WELCOME TO INDIANA SPINE GROUP! We are pleased that you have chosen us for your care. Indiana Spine Group is a center of excellence for comprehensive spine care –treating patients with back and neck; providing comprehensive care for patients with spinal disorders and abnormalities.

Please bring the following items to your first appointment:

New Patient Forms
Please complete all of the printed forms. The details and specifics of your overall medical history and condition are important. Please take the time to fully and accurately complete all of this information.

Listing of Medications with Dosage, Frequency and Reason
Make a list of all medications that you are taking; including the dosage, frequency, and the reason you are taking the medication. In this listing, also include all of the over-the-counter medications and herbal supplements you are taking. If you prefer, bring all of your medications in a bag, and we will make the list for you.

Prior Tests or Studies
If you have had any tests or studies completed prior to your appointment, such as X-rays, MRIs or other tests - bring these to your first appointment. This includes any tests from another physician, hospital or testing facility.

To obtain your films or test results, contact the facility where the films/tests were performed **several days prior to when you will pick them up.** Each facility will have their own procedure to obtain films/test results. You will need to hand carry your films and test results to your appointment. If you have difficulty or are unable to obtain your films, please call our office one week prior to your scheduled appointment at (317) 228-7000, and one of our staff will assist you.

Do not have the facility mail the films to us.

If you are unable to obtain your films for your appointment, please call our office, and we will reschedule your appointment.

Insurance Card(s) and Co-Pay
Indiana Spine Group participates in most health insurance plans. To bill your insurance company, we will need your insurance card. **If you fail to bring your insurance card, your appointment will be rescheduled**. Most insurance plans require a co-payment for office visits. If your insurance carrier requires a co-payment, we will collect this at the time of service. If you do not have health insurance, payment is expected at the time of service. For your convenience, we accept cash, checks, MasterCard or Visa.

Again, thank you for choosing Indiana Spine Group. If you have any questions, please call us at (317) 228-7000 or toll-free at (866) 947-7463.

The Physicians and Staff of Indiana Spine Group

For more information about Indiana Spine Group and spine education, visit us online at www.indianaspinegroup.com.

CONFIDENTIAL PATIENT INFORMATION FORM

Patient Information:

Name: (First) ____________________ (MI) ______ (Last) _______________________________
Date of Birth: ______________________________ Sex: ___ Male ___ Female

Social Security Number: _______________________________

Address: ____

City: ________________________ State: ___________ Zip Code: ________________

Phone: ____________________________ ( ) Home ( ) Work ( ) Other

Phone: ____________________________ ( ) Home ( ) Work ( ) Other

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Are you currently living in a skilled nursing facility/home health agency? Yes______
No_____

If yes: Name of Facility:____

Address:____

Phone Number:____

Insurance Information:

Primary Insurance: _________________ ID#__________________ Group# ________________

Insurance Subscriber Name: ___________________________________ DOB: _______________

Subscriber's Social Security Number: _______________________Effective date:___________

Insurance Subscriber Employer: ____

Is your visit due to an injury suffered on the job? ( ) Yes ( ) No

Is your visit due to an automobile accident? ( ) Yes ( ) No

Date of Accident:____________________________ State of Accident:__________________

Patient Employment:

Work Status: ( ) Employed ( ) Unemployed ( ) Retired ( ) Student ( ) Other

Employer Name: ____

Employer Phone Number: ____

Occupation: ____

Physician Information:

Name of Physician who referred you to our Group: _____________________________________

Referring Physician's phone number: ____

Name of your Family Physician: ____

Family Physician's phone number: ____

Emergency Contact:

Name of person to contact in case of emergency: _____________________________________

Phone Number:______________________________Relationship:_________________________

I Verify All Information On This Form Is Accurate & Correct.

Patient (or guardian) Signature: __________________________________ Date: _____________

DID YOU REMEMBER TO . . .

☐ Fill out your paperwork and medication sheet with your pill bottles in front of you?

☐ Pick-up your films/X-rays to bring to your appointment?

☐ Bring the reports from your test results to your appointment?

☐ Make plans to arrive at Indiana Spine Group 15 minutes before your appointment time?

☐ Bring your insurance card and co-pay to your appointment? We accept cash, check, Master Card and VISA.

☐ Bring a referral from your primary care physician, if required by your insurance.

Thank you,

Indiana Spine Group

Patient Medical History & Review of Symptoms Form

Date Form Completed: ____________________

Patient Name: ____________________ Date of Birth: __________

Please mark "X" in the box below, if you have any of the conditions or symptoms listed. Explain any box that you mark on page 2.

GASTROINTESTINAL/ GENITOURINARY

- ❑ Poor Appetite
- ❑ Abdominal Pain
- ❑ Indigestion
- ❑ Trouble Swallowing
- ❑ Kidney Disease
- ❑ Painful Urination
- ❑ Trouble Starting Urination
- ❑ Blood in Urine
- ❑ Loss of Bladder Control
- ❑ Loss of Bowel Control
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcer
- ❑ Liver Disease
- ❑ Enlarged Prostate

CARDIOVASCULAR

- ❑ Chest Pain
- ❑ Diaphoresis
- ❑ Poor Circulation/Swelling
- ❑ Irregular Heart Beat
- ❑ High Blood Pressure/Hypertension
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ Heart Stents
- ❑ Open Heart Surgery
- ❑ Rheumatic Fever
- ❑ Heart Disease

PULMONARY/LUNGS

- ❑ Shortness of Breath
- ❑ Persistent Cough
- ❑ Coughing up Blood
- ❑ Wheezing
- ❑ CPAP Use
- ❑ Oxygen Use
- ❑ COPD
- ❑ Emphysema
- ❑ Asthma
- ❑ TB
- ❑ Sleep Apnea

SKIN

- ❑ Itching
- ❑ Rash
- ❑ Easy Bruising
- ❑ Skin Tears Easily
- ❑ Skin Conditions
- ❑ Eczema

MUSCLE/JOINT/BONE

- ❑ Back Pain
- ❑ Leg Pain
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Weakness Arms/Legs
- ❑ Arthritis
- ❑ Gout
- ❑ Osteoporosis

NEUROLOGIC

- ❑ Fainting
- ❑ Dizziness
- ❑ Slurred Speech
- ❑ Loss of Consciousness
- ❑ Headache
- ❑ Memory Loss
- ❑ Depression
- ❑ Anxiety
- ❑ Seizure Disorder
- ❑ Alzheimer's Disease
- ❑ Parkinson Disease
- ❑ Psychiatric Illness
- ❑ Claustrophobic
- ❑ Fibromyalgia
- ❑ TIA or Mini Stroke(s)
- ❑ Stroke

EYES/EARS/NOSE/THROAT

- ❑ Blurred Vision
- ❑ Hoarseness
- ❑ Loss of Hearing
- ❑ Nose Bleeds
- ❑ Sinus Problems
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Contacts/Glasses
- ❑ Hearing Aids
- ❑ Vocal Cord Damage
- ❑ Throat Surgeries
- ❑ Other Throat Conditions

ENDOCRINE

- ❑ Excessive Thirst
- ❑ Excessive Sweating
- ❑ Excessive Hot
- ❑ Excessive Cold
- ❑ Diabetic Type 1
- ❑ Diabetic Type 2
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Pituitary Tumor

Patient Medical History & Review of Symptoms Form - Page 2

Patient Name: ____

Please mark "X" in the box below, if you have any of the conditions or symptoms listed.
Explain any box that you mark below.

HEMATOLOGIC/LYMPHATIC

- ❑ Bleed Easily
- ❑ Clot Easily
- ❑ Abnormal Blood Cells
- ❑ Lymph Node Swelling
- ❑ History of Anemia
- ❑ History of Blood Clots or DVT
- ❑ History of Pulmonary Embolism or PE
- ❑ Any Blood Condition or Bleeding Disorder

GENERAL

- ❑ History of any Type of Cancer
- ❑ History of MRSA
- ❑ History of Chronic Infection
- ❑ Genetic Disorders
- ❑ Immunodeficiency
- ❑ Trouble with Anesthesia

Please use the space below to explain any of the above areas that you marked on page 1 or page 2.

____
____
____
____
____
____
____

Please list all previous surgeries with date and name of surgeon, if known.

____
____
____
____
____
____
____

Vaccinations

Please list most recent vaccination dates or not applicable:

Flu Vaccination __________ Pneumonia Vaccination __________ Tetanus Vaccination __________

Patient Medication and Allergy Form

Date Form Completed: ______________________

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________

Home Phone: ______________ Cell Phone: ______________

Pharmacy Phone Number: ______________ Pharmacy Address: ______________

List all drug allergies and reactions that occur: (Example: Penicillin - rash, vomiting, trouble breathing)

1 ______________________
2 ______________________
3 ______________________
4 ______________________
5 ______________________
6 ______________________

Are you allergic to latex? ❑ No ❑ Yes If yes, what reaction do you have? ______________

Are you allergic to tape ? ❑ No ❑ Yes If yes, what type(s)? ______________

List Food or Environmental Allergies: ______________________

List all medications you are taking. Please include all prescription, over-the-counter medications, vitamins and any other natural supplements.

Name and Dose of Medication(s) (Example: Aspirin, 81 mg.)	Number of times you take it and why. (Example: 1 per day - Blood thinner)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

ISG MD's Signature: ______________________ Date: ______________
after review with patient

Patient Social History Form

Date Form Completed: ____________________

Patient Name: ____________________ Date of Birth: __________

Tobacco Use ? ❑ No ❑ Yes If yes, how many packs per week/day? __________

Alcohol Use ? ❑ No ❑ Yes
- ❑ Rare - less than 1 drink/month
- ❑ Occasionally - 1-4 drinks/month
- ❑ Socially - 1-2 drinks/week
- ❑ Occasionally - 3-5 drinks/week
- ❑ Frequently - 5 or more drinks/week

Recreational Drug Use ❑ No ❑ Yes If yes, please specify

Types: __________ Frequency of use: __________

Educational Level (Grade Completed)
- ❑ Grade School
- ❑ High School/GED
- ❑ College
- ❑ Graduate Level

Exercise Level ❑ Never ❑ Rarely ❑ Weekly ❑ Daily

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Number of Children and Ages __________

Do you live ❑ Alone ❑ With Someone ❑ Assisted Living ❑ Nursing Home

Nationality __________ Primary Language __________

Patient Family History Form

Date Form Completed: ______________________

Patient Name: ______________________ Date of Birth: ______________

Please mark “X” below to identify all illnesses/conditions within your family.
(Please only include blood relatives).

FAMILY MEMBER

ILLNESS/CONDITION	Grandpa	Grandma	Father	Mother	Brother	Sister	Son	Daughter
❑ Cancer and Type								
❑ Diabetes								
❑ High Blood Pressure								
❑ Heart Disease								
❑ Liver Disease								
❑ High Cholesterol								
❑ Alcohol Abuse								
❑ Drug Abuse								
❑ Depression								
❑ Psychiatric Illness								
❑ Genetic Disorder								
❑ Blood Disorder								
❑ Blood Clots								
❑ COPD								
❑ Asthma								
❑ Stroke/TIA								
❑ Parkinson Disease								
❑ Alzheimer’s Disease								
❑ Other, please specify								

Please provide any other information that may be helpful in your care:

____

____

____

INDIANA SPINE GROUP
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
NOTIFICATION OF FINANCIAL INTERESTS IN OTHER HEALTHCARE ENTITIES

I have received Indiana Spine Group's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Your doctor may have a financial interest in a health care entity to which you are referred. You may choose to be referred to another healthcare entity for your care.

Patient Name: ____ Date of Birth: __________

Patient (or guardian) Signature: ____________________________________ Date: ___________

For your protection, information *will not* be released to any outside parties unless listed below.

_______I decline to authorize release of information regarding my care to any further parties.
Initial

Indiana Spine Group may release information regarding my care to the following parties:

____
Name Relationship Date of Birth

____
Name Relationship Date of Birth

____
Name Relationship Date of Birth

This authorization will remain in effect until I change or revoke it. This authorization can be revoked by writing to Indiana Spine Group or by completing a new form at any time.

Revised: 07/16/08