Date: / /

SPINE & SPORT REGISTRATION FORM

Referring Physician:_____ Primary Care Physician:_____

Date Last Seen:_____ Date last Seen:_____

PATIENT INFORMATION

Patient's Last Name:_____ First:_____
Middle:_____

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss.

Marital Status (circle one)
Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security Number:	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street Address:	Cell Phone: ( )	Home Phone: ( )

Mailing Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone Number: ( )

Chose clinic because/ Referred to clinic by (please check one box): . ☐ Other family members seen here:_____

☐ Dr ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Close to home/ work ☐ Yellow Pages ☐ Other

How would you like to be contacted? (Please check one box):

☐ Mail ☐ E-Mail:_____

INSURANCE INFORMATION

(Please Give Insurance Card & Picture ID to Receptionist)

RELEASE OF MEDICAL RECORDS

I am hereby authorizing Spine & Sport to request on my behalf, Medical Records and/ or Health Information from past/ current physicians. I understand that may revoke this authorization, in writing, at any time. Disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization. Without my written revocation, the authorization will automatically expire upon satisfaction of the need for disclosure.

Patient/ Guardian Signature_____ ***Relation to Patient:***_____

Date:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): _____

Relationship to patient:_____

Home Phone: ( ) **Work Phone:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Spine & Sport or the insurance company to release any information required to process my claims.

Patient/ Guardian Signature:_____

Date:_____

Date:_____

SPINE & SPORT

MEDICAL SCREENING FORM

Circle YES or NO…

Have you or any immediate family members ever been told you have …	**Self**	**Family**
Cancer?	yes...no	yes...no
Diabetes?	yes...no	yes...no
High blood pressure?	yes...no	yes...no
Heart disease?	yes...no	yes...no
High Cholesterol?	yes...no	yes...no
Angina/chest pain?	yes...no	yes...no
Stroke?	yes...no	yes...no
Osteoporosis	yes...no	yes...no
Osteoarthritis?	yes...no	yes...no
Rheumatoid arthritis?	yes...no	yes...no

In the past 3 months have you had or do you experience:

A change in *your* health?.....yes...no
Nausea/Vomiting? .....yes...no
Fever/chills/sweats?.....yes...no
Unexplained weight change?.....yes...no
Numbness or tingling?.....yes...no
Changes in appetite?.....yes...no
Difficulty swallowing?.....yes...no
Changes in bowel or bladder function?.....yes...no
Shortness of breath?.....yes...no
Dizziness?.....yes...no
Upper respiratory infection? .....yes...no
Urinary tract infection?.....yes...no

Circle YES or NO

Do you have a history of:

Allergies/Asthma? .....yes...no
Headaches?.....yes...no
Bronchitis? .....yes...no
Kidney disease?.....yes...no
Rheumatic fever? .....yes...no
Ulcers? ..... yes...no
Sexually transmitted disease?.....yes...no
Seizures?.....yes...no

Are you currently:

Pregnant?.....yes...no
Depressed?.....yes...no
Under Stress?.....yes...no

Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

Do you have a problem with?... (check all that apply)

☐ Hearing ☐ Vision
☐ Speech ☐ Communication
☐ Energy ☐ Focusing

Do you or have you in the past smoked tobacco?
Circle YES or NO

If yes, how many packs?_____
How many years?_____
When was your last use of tobacco_____

Do you drink alcoholic beverages?
Circle YES or NO

If yes, how many drinks do you routinely have per week?
_____ per week.

Date of last physical examination_____
List medications currently using:_____
_____
_____
List any vitamins/supplements currently using:_____
_____
What brand?:_____

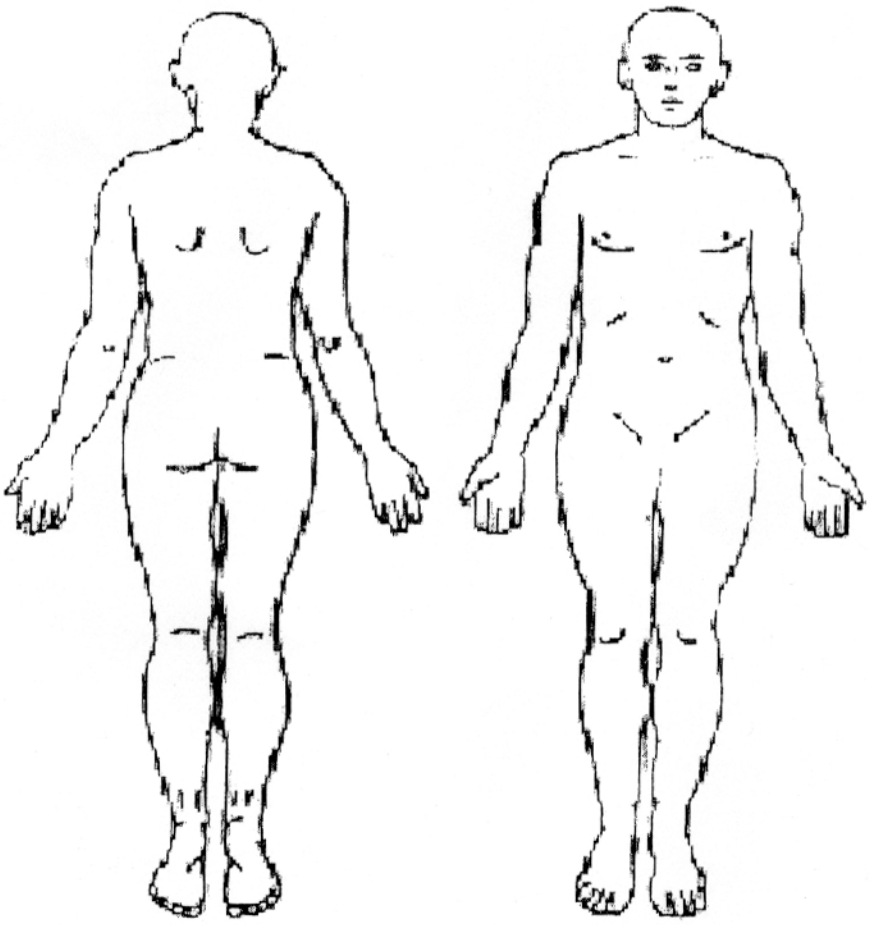
Would you like to talk with our AmeriSciences Vitamin Product Specialist about preventing or treating any of the following issues below through vitamin supplementation?

Please Circle All That Apply:

Arthritis
Children's Health
Vision
Heart Disease
Men's Health
Weight Loss
High Cholesterol
Memory & Focus
Osteopenia/ Osteoporosis
Prenatal
Sleep Difficulty
Tiredness/ Fatigue
Women's Health

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY: Pins & Needles = 00000 Stabbing = /////
Burning = XXXXX Deep Ache = zzzzz



SPINE & SPORT

www.spinesport.org

Effingham
135 Goshen Road Ext.
Suite 206
Rincon, GA 31326
(912) 826-3797
Fax: (912) 826-9767

Richmond Hill
1203 Gandy Dancer
Richmond Hill, GA 31324
(912) 459-2230
Fax: (912) 459-2240

Downtown
22 West Oglethorpe Ave.
Savannah, GA 31401
(912) 443-1400
Fax: (912) 443-1772

Islands
461 Johnny Mercer Blvd
Suite C-5
Savannah, GA 31410
(912) 898-7714
Fax: (912) 898-7715

Acknowledgement of Receipt of Privacy Notice

I have received a copy of Spine & Sports Notice of Privacy Practices, explaining how my Protected Health Information (PHI) may be used and shared as permitted by law. I understand the contents of the notice and I request the following restriction(s) concerning the use of my protected PHI:

_____

_____

_____

_____

Further, I permit a copy of this permission to be used in place of the original.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (ex. Spouse)

Relationship: _____

Witnessed by: _____ Date: _____

For Internal Use Only:

If patient's representative refuses to sign acknowledgement of notice, please document date and time the notice was presented to patient and sign below.

Date: _____ Time: _____

Person presenting document: _____

Title: _____

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Patient Notice of Privacy Practices

Effective April 13, 2006

Introduction

At Spine & Sport, we are committed to treating and protecting health information about you. This Patient Notice of Privacy describes the health information we collect and shows how and when we use or share that information. This notice is effective April 13, 2006 and apples to all protected health information as defined by federal laws.

Your personal medical information is called Protected Health Information or "PHI".

Understanding Your Health Record/Information

Each time you visit Spine & Sport, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record.

Your Rights

Although your health record is the physical property of Spine & Sport, the information belongs to you. You have the right to:

- Obtain a per copy of this notice of privacy practices upon request
- Inspect and copy your health record
- Make changes in your health record
- Obtain a list of who your PHI was shared with
- Request communication of your PHI in certain places (for example, you may want us to call you at work instead of home)
- Request a restriction on certain uses and sharing of your information
- Revoke your permission for use or sharing of your PHI except to the extent that action has already been taken

Our Responsibilities

Spine & sport is required to:

- Maintain the privacy of your PHI
- Provide you with this notice as to our legal duties and privacy practices with respect to PHI we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate PHI by alternative locations

We reserve the right to change our practices and to make the new provisions effective for all PHIs we maintain.

We will not use or share your PHI without permission, except as described in this notice. We will also discontinue the use of the Patient Notice of Privacy Practices and share your PHI after we have received notice in writing that you have revoked your permission.

Use and Sharing of PHI for Treatment, Payment and Health Operations

The law allows us to use your PHI without your permission for treatment, payment and business operations. The following are some examples: patient billing, third party billing, quality od care and improved services, other specialty care, caregiver/family member notification/communication, research, organ and tissue donation, marketing, fundraising, Food and Drug Administration (FDA), Workers Compensation, law enforcement, and public health.

Federal law makes provision for your PHI to be released to an appropriate health over sight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For more information or to report a problem:

If you have any questions and would like additional information, you may contact the practice's Privacy Officer at 912-826-3797.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or the Office of Civil Rights, U.S. Department of Health and Human Resources. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department Of Health and Human Services
200 Independence Avenue S.W.
Room 509F, HHH Building
Washington, DC 20201