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**TIER ORTHOPEDICS SPINE PATIENT INFORMATION PACKET**

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We know that filling out these forms can be difficult – but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. From this information, we can provide you the best medical care possible.

Please help us and you, by taking the time required to answer the questions accurately.  
Thank you for your cooperation!

Please print

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male Female

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Which is your dominant hand? RIGHT HANDED LEFT HANDED

Current Occupation? \_\_\_\_\_

Please indicate your current work status (circle one answer):

Working full time

Working part time

Seeking employment

Not working by choice (homemaker, retired, student, etc.)

Physically unable to work due to back/neck problem

Physically unable to work not due to back/neck problem

Is your spine problem the result of an on the job injury (worker's compensation)? YES NO

Is your spine problem the result of a Motor Vehicle Accident? YES NO

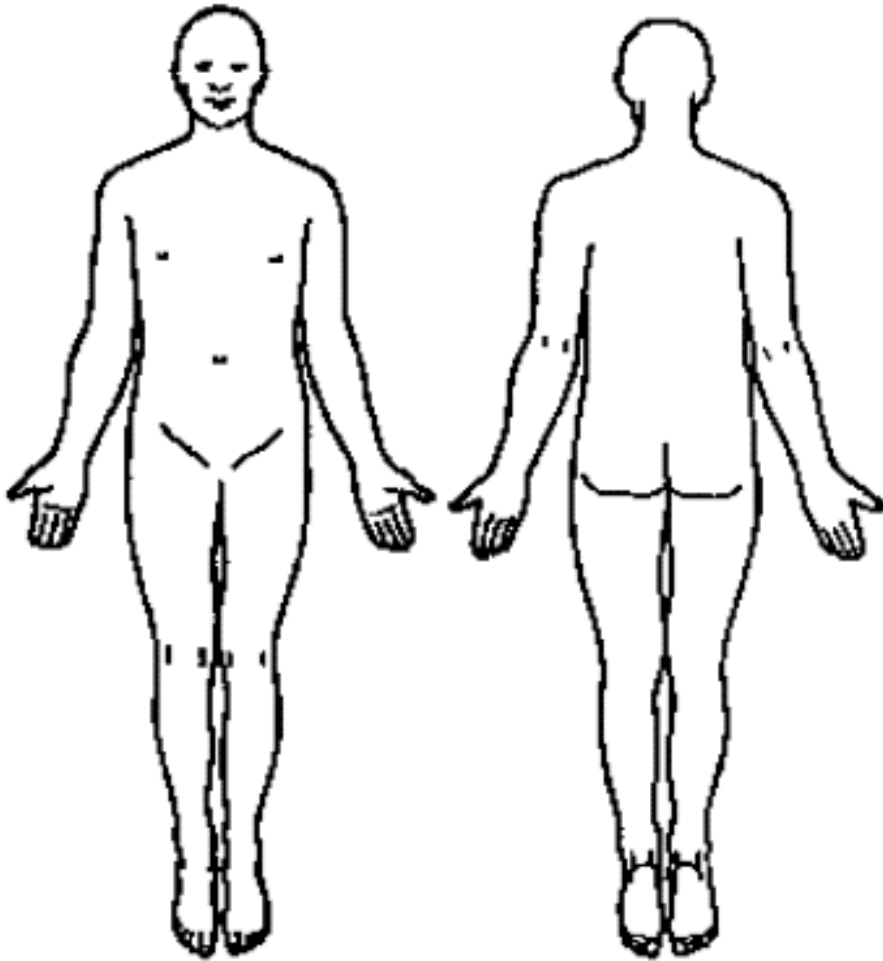
# PAIN DIAGRAM

Please mark the areas where you experience the following sensations:

	^^^	000	===	XXX	///
Ache	^^^	Numbness 000	Pins & 000	Burning XXX	Stabbing ///
	^^^	000	Needles 000	XXX	///

FRONT

BACK



RIGHT

LEFT

LEFT

RIGHT

## FACTORS OF COMPLAINT

What do you want to happen as a result of this visit? \_\_\_\_\_

**How and when did your problem begin** (please mark each answer that applies to you back/neck pain):

- I don't know how it began
- It comes and goes
- I've had it a long time (about \_\_\_\_\_ years)
- Injury (date of injury: \_\_\_\_\_ )
- On the job injury (date: \_\_\_\_\_ Place of employment: \_\_\_\_\_ )
- Explain how the injury happened: \_\_\_\_\_

**How bad is your pain?** Place an "X" (----X----) on each of the lines below to indicate your current pain.

**Low back?**

No pain ----- Worst possible

**Leg?**

No pain ----- Worst possible

**Middle back?**

No pain ----- Worst possible

**Neck?**

No pain ----- Worst possible

**Arm?**

No pain ----- Worst possible

**Do you have the following problems? Please circle an answer for each question.**

Weakness	arms/hands	legs/feet	none
Numbness (loss of feeling)	arms/hands	legs/feet	none
Tingling (falling asleep)	arms/hands	legs/feet	none
Does coughing effect your pain?	Yes	No	
Does you pain awaken you from sleep?	Yes	No	

Do your legs tire/hurt if you walk too far? Yes No

*If yes, answer the following:*

How far can you walk? Less than 1 block 1-3 blocks More than 3 blocks

Is this relieved by resting your legs? Yes No

Is this relieved by bending forward? Yes No

Bladder control (urine):	No problem	Can't empty bladder	Loss of urine (accidents)
Bowel control:	No problem	Constipation	Loss of control (accidents)



## GENERAL MEDICAL HISTORY

Circle all the conditions below that you have been diagnosed with.

Heart attack	Degenerative arthritis
Heart murmur	Rheumatoid arthritis
Angina	Gout
High blood pressure	Anxiety
Stroke	Depression
Varicose veins	Emphysema
Stomach ulcer	Tuberculosis
Duodenal problems	Chronic bronchitis
Colon problems	Frequent pneumonia
Diabetes	Asthma
Hepatitis	Anemia (low blood count)
Cirrhosis	Bleeding tendency
Kidney stones	Sexual difficulty
Kidney infection	Enlarged prostate
	Menstrual problems

Cancer, type? \_\_\_\_\_ Currently active? Yes No

Other diagnosis not listed above: \_\_\_\_\_

List any major surgery that you have had, other than on your back or neck.

Type of surgery	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

## FAMILY MEDICAL HISTORY

I do not know the medical history of my biological parents or other family members.

**Mother:**  She is alive and is \_\_\_\_\_ yrs old

She is in good health

She suffers with \_\_\_\_\_

She is deceased, cause \_\_\_\_\_

**Father:**

He is alive and is \_\_\_\_\_ yrs old

He is in good health

He suffers with \_\_\_\_\_

He is deceased, cause \_\_\_\_\_

I have \_\_\_\_\_ living brothers/sisters

I have \_\_\_\_\_ deceased brothers/sisters, cause(s) \_\_\_\_\_

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

(Circle)

Stroke	Back problems	Arthritis	Diabetes	Lung disease	Osteoporosis
Scoliosis	Heart trouble	Cancer	High blood pressure		
None of these					

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## PERSONAL AND SOCIAL HISTORY

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**Marital Status** (circle one answer)

Married/Domestic Partner

Single

Separated

Divorced

Widow/Widower

**Habits** (circle)

Do you, or have you ever smoked?      Yes      No      If yes, complete the following:

I smoke \_\_\_\_\_ packs per day and I have smoked for \_\_\_\_\_ years

I did smoke \_\_\_\_\_ packs per day, but I quit smoking \_\_\_\_\_ years ago

Do you use any smokeless tobacco products? Yes      No

How often do you drink alcohol?

**Beer**      Daily      Often      Socially      Rarely      Never**Wine**      Daily      Often      Socially      Rarely      Never**Liquor**      Daily      Often      Socially      Rarely      Never

Do you use recreational/street drugs?      Yes      No

If so, what? \_\_\_\_\_

**Education** (Circle the highest level of education that you have completed)

Grammar school

High school

College

Post-graduate

**Effect of you back/neck pain on your lifestyle** (circle)

Has your pain affected your ability to do your job or get a job?      Yes      No

Do you like your work situation?      Yes      No

Have you been laid off from your job?      Yes      No

My pain has affected my interaction with my family and friends      Yes      No

Are you currently involved in a law suit with regards to your back pain?      Yes      No

What is your ability to enjoy life?      Excellent      Very Good      Good      Fair      Poor

Is there anything that we have failed to ask that you believe is important for us to know? \_\_\_\_\_

\_\_\_\_\_

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## REVIEW OF SYSTEMS

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Do you have any of the following? Please circle Yes or No for *each* item.

### General

Recent unintentional weight loss of more than 10 pounds	Yes	No
Recent weight gain of more than 10 pounds	Yes	No
Seen by primary care physician in the last year	Yes	No
Fever	Yes	No
Chills	Yes	No
Night sweats	Yes	No
Decreased energy level	Yes	No
Decreased appetite	Yes	No

### Cardiac

Chest Pain	Yes	No
Shortness of breath	Yes	No

### Respiratory

Wheezing	Yes	No
Chronic cough	Yes	No
Pneumonia	Yes	No

### Gastrointestinal

Abdominal pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Liver problems	Yes	No

### Skin

Open sores	Yes	No
New moles	Yes	No
Poor healing	Yes	No
Skin infection	Yes	No

### Hematologic/Oncologic

Easy bruising	Yes	No
Blood thinning medications	Yes	No
Blood transfusion	Yes	No
Organ transplant	Yes	No

### Bones/ Joints

Shoulder pain	Yes	No
Wrist/hand pain	Yes	No
Hip pain	Yes	No
Knee pain	Yes	No
Lupus	Yes	No
Muscle weakness	Yes	No
Fibromyalgia	Yes	No

### Genitourinary

Abnormal kidney function	Yes	No
Pain with urination	Yes	No
Frequent urinary infections	Yes	No

### Mental Health

Sleep disturbance	Yes	No
Feeling of hopelessness	Yes	No

### Nervous System

Headaches	Yes	No
Tremors	Yes	No
Poor speech	Yes	No
Changes in vision	Yes	No

### Endocrine

Thyroid problems	Yes	No
Diabetes	Yes	No

**Tier Orthopedic Associates, PC  
100 Plaza Drive  
Vestal, NY 13850  
607-798-9356**

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes, treatment, payment and health care operations.

- **Treatment:** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment:** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Health care operations:** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information , including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office by speaking with our Privacy Official or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT.**

I Understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Tier Orthopedic Associates, P.C. has the right to change the Notice of Privacy Practices from time to time and that I may contact Tier Orthopedic Associates, P.C. at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

**I do hereby acknowledge that I have received a copy of the Notice of Privacy Practice.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature and acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below.

Reason: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TIER ORTHOPEDIC ASSOCIATES, P.C.**

100 Plaza Drive - Vestal, New York 13850

Telephone 798-9356

Social Security No. \_\_\_\_\_

**PATIENT INFORMATION**

**PATIENT NAME:**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone No. \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Primary Care Physician/Referring Physician:  
\_\_\_\_\_

Patient's Employer \_\_\_\_\_

Work Phone \_\_\_\_\_

Spouse's Name or Nearest Relative \_\_\_\_\_

Address \_\_\_\_\_

Phone No. \_\_\_\_\_

Employed by \_\_\_\_\_

**IF CHILD:**

Parent's Name \_\_\_\_\_

Employed by \_\_\_\_\_

**WHAT ARE YOU BEING SEEN FOR?**

Right \_\_\_\_\_ Left \_\_\_\_\_ Body Part \_\_\_\_\_

WERE X-RAYS TAKEN? Yes \_\_\_ No \_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

WERE MRI'S TAKEN? Yes \_\_\_ No \_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

WAS EMG DONE? Yes \_\_\_ No \_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

**INSURANCE INFORMATION:**

**WERE YOU INJURED AT WORK?**

Yes \_\_\_ No \_\_\_ Date of injury \_\_\_\_\_

Comp Carrier \_\_\_\_\_

**WERE YOU INJURED IN AN AUTO ACCIDENT?**

Yes \_\_\_ No \_\_\_ Date or Accident \_\_\_\_\_

PRIMARY INSURANCE CO. \_\_\_\_\_

ID No. \_\_\_\_\_

Subscriber \_\_\_\_\_

SECONDARY INSURANCE CO. \_\_\_\_\_

ID No. \_\_\_\_\_

Subscriber \_\_\_\_\_

**OFFICE USE ONLY**

DOCTOR \_\_\_\_\_

DATE SEEN \_\_\_\_\_

Initial \_\_\_\_\_

**MEDICAL INSURANCE WAIVER**

**I, THE UNDERSIGNED, AGREE TO THE PROVISION THAT IF MY MEDICAL INSURANCE DOES NOT COVER ANY AND ALL EXPENSES INCURRED DURING THE COURSE OF MY MEDICAL TREATMENT, I AM RESPONSIBLE FOR SAID PAYMENTS.**

\_\_\_\_\_  
**PATIENT OR GUARDIAN SIGNATURE**

**DATE** \_\_\_\_\_

Payment Authorization to Provider \_\_\_\_\_

**FOR OFFICE USE ONLY** Account No. \_\_\_\_\_ X-Ray No. \_\_\_\_\_

Date	Birthdate	Age	SSN
Name		Male	Female
Address		Telephone	
Occupation			
Primary Care Physician/Referring Physician			
Were x-rays brought with you?		Where taken?	
Nearest Relative	Relationship	Phone	

**CHIEF COMPLAINT**

Why are you seeing the doctor today? \_\_\_\_\_

Current problem is the result of a(n): Please check all that apply:

- Car Accident       Work Accident       Accident       Other

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication
			<b>ALLERGIC TO:</b>		
			<input type="checkbox"/> Antibiotics, what: _____		
			<input type="checkbox"/> Aspirin <input type="checkbox"/> Codine <input type="checkbox"/> Other _____		

Are all immunizations up to date?     Yes     No

If no, which immunizations are due? \_\_\_\_\_

**REVIEW OF SYSTEMS**

Are you currently having or have you had problems with your:

	Circle	Describe all "Yes" responses
Eyes	No    Yes	_____
Ears, Nose, Throat	No    Yes	_____
Lungs, Breathing	No    Yes	_____
Chest Pain, Heart Problems	No    Yes	_____
Digestion	No    Yes	_____
Bowel movement	No    Yes	_____
Bladder problem	No    Yes	_____
Diabetes	No    Yes	_____
High blood pressure	No    Yes	_____
Bleeding problems	No    Yes	_____
Balance problems	No    Yes	_____
Numbness/tingling	No    Yes	_____
Blackout/fainting/seizure	No    Yes	_____
Psychological Problems	No    Yes	_____
AIDS	No    Yes	_____
Cancer	No    Yes	_____
Arthritis	No    Yes	_____
Polio	No    Yes	_____
TB	No    Yes	_____
Epilepsy	No    Yes	_____
Liver	No    Yes	_____
Hepatitis	No    Yes	_____
Kidney	No    Yes	_____

PAST MEDICAL HISTORY

Table with 3 columns: Surgeries/Hospitalizations, Year, Complications. Multiple empty rows for data entry.

Have you ever had general anesthesia? [ ] NO [ ] YES

Have any problems with anesthesia? [ ] NO [ ] YES

Describe: \_\_\_\_\_

FAMILY HISTORY (IMMEDIATE FAMILY ONLY):

Table with 5 columns: Member, Alive, Deceased, Age, Health status or cause of death. Multiple empty rows for data entry.

Do any diseases run in your family-Describe:

Empty rectangular box for describing family diseases.

SOCIAL HISTORY

[ ] Work in the home [ ] Employed (occupation \_\_\_\_\_) [ ] Student [ ] Daycare [ ] Retired

[ ] Employed (occupation \_\_\_\_\_) Currently Working [ ] Yes [ ] No

Regular Duty [ ] Yes [ ] No Restricted Duty [ ] Yes [ ] No If Yes, please state restrictions \_\_\_\_\_

Who took you out of work or put you on light duty? \_\_\_\_\_

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Children? [ ] No [ ] Yes # \_\_\_\_\_

Do you live alone? [ ] No [ ] Yes

Exercise? [ ] Daily [ ] Weekly [ ] Monthly [ ] Rarely [ ] Never

What type of exercise? \_\_\_\_\_

History of substance abuse? [ ] No [ ] Yes What? \_\_\_\_\_

Smoke currently? [ ] No [ ] Yes \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit smoking? [ ] This year [ ] > 1 year [ ] > 5 years [ ] > 10 years Height: \_\_\_\_\_ Weight \_\_\_\_\_

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Drink alcohol? [ ] Daily [ ] 1-2 x/week [ ] 1-2 x/month [ ] 1-2 x/year

INSURANCE MEDICAL RELEASE/ASSIGNMENT:

I hereby authorize release of medical information necessary to process my insurance claim, and I also hereby authorize payment directly to the physician for benefits due me for his services as described. I understand I am financially responsible for charges not covered by this authorization.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_, M.D. Date: \_\_\_\_\_

TIER ORTHOPEDIC ASSOCIATES  
100 PLAZA DRIVE  
VESTAL, NY 13850

**Authorization to Share Information**

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**Leave appointment and billing messages on/with:      Leave medical information messages on/with:**

Answering machine?	___ Yes	___ No	Answering machine?	___ Yes	___ No
Office Voice Mail?	___ Yes	___ No	Office Voice Mail?	___ Yes	___ No
With another person?	___ Yes	___ No	With another person?	___ Yes	___ No
Send through the mail?	___ Yes	___ No	Send through the mail?	___ Yes	___ No
Send via email?	___ Yes	___ No	Send via email?	___ Yes	___ No
Cell Phone?	___ Yes	___ No	Cell Phone?	___ Yes	___ No

If you answered YES to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name:	Relationship:	Phone:	Cell Phone:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Additional HIPAA Contact instructions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: \_\_\_\_\_

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP: \_\_\_\_\_

DATE: \_\_\_\_\_