AZ SPINE DISC AND SPORT
4960 W Ray Rd Chandler AZ 85226
P: (480) 759-1668

Patient Paperwork

Demographics:

Name: _____ Birthdate: _____/_____/_____ Sex: M / F

Address: _____ SSN: _____-_____-_____

City: _____ State: _____ Zip Code: _____

Preferred Phone: (____) _____ Cell/Home/Work Secondary Phone: (____) _____

Email: _____ I would **NOT** like text reminders? ▢

Marital Status: ▢ Married ▢ Single ▢ Widowed ▢ Divorced ▢ Separated

Employment Status: Employer: _____ Occupation: _____
▢ Full-Time ▢ Part-Time ▢ Homemaker ▢ Full-Time Student ▢ Part-Time Student ▢ Unemployed ▢ Retired
▢ Permanently Disabled ▢ Temporary/Short Term Disabled ▢ Other

Race:
▢American Indian/Alaskan Indian ▢ Asian ▢ Other Asian ▢ Black/African American ▢ Chinese
▢ Guamanian/Chamorro ▢ Hispanic/Latino ▢ Filipino ▢ Korean ▢ Japanese ▢ Native Hawaiian/Other Pacific Island ▢
Samoan ▢ Vietnamese ▢White ▢ I choose not to specify ▢ Other: _____

Preferred Language:
▢ English ▢ Spanish ▢ German ▢ Chinese ▢ French ▢ Tagalog ▢ Vietnamese ▢ Italian ▢ Korean ▢ Persian
▢ American Sign Language ▢ Polish ▢ Russian ▢ Arabic ▢ Portuguese ▢ Japanese ▢ Greek ▢ Hindi
▢ I choose not to specify ▢ Other:_____

How did you hear about our clinic? _____

Emergency Contact:

1st Emergency Contact: _____ Phone: _____ Relationship: _____

2nd Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Information:

Insurance Company: _____ Policy Number: _____
Policy Holder (if different than above): _____ Group Number: _____
Policy Holder's Birthday: _____/_____/_____ Relationship to Insured: _____

Motor Vehicle or Workman Compensation Cases:

Are you being seen as the result of a motor vehicle accident or work-related injury? ▢ Yes ▢ No

*** If you answered yes, the front desk has additional paperwork for you to finish prior to being seen ***

Dr. Eric Breure DC

FRONT & BACK

Medical History:

Please check any conditions that you have had in the past or currently have:

GENERAL CONDITIONS: ▢ Diabetes ▢ Hypertension ▢ High Cholesterol ▢ HIV/AIDS ▢ Chronic Pain
ARTHRITIS: ▢ Neck ▢ Lower Back ▢ Shoulder(s) ▢ Elbow(s) ▢ Wrist//Hand(s) ▢ Finger(s) ▢ Hip(s) ▢ Knee(s) ▢ Ankle/Feet ▢ Rheumatoid
HEAD: ▢ Migraines ▢ Tension Headaches ▢ Concussion ▢ Head Injuries ▢ TMJ
EYES/EARS: ▢ Vision Loss ▢ Hearing Loss ▢ Cataracts ▢ Glaucoma ▢ Macular Degeneration
THYROID: ▢ Hyperthyroidism ▢ Hypothyroidism ▢ Hyperparathyroidism ▢ Hypoparathyroidism
HEART: ▢ Atrial Fibrillation▢ Heart Attack ▢ Heart Failure ▢ Blood Clots ▢ Heart Murmur ▢ Pacemaker/Defibrillator
LUNGS: ▢ Asthma ▢ COPD ▢ Emphysema ▢ Cystic Fibrosis
DIGESTIVE: ▢ Acid Reflux ▢ Stomach Ulcers ▢ Crohn's's Disease ▢ Ulcerative Colitis ▢ IBS ▢ Hepatitis
URINARY: ▢ Enlarged Prostate ▢ Kidney Stones ▢ Kidney Disease ▢ Urinary Incontinence
PSYCHIATRIC: ▢ Anxiety ▢ Depression ▢ Bi-Polar Disorder ▢ Attention Deficit Disorder
NEUROLOGIC: ▢ Stroke ▢ TIA ▢ Vertigo ▢ Neuropathy ▢ Carpal Tunnel ▢ Parkinson's Disease ▢ Seizures
MUSCULOSKELETAL: ▢ Sciatica ▢ Herniated Disc ▢ Gout Scoliosis ▢ Osteoporosis ▢ Osteopenia ▢ Fibromyalgia
SHOULDER/KNEE INJURY: ▢Meniscus Injury ▢ Ligament Injury ▢ Rotator Cuff Tear/Tendonitis
OTHER CONDITIONS: _____

ARE YOU PREGNANT (or is there a possibility that you could be pregnant)? ▢ Yes ▢ No

Have you had or do you have Cancer? ▢ Yes ▢ No If YES, please explain: _____
Have you had any surgery? ▢ Yes ▢ No
If YES, please give us the surgery type, dates and surgeon if known: _____

ALLERGIES: Please list all allergies and include medications and reactions ▢ NO KNOWN ALLERGIES

_____

Have you ever had a reaction to any of the following? ▢ Latex ▢ Shellfish ▢ Iodine ▢ IV Contrast

MEDICATIONS: Please list all the medications (Ok to attach separate sheet)

▢ I DO NOT TAKE MEDICATIONS

1) _____
Medication Name Dose How Often

2) _____
Medication Name Dose How Often

3) _____
Medication Name Dose How Often

4) _____
Medication Name Dose How Often

5) _____
Medication Name Dose How Often

DATE OF LAST IMMUNIZATIONS AND SCREENINGS:

Tetanus: _____ Pneumonia: _____ Flu:_____ TB Test: _____ Hepatitis B: _____
Colonoscopy: _____ Eye Exam: _____ Dental Exam: _____

Substance Use:

Do you smoke cigarettes? ▢ Yes ▢ No If YES, Packs per day _____ Number of years _____
Do you want to quit? _____
Do you chew tobacco? ▢ Yes ▢ No If YES, Cans per day _____ Former Chewer _____
When did you quit? _____
Are you a former smoker? ▢ Yes ▢ No If YES, Packs per day _____ Number of years _____
When did you quit? _____
Do you drink alcohol? ▢ Yes ▢ No If YES, how many drinks do you consume? _____ Day/Week/Month
Are you/others concerned with how much alcohol you consume? ▢ Yes ▢ No
Do you smoke marijuana? ▢ Yes ▢ No If YES, is it ▢ Daily ▢ Social ▢ Medical ▢ Recreational
Do you use any illicit drugs? ▢ Yes ▢ No If YES, what drugs do you currently use? _____
Do you have a history of drug abuse? ▢ Yes ▢ No If YES, what drugs were abused? _____

Family History

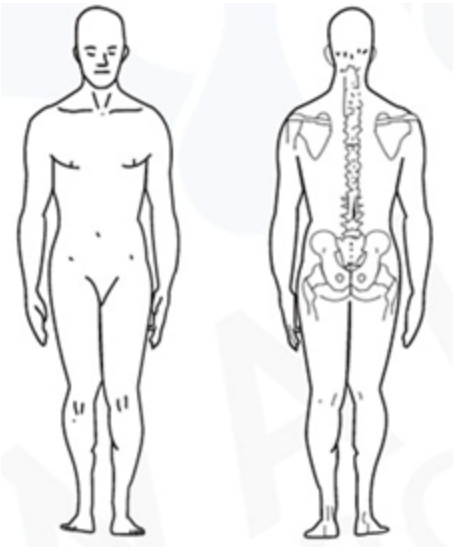
Please check mark the box where appropriate:

	FATHER	MOTHER	CHILD	SIBLING	GRANDMOTHER	GRANDFATHER
Alcohol/Drug Abuse						
Arthritis						
Bleeding Disorder/Blood Clots						
Dementia						
Cancer (please list type)						
Depression						
Diabetes (Type I & Type II)						
Glaucoma						
Heart Disease/Failure/Attack						
High Blood Pressure						
High Cholesterol						
Kidney Disease/Kidney Failure						
Lupus						
Migraines						
Osteoporosis						
Stroke						
Suicide						

FRONT & BACK

Discomfort and Pain:

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, etc.



In order of importance, list the body parts that are bothering you the most:

1) _____ 2) _____
3) _____ 4) _____

Was there a trauma or injury that caused your pain? ▢ Yes ▢ No
If yes, please explain: _____
_____
How long have your symptoms been present? _____
How often are your symptoms present?
▢ Constant ▢ Frequent ▢ Intermittent ▢ Infrequent
Are your symptoms changing?
▢Getting Worse ▢ Staying the Same ▢ Getting Better
Does your pain radiate to your arm or leg?
▢ Yes ▢ No ▢ Left Side ▢ Right Side

On a scale of 0 – 10 with 0 being NO PAIN and 10 being MOST SEVERE PAIN please indicate your pain levels:

Today: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Pain levels at its worst? _____ Best? _____

How would you describe your symptoms?

▢ Deep ▢ Dull ▢ Aching ▢ Throbbing ▢ Stiffness ▢ Cramping ▢ Pressure ▢ Sharp ▢ Stabbing ▢ Electrical

▢ Numbness ▢ Tingling ▢ Burning ▢ Popping ▢ Clicking ▢ Spasms ▢ Weakness▢ Other: _____

What positions or activities make it WORSE? _____

What positions or activities make it BETTER? _____

Are you experiencing any loss of bowel or bladder control? ▢ Yes ▢ No

In the past have you had any chiropractic, physical therapy, massage therapy or pain management? ▢ Yes ▢ No

If yes, when and what for? _____ Did it help? ▢ Yes ▢ No

Please indicate any concerns you have about these services: _____

Have you had any injections before? ▢ Yes ▢ No If YES, what were they? _____

Were they Beneficial? ▢ Yes ▢ No ▢ Somewhat

Have you had any imaging? ▢ CT ▢ MRI ▢ X-Ray When? _____ What area of the body? _____

Do you currently experience any of the following symptoms?

▢ Fatigue ▢ Weight Gain ▢ Weight Loss ▢ Difficulty Sleeping ▢ Double/Blurred Vision ▢ Dizziness ▢ Itching
▢ Difficulty Swallowing▢ Ringing in Ears▢ Hearing Loss ▢ Chest Pain ▢ Leg Swelling ▢ Irregular Heartbeat
▢ Poor Circulation ▢ Shortness of Breath ▢ Wheezing ▢ Constipation ▢ Diarrhea ▢ Nausea/Vomiting
▢ Bloody Stools ▢ Frequent Urination ▢ Blood in Urine▢ Easy Bruising ▢ Easy Bleeding ▢ Night Sweats
▢ Rashes ▢ Joint Stiffness ▢ Joint Pain ▢ Muscle Pain ▢ Muscle Spasms ▢ Numbness ▢ Muscle Weakness
▢ Pinched Nerves ▢ Vertigo

Healthcare Privacy Notice, Informed Consent, Assignment of Benefits and Authorizations & Lien:

This office is committed to providing patients with quality health care services delivered with dignity, respect and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff. This Facility is required by law to abide by the terms of this Health Care Privacy Notice, Patient Bill of Rights and Informed Consent as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concerns to the Compliance Officer of this Facility. Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility. I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot and has not been made and it is even possible that no change will occur. Our Facility further wants you to understand your Patient Bill of Rights, options for care and risks of treatments rendered by us. In the practice of medicine, surgery, chiropractic, spinal or joint manipulations/adjustments, podiatry, psychological counseling, massage, physical, occupation, speech & respiratory therapy there are some risks. These risks may include but are not limited to soreness, dizziness, fractures or joint injuries, disk injuries, strokes, heart-attacks, dislocations, sprains-strains, drug interactions, procedural complications, reactions and/or other injuries which may be short or long term or side effects which cannot be predetermined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. As our patient you can voluntarily stop care or ask questions about reasonable alternatives to the procedures, we will recommend including but not limited to rest, home applications of therapy, prescription or over-the-counter medications, exercises and/or referral to a medical/surgical specialist. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility. I, the assignee, being the patient or legal guardian of said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility. I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

Patient Initials: _____

Please Read the Following Information:

Welcome to our multi-specialty group practice, offering sports medicine, pain management, chiropractic, physical therapy, rehabilitation, massage therapy, acupuncture, family medicine and personal training. We will strive to help reduce pain and improve function, but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, documents or any other items. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment that are deemed medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice below, which will become a permanent part of your medical records maintained in this office. You may receive a free photocopy of this document that you signed just by asking one of our staff. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. **If you must miss an appointment please notify us at least 24 hours in advance. If you do not show up for your scheduled appointment you may be charged $50.00 as a missed appointment fee that you must pay before you are seen or treated again.** We are usually available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards, please let us know in writing for your file.

Insurance Benefits, Credit Policies and Payment Terms & Conditions:

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

Patient Consent and Signature:

By my signature below I acknowledge that I have read or have read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as the original. I have made my decision voluntarily and freely to submit for healthcare services in this facility.

_____ _____

Signature Date