SPINE AND ORTHOPEDIC CENTER

Pran N. Sood, M.D. **1287 Georgia Highway 138 Spur Rd., Suite 8** **Rajiv Sood, D.O.**
Jonesboro, GA 30236
Tel: 770-473-0038 •Fax: 770-471-4290

Name _____Age _____

PLEASE INDICATE YOUR PRIMARY PHYSICIAN (PCP):

PHYSICIAN'S NAME: _____
OFFICE ADDRESS: _____
SPECIALITY: _____
PHONE #: _____

PLEASE INDICATE ANY PHYSICIAN'S THAT HAS TREATED YOUR CONDITION:
EX: HOSPITAL, URGENT CARE, OR PAIN MANAGEMENT CLINIC

PHSICIAN'S NAME: _____PHYSICIAN'S NAME: _____
OFFICE NAME: _____OFFICE NAME: _____
ADDRESS: _____ADDRESS: _____
PHONE #: _____PHONE #: _____

****IF YOU HAVE AN ATTORNEY YOU MUST COMPLETE THIS SECTION****

1. **Have you been involved in a motor vehicle accident or a slip and fall?** **Yes or No**

   If yes, please indicate which one. _____

2. **Do you have Med-Pay? (Circle one)** **Yes or No**

   If so, how much do you have available? $_____

3. **Do you have Workman's Compensation? (Circle one)** **Yes or No**

4. **Do you have an attorney? (If "yes" complete the information below.)** **Yes or No**

   Attorney's name: _____

   Name of the Law Firm: _____

   Address: _____

   Phone #: _____

   Fax #: _____

   Case Manger Name: _____

   Case#: _____

PLEASE BE PROACTIVE AND USE YOUR PHONE TO HELP GOOGLE THE INFORMATION THAT IS NEEDED. THIS HELPS TO SPEED UP THE PROCESSING OF YOUR INFORMATION AND HELPS TO REDUCE YOIUR WAIT TIME. WE APPRECIATE YOUR COOPERATION.

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PATIENT INFORMATION:

NAME: _____D.O.B_____

SSN: _____-_____-_____ MARITAL STAUS: S M W SEP D

ADDRESS _____

CELL NUMBER ( ) _____ HOME ( ) _____

SPOUSE'S NAME: _____

SPOUSE'S ADDRESS (IF DIFFERENT) _____

EMERGENCY CONTACT NAME: _____ #: ( ) _____

EMPLOYER INFORMATION:

EMPLOYER'S NAME: _____

EMPLOYER'S ADD.: _____

PHONE NUMBER: _____

Your position: _____

- ☐ NON-EMPLOYED

PRIMARY HEALTHCARE INSURANCE:

NAME OF INSURANCE: _____ MEMBER ID #: _____

PRIMARY SUBSCRIBER: _____

TO PROVIDER SERVICES (ON THE BK OF YOUR CARD): _____

SECONDARY HEALTHCARE INSURANCE:

NAME OF INSURANCE: _____ MEMBER ID #: _____

PRIMARY SUBSCRIBER: _____

TO PROVIDER SERVICES (ON THE BK OF YOUR CARD): _____

HOW DID YOU HEAR ABOUT US?

- ☐ **PHONE BOOK**
- ☐ **INTERNET**
- ☐ **PATIENT/FRIEND**
- ☐ **REFERRAL (FROM WHOM) _____**

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PERSONAL MEDICAL HISTORY:

CIRCLE ALL THAT APPLY:

□CHEST PAIN/PRESSURE/LIGHTENING	□ ASTHMA	□ KIDNEY DISEASE
□ HYPERTENSION	□ DIZZY SPELLS	□ SHORTNESS OF BREATH
□ HEART ATTACK	□ CANCER _____	□ TB/LUNG DISORDER
□ STROKE	□DIABETES	□ ULCER
□ HEADACHES	□ ARTHRITIS	□ SKIN DISORDER
□ GLAUCOMA	□ HEPATITIS	□ DIFFICULTY HEARING
□ ALLERGIES/EXCEMA	□ CATARACTS	□ DEPRESSION
□ HEMORRHOIDS	□ FREQUENT URINARY INFECTIONS	

□ OTHER _____

GENERAL INFORMATION:

REASON FOR TODAY'S VISIT: _____

PRESENT MEDICATION:

_____

_____

_____

ALLERGIES TO MEDICATION: _____

ALLERGIES TO SPECIFIC LAUNDRY DETERGENT: _____

LIST ANY SURGERIES OR HOSPITALIZATIONS (INCLUDE MISCARRIAGES/LIVE

BIRTHS_____

_____

FEMALES: ARE YOUR PREGNANT OR PLANNING A PREGNANCY? (CIRCLE ONE) YES OR NO

DO YOU SMOKE? (CIRCLE ONE) YES OR NO

□ CIGARETTES □PIPE □CIGARS □ ILLEGAL SUBSTANCE _____

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HOW MANY YEARS? _____ HOW MUCH? _____

DO YOU DRINK? **YES OR NO**

□ DAILY _____ (CUPS) **□ OCCASSIONAL**

DO YOU REGULARLY DRINK COFFEE? (CIRCLE ONE) **YES OR NO**

1. IS THIS AN "ON-THE-JOB INJURY? (CIRCLE ONE) **YES OR NO**

2. IS THIS AN AUTOMOBILE ACCIDENT? (CIRCLE ONE) **YES OR NO**

3. DOES THIS VISIT PERTAIN TO ACCIDENTAL INJURY? (CIRCLE ONE) **YES OR NO**

IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION:

DATE OF ACCIDENT: _____ TIME_____

DESCRIBE HOW IT HAPPENED:

_____

_____

_____

PATIENT COMFORT ASSESSMENT GUIDE:

WHERE IS YOUR PAIN? PLEASE CIRCLE ALL THAT APPLY.

□ SHOULDER (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ ARM (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ HAND (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ LEG (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ ANKLE (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ KNEE (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ BACK (**CIRCLE ONE)**	UPPER	LOWER	MID
□ FOOT (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ ELBOW (**CIRCLE ONE)**	LEFT	RIGHT	BOTH
□ WRIST/HIP (**CIRCLE ONE)**	LEFT	RIGHT	BOTH

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DESCRIBE YOUR PAIN. CIRCLE ALL THAT APPLY.

ACHING	**SHOOTING**	**SHARP**	**PENETRATING**
THROBBING	**TENDER**	**NAGGING**	**BURNING**
RADIATING	**NUMB**	**STABBING**	**EXHAUSTING**
MISERABLE	**GNAWING**	**TIRING**	**UNBERABLE**

OCCASSIONAL_____ CONTINUOUS_____

RATE YOUR LEVEL OF PAIN.

PAIN SCALE: 1 LEAST AMOUNT OF PAIN/10 WORST AMOUTN OF PAIN

1. PAIN AT ITS WORST IN THE LAST MONTH 0 1 2 3 4 5 6 7 8 9 10

2. PAIN AT ITS LEAST IN THE LAST MONTH 0 1 2 3 4 5 6 7 8 9 10

3. PAIN AT ITS AVERAGE IN THE LAST MONTH 0 1 2 3 4 5 6 7 8 9 10

4. PAIN RIGHT NOW IN THE LAST MONTH 0 1 2 3 4 5 6 7 8 9 10

5. WHAT INCREASES THE PAIN? _____

6. WHAT DECREASES THE PAIN? _____

WHAT TREATMENTS OF MEDICINES ARE YOU RECEIVING FOR YOUR PAIN?

A) _____ NO COMPLETE 0 1 2 3 4 5 6 7 8 9 10COMPLETE RELIEF

TREATMENT/MEDICINE/DOSAGE

B) _____ NO COMPLETE 0 1 2 3 4 5 6 7 8 9 10COMPLETE RELIEF

TREATMENT/MEDICINE/DOSAGE

C) _____ NO COMPLETE 0 1 2 3 4 5 6 7 8 9 10COMPLETE RELIEF

TREATMENT/MEDICINE/DOSAGE

D) _____ NO COMPLETE 0 1 2 3 4 5 6 7 8 9 10COMPLETE RELIEF

TREATMENT/MEDICINE/DOSAGE

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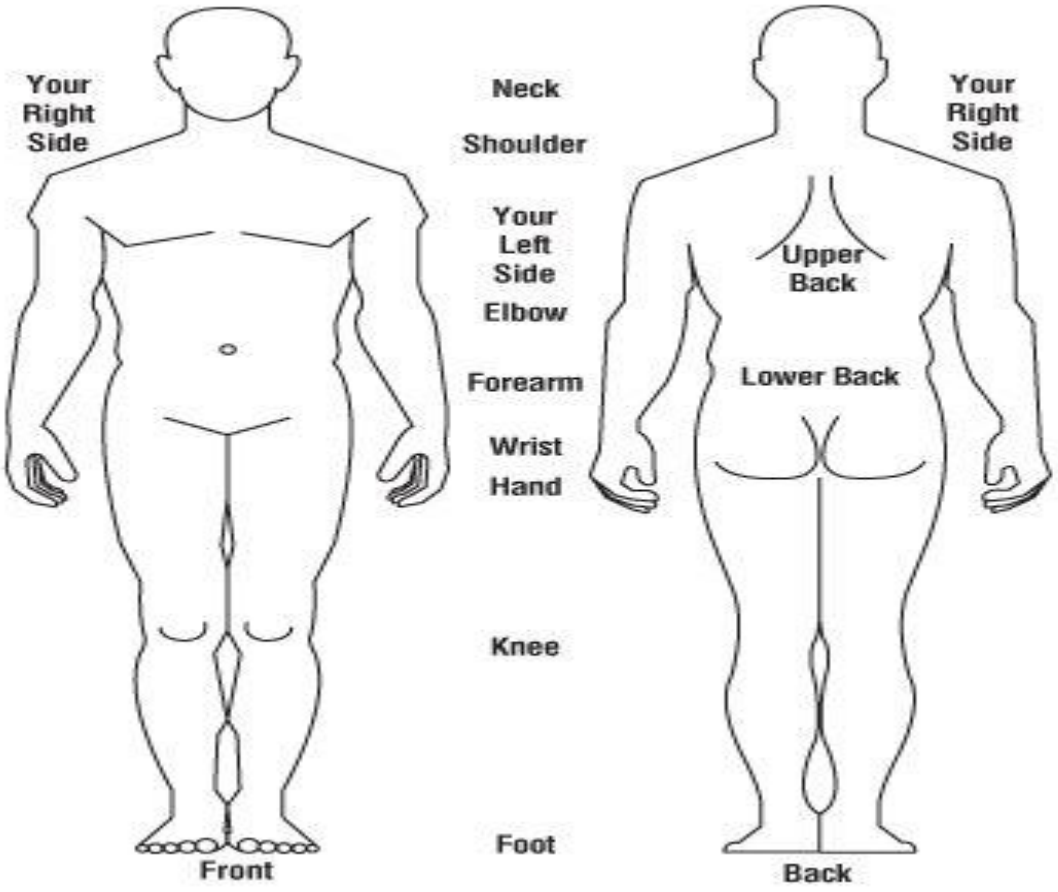
PLEASE CIRCLE YOUR POINTS OF PAIN



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NARCOTICS CONTRACT

NARCOTICS CONTRACT (PLEASE REVIEW THE INFORMATION AND SIGN AT THE BOTTOM)

CONTROLLED SUBSTANCE MEDICATIONS (NARCOTICS, TRANQUILLIZERS, AND BARBITUATES) ARE VERY USEFUL, BUT HAVW HIGH POTENTIAL FOR MISUSE AND ARE, THEREFORE, CLOSELY CONTROLLED BY LOCAL, STATE, AND FEDERAL GOV'T. THEY ARE INTENDED TO RELIEVE PAIN TO IMPROVE FUNCTION AND/OR ABILITYTO WORK, NOT TO SIMPLY FEEL GOOD.

BECAUSE MY PHYSICIAN IS PRESCRIBING SUCH MEDICATION FOR ME, I AGREE TO THE FOLLOWING CONDITIONS:

1. I WILL DISCLOSE AL CURRENT DOCTOR RELATIONSHIPS AND OBTAIN AND ALL PAIN MEDICATIONS SUCH AS NARCOTICS OR OTHER CONTROLLED SUSBSTANCE MEDICATIONS ("NERVE MEDICATIONS", "ANXIETY MEDICATIONS", SEDATIVES, SLEEPING PILLS, OR MUSCLE RELAXANTS) ONLY FROM SPINE AND ORTHOPEDICS CENTER. I UNDERSTAND THESE DRUGS HAVE AN ABUSE POTENTIAL BECAUSE THE CAN PRODUCE PHYSICAL AND PSYCHOLOGICAL DEPENDANCE.

2. I WILL NOT REQUEST OR EXCEPT CONTROLLED SUBSTANCE MEDICATIONS FROM ANY OTHER PHYSICIAN OR INDIVIDUALS WHILLE I AM RECEIVING SUCH MEDICATIONS FROM SPINE & ORTHOPEDIC CENTER. BESIDES BEING ILLEGAL TO DO SO, IT MAY ENDANGER MY LIFE.

3. REFILLS OF CONTROLLED SUBSTANCE MEDICATIONS:

A) ARE COMPLETED ONLY ON MONDAYS, TUESDAYS, AND FRIDAYS ONLY

B) WILL NOT BE MADE IF "I RUN OUT EARLY" YOU ARE RESPONSIBLE FOR TAKING YOUR MEDICATIONS IN THE DOSE IT IS PRESCRIBED

C) WILL NOT BE MADE IF LOST OR STOLEN. YOU ARE RESPONSIBLE FOR YOUR MEDICATION.

PHARMACY NAME_____TELEPHONE:_____

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WAYS TO STAY COMPLIANT CONTRACT

□ REFRAIN FROM GOING TO THE ER AND SEEKING PAIN MEDICATIONS EXCEPT FOR AN ACUTE EMERGENCY.

□ ADVISE SPINE & ORTHOPEDIC CENTER IN ADVANCE IF ANY ACUTE SITUATIONS ARISE THAT REQUIRE OTHER PHYSICIANS TO PRESCRIBE PAIN OR CONTROLLED MEDICATIONS.

□ COOPERATE WITH URINE DRUG SCREENS OR FAMILY CONFERENCES WHEN ASKED TO DO SO. I UNDERSTAND THIS MAY BE NEEDED TO FURTHER EVALUATE MY MEDICAL CONDITION AND RESPONSE TO THESE DRUGS.

□ REFRAIN FROM USING ILLEGAL DRUGS/SUBSTANCES

□ COMPLY WITH YOUR RECOMMENDED TREATMENT PLAN ******IF YOU DON'T AGREE WITH YOUR TREATMENT PLAN IT MUST BE DISCUSSED WITH THE TREATING PHYSICIAN.

□ ATTEND ALL APPOINTMENTS (PRESCRIPTION REFILL, INJECTIONS, AND THERAPY) AS SCHEDULED, ALL SAME DAY CANCELLATIONS FOR FOLLOW-UP AND THERAPY ARE $35.00 AND ALL PROCEDURES ARE $75.00. ~NO EXCEPTIONS~

□ I UNDERSTAND THAT IF I VIOLATE ANY OF THE ABOVE INFORMATION MY TREATMENT AT SPINE & ORTHOPEDIC CENTER MAY BE ENDED IMMEDIATELY.

□ REFRAIN FROM BEING DISRESPECTFUL TO STAFF

□ PAY YOUR COPAY, DEDUCTIBLES, AND BALANCES AT THE TIME SERVICES ARE RENDERED.

I HAVE READ THE "NARCOTICS CONTRACT" AND "WAYS TO STAY COMPLIANT CONTRACT" AND I FULLY UNDERSTAND THE CONSEQUESNCES OF VIOLATING ANY OF THE INFORMATION LISTED.

_____ _____

PATIENT'S SIGNATURE/DATE **PHYSICIAN'S SIGNATURE/DATE**