☐ Spouse ☐ Dependent Child ☐ Other ☐ Phone (Cell) .....

SSN .....

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

Insurance Company Name ..... Subscriber Name .....

Subscriber Date of Birth ..... Subscriber SSN ..... Subscriber Gender M ☐ F ☐

Patient's Relationship to Insured Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

Policy # ..... Group # ..... Plan # ..... Effective Date .....

SECONDARY MEDICAL INSURANCE COMPANY

Insurance Company Name ..... Subscriber Name .....

Subscriber Date of Birth ..... Subscriber SSN ..... Subscriber Gender M ☐ F ☐

Patient's Relationship to Insured Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

Policy # ..... Group # ..... Plan # ..... Effective Date .....

WORKERS' COMPENSATION / THIRD PARTY PAYER

Insurance Company Name ..... Employer's Name .....

Billing Address .....

Patient's Relationship to Insured Self ☐ Spouse ☐ Dependent Child ☐ Other ☐

Claim No. ..... DOI ..... Body Part ..... Effective Date .....

IS THIS AN ACCIDENT? DATE ..... Fall? ..... Motor Vehicle Accident? .....

ATTORNEY'S NAME AND ADDRESS .....

IN CASE OF EMERGENCY, CONTACT .....

RELATIONSHIP ..... TELEPHONE .....

....

Patient/Guarantor Signature Witness Date

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SUMMARY NOTICE OF PRIVACY PRACTICES

Effective August 4, 2005

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes the privacy practices of Spine and Orthopedic Pain Center, P.C.

OUR PLEDGE: We understand that medical information about you and your health is personal. We are committed to protecting it.

HOW WE USE OR DISCLOSE YOUR HEALTH INFORMATION: We may use your protected health information (PHI) in order to provide you with medical treatment, obtain payment for services provided to you and to conduct our health care operations to ensure all of our patients receive quality services.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding your medical information (some require your written request): You may request access to your medical record and billing information. You have the right to request restrictions regarding your PHI. You have the right to request an amendment if you think your PHI is incorrect. You have the right to an accounting of the disclosures we have made regarding your PHI. You have the right to revoke any former authorization you have given us regarding disclosure of your PHI. You have the right to receive confidential communications. You have the right to file a complaint if you feel we have violated your privacy rights.

You may receive a full paper copy of Spine and Orthopedic Pain Center, P.C.'s Notice of Privacy Practices by asking in person at our front desk or in writing to our privacy officer. For further information, please contact our privacy officer at (757)333-3360.

Please direct all written correspondence to our Norfolk office as indicated above.

....

Patient Signature Date

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PATIENT INFORMATION RELEASE

The Spine and Orthopedic Pain Center recognizes and respects a patients' right to privacy of their medical records and billing matters. Your medical and/or billing matters will not be discussed with anyone without permission. This includes your spouse, family members, friends and others. In order for us to speak with anyonc regarding you, **even in the event of an emergency**, you must specify to whom we may speak.

If you wish for us to be able to release information regarding you, please indicate below.

I give permission for the physician and staff of the Spine and Orthopedic Pain Center to discuss information indicated, regarding myself to:

Name:	Relationship:	Type of Information To Be Released:
.....	.....	Medical ☐ Financial ☐
.....	.....	Medical ☐ Financial ☐
.....	.....	Medical ☐ Financial ☐

In the event of an emergency, please contact:

Name: ..... Relationship: .....

Home Phone: ..... Cell Phone: .....

Patient Name: .....

Signature: .....

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MISSED APPOINTMENTS

I understand that if I fail to give 48 hours notice for cancellation of my appointments, I will be charged $25.00 for that missed appointment.

....
Patient Signature (Parent or Guardian) Date

....
Witness Date

Policy effective April 4, 2007

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Patient Name: ..... **Date:** .....

ANEMIA	YES ☐	NO ☐	DIVERTICULITIS	YES ☐	NO ☐
HIGH CHOLESTEROL	YES ☐	NO ☐	PACEMAKER	YES ☐	NO ☐
ANXIETY	YES ☐	NO ☐	FIBROMYALGIA	YES ☐	NO ☐
HYPERTENSION	YES ☐	NO ☐	PULMONARY EMBOLISM	YES ☐	NO ☐
ASTHMA	YES ☐	NO ☐	GERD/REFLUX	YES ☐	NO ☐
HYPERTHYROIDISM	YES ☐	NO ☐	GOUT	YES ☐	NO ☐
BLEEDING DISORDER	YES ☐	NO ☐	RHEUMATOID ARTHRITIS	YES ☐	NO ☐
KIDNEY DISEASE	YES ☐	NO ☐	SEIZURES/EPILEPSY	YES ☐	NO ☐
BLOOD CLOTS	YES ☐	NO ☐	HIV/AIDS	YES ☐	NO ☐
KIDNEY STONE	YES ☐	NO ☐	STROKE	YES ☐	NO ☐
COPD	YES ☐	NO ☐	HEART ATTACK	YES ☐	NO ☐
LEG OR FOOT ULCER	YES ☐	NO ☐	THYROID PROBLEMS	YES ☐	NO ☐
CANCER	YES ☐	NO ☐	HEART DISEASE	YES ☐	NO ☐
LIVER DISEASE	YES ☐	NO ☐	TUBERCULOSIS	YES ☐	NO ☐
CORONARY ARTERY DISEASE	YES ☐	NO ☐	HEART PROBLEMS	YES ☐	NO ☐
LUNG DISEASE	YES ☐	NO ☐	ULCERS	YES ☐	NO ☐
DEPRESSION	YES ☐	NO ☐	HEPATITIS	YES ☐	NO ☐
MIGRAINES	YES ☐	NO ☐	VASCULAR DISEASE	YES ☐	NO ☐
DIABETES	YES ☐	NO ☐	HERNIA	YES ☐	NO ☐
OSTEOPOROSIS	YES ☐	NO ☐			

LIST ANY SURGERIES

DATE:	TYPE OF SURGERY:
.....	.....
.....	.....
.....	.....
.....	.....

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Where is the pain today?

Is your pain today: Same ☐ Better ☐ Worse ☐ compared to when it began? .....

What activities make it worse?

Exercise (during) ☐	Standing ☐	Coughing ☐
Exercise (after) ☐	Walking ☐	Sneezing ☐
Sitting ☐	Bending forward ☐	Reaching ☐
Driving ☐	Bending backward ☐	Lifting ☐

What reduces the pain?

Lying down ☐	Manipulation ☐	Muscle relaxant pills ☐
Sitting ☐	Home exercises ☐	Aspirin/Anti-inflammatory pills ☐
Standing ☐	Exercises in physical therapy ☐	Nothing ☐
Walking ☐	Pain pills ☐	Heat / Ice ☐
Injections for pain ☐	Other ☐	☐

What is the time interval between attacks of pain?

Constantly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐

Have you been in constant pain since it began or is your pain intermittent?

Describe: .....
.....
.....

Have you noticed any: Numbness ☐ Tingling ☐

Do your arms/legs get weak with your pain? .....
Do you have full control of your bladder and bowels? .....
Do you experience pain with sexual activity? Yes ☐ No ☐

Choose the number of the word which best describes your pain:

0 ☐	2 ☐	4 ☐	6 ☐	8 ☐	10 ☐
NONE	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING

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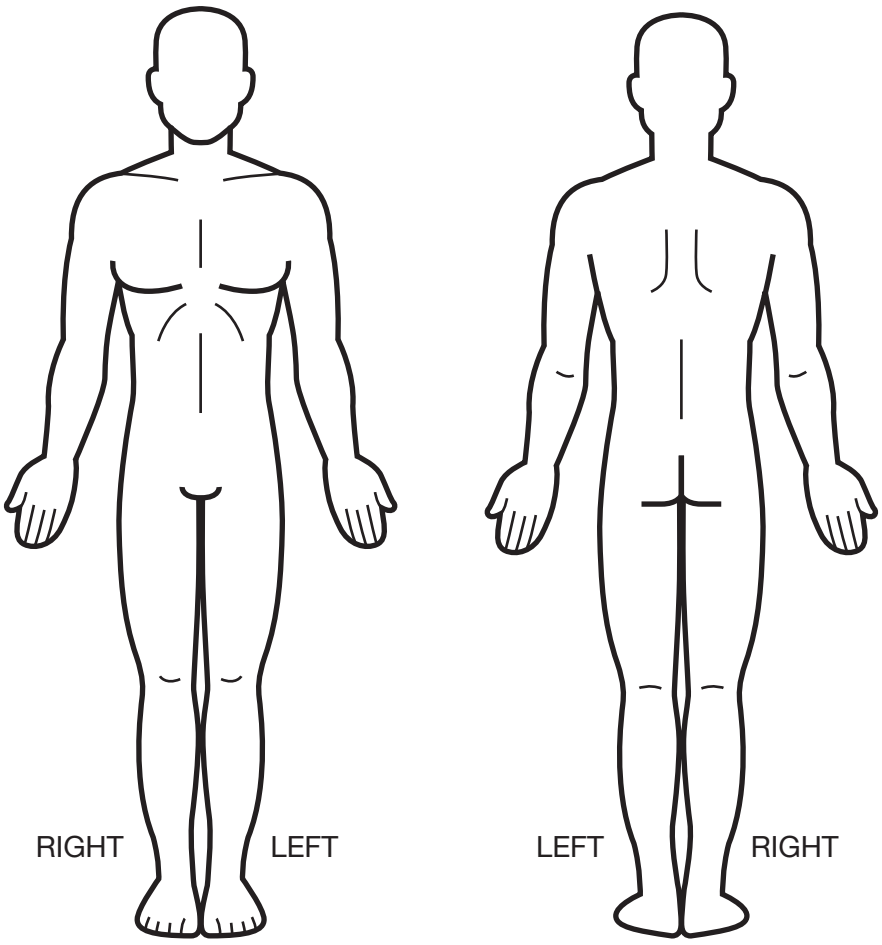
INITIAL MEDICAL QUESTIONNAIRE

Patient: ..... Date: ..... Chart No.: .....

WHERE IS YOUR PAIN NOW?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
△△△	= = =	o o o	x x x	/ / /



FRONT **BACK**

HOW BAD IS YOUR PAIN NOW?
Please mark with an **X** on the pain drawing where the pain is worst now.

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ARE YOU CURRENTLY TAKING ANY MEDICATIONS: YES ☐ NO ☐
PLEASE LIST ALL MEDICATIONS:

.....
.....
.....

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS: YES ☐ NO ☐
PLEASE LIST ANY ALLERGIES MEDICATION: REACTION:

....
....
....
....

I AUTHORIZE THE REVIEW OF ANY REPORT GENERATED UNDER MY NAME IN THE VA PRESCRIPTION MONITORING PROGRAM. ..... (INITIAL HERE)

WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN?
NAME: ..... PHONE: .....

SOCIAL HISTORY:
EDUCATION LEVEL
OCCUPATION .....
MARITIAL STATUS SINGLE☐ MARRIED☐ DIVORCED☐ WIDOWED☐ DOMESTIC☐ PARTNER☐
LIVE ALONE OR WITH OTHERS .....
SMOKING STATUS .....
SMOKING-HOW MUCH? .....
ALCHOL INTAKE .....
ILLICIT DRUG USE .....
CHEWING TOBACCO .....
SEAT BELTS USED ROUNTINELY YES ☐ NO ☐
NUMBER OF CHILDREN .....
HAND DOMINANCE RIGHT ☐ LEFT ☐ BILATERAL ☐
WORK RELATED INJURY YES ☐ NO ☐
AUTO RELATED INJURY YES ☐ NO ☐
ABLE TO CARE FOR SELF YES ☐ NO ☐

FAMILY HISTORY: RELATIONSHIP TO YOU:

ARTHRITIS ☐ .....
HEART DISEASE ☐ .....
MUSCULAR DISEASE ☐ .....
CANCER ☐ .....
HIGH BLOOD PRESSURE ☐ .....
HIGH CHOLESTEROL ☐ .....
DIABETES ☐ .....

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REVIEW OF SYSTEMS

Constitutional Systems:
- ☐ Fever/Chills
- ☐ Weight Loss
- ☐ Fatigue

Eyes:
- ☐ Double Vision
- ☐ Blurring
- ☐ Trauma
- ☐ Glasses/Contacts

ENT & Mouth:
- ☐ Deafness
- ☐ Sinusitis
- ☐ Tinnitus
- ☐ Hoarseness
- ☐ Vertigo

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Hypertension
- ☐ Irregular Beats

Hematologic/Lymphatic:
- ☐ Bleeding Tendency
- ☐ Lymph Node Pain
- ☐ Lymph Node
- ☐ Enlargement

Respiratory:
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ COPD
- ☐ Cough
- ☐ Coughing up Blood

GI:
- ☐ Loss of Appetite
- ☐ Weight Change
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Bloody Stools

GU:
- ☐ Incontinence
- ☐ Pain with Urination
- ☐ Sexual Dysfunction
- ☐ Hesitancy

MS:
- ☐ Fracture
- ☐ Sprains
- ☐ Pain
- ☐ Swelling
- ☐ Arthritis
- ☐ Stiffness
- ☐ Muscle Wasting

Skin/Breast:
- ☐ Lesions
- ☐ Scars
- ☐ Masses

Neurological:
- ☐ Speech
- ☐ Trouble Swallowing
- ☐ TIA/CVA
- ☐ Numbness
- ☐ Tingling
- ☐ Seizures
- ☐ Weakness
- ☐ Balance/coordination
- ☐ Memory

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Sleep Disturbances

Endocrine:
- ☐ Increase in thirst
- ☐ Increase in appetite
- ☐ Hypo/Hyeractivity
- ☐ Growth/Hair Changes