SPINAL AND NEUROLOGICAL SURGERY OF SOUTH MS, PLLC
15190 COMMUNITY ROAD, SUITE 300, GULFPORT, MS 39503
228-831-2229 FAX 228-539-8313

PATIENT REGISTRATION

PATIENT INFORMATION

Referring Physician _____ Primary Physician _____

Pain Management Physician _____

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ____/____/____ Sex □ M □ F Social Security number _____

Race: □ Asian □ Black or African American □ White □ Other **Ethnicity:** □ Hispanic or Latina □ Non-Hispanic or Latina

Street Address _____

City _____ State _____ Zip _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (____)_____ Cell Phone (____) _____ Emergency Phone (___ _) _____

Employer Name _____ Employer Number (____) _____

Employer Address _____ City _____ State____ Zip_____

If Patient is a student please indicate school attending:_____

Marital Status: □ Single □ Married □ Widow □ Divorced □ Separated

PATIENT'S SPOUSE

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ____/____/____ Sex □ M □ F Social Security number _____

Employer Name _____ Employer Number (____) _____

Employer Address _____ City _____ State____ Zip_____

EMERGENCY INFORMATION (Please list the name of someone who does not live with you to contact in the event of an emergency)

Name _____ Phone (____)_____

Address _____City _____State _____ Zip _____

VISIT INFORMATION

Is this visit today work related? □ Yes □ No If yes, date of injury_____

Is this visit today related to an auto accident? □ Yes □ No

WE DO NOT FILE 3RD PARTY INSURANCE. YOU MUST PAY FOR YOUR VISIT IN FULL AT TIME OF SERVICE.

_____ _____ _____

Patient Signature (Parent or Legal Guardian if Minor) Date

INSURANCE INFORMATION

Primary Insurance Name _____ Phone number (___)_____

Primary Insurance Address _____

Name of Insured _____ Insured's SSN_____

Insured's Date of Birth ____/____/____ Insured's Sex □ M □ F Insured's Phone Number (___)_____

Policy Number _____ Group Number_____ Effective Date ____/____/_____

Insured's Address _____ City _____ State_____ Zip _____

Relation Ship to Patient _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Name _____ Phone number (___)_____

Secondary Insurance Address _____

Name of Insured _____ Insured's SSN_____

Insured's Date of Birth ____/____/____ Insured's Sex M □ F □ Insured's Phone Number (___)_____

Policy Number _____ Group Number_____ Effective Date ____/____/_____

Insured's Address _____ City _____ State_____ Zip _____

Relation Ship to Patient _____

GUARANTOR

Guarantor's Name _____ **Date of Birth** ____/____/____

Guarantor's Billing Address _____

City _____ **State**_____ **Zip** _____ **Phone number (___)**_____

I have received a copy of the Notice of Privacy Practice.

_____ _____

Signature of Patient or Legal Guardian Date

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by a collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. I authorize Spinal & Neurological Surgery of South MS and all employees and other personnel of/or associated with Spinal & Neurological Surgery of South MS to have access to my existing and future medical records and copies thereof in connection with all medical services or treatment under confidentiality which I may now or hereafter receive from the staff.

I hereby also authorize payment of medical benefits to Spinal & Neurological Surgery of South MS for all services provided to me. I authorize the physician to release any information acquired in the course of my treatment to process insurance claims, workers compensation claims, or any other agents that have been involved in my medical treatment. I also permit release of medical information to continue the process of care on my behalf. All other releases will require a release of information form to be completed.

I hereby acknowledge and agree to accept the policies as stated above.

_____ _____

Signature of Patient or Legal Guardian Date

If not the patient, what is your relationship to the patient _____

Patient Name _____ Age _____ DOB ____/____/____

Chief Complaint _____

PAST MEDICAL HISTORY

Have you ever had any of the following? Please check all pertinent boxes:

□ AIDS or HIV+	□ Anemia	□ Arthritis	□ Asthma
□ Back Trouble	□ Bladder Infection	□ Bleeding Tendency	□ Blood Transfusion
□ Bronchitis	□ Chickenpox	□ Diabetes	□ Epilepsy /Seizures
□ Glaucoma	□ Heart Disease	□ Hepatitis	□ High Blood Pressure
□ Kidney Disease	□ Low Blood Pressure	□ Measles	□ Mitral Valve Prolapse
□ Mump	□ Pneumonia	□ Polio	□ Scarlet Fever
□ Small Pox	□ Stroke	□ Tuberculosis	□ Ulcer
□ Venereal Disease	□ Whooping Cough	□ other _____	□ _____

PAST SURGICAL HISTORY

Please list previous Hospitalizations /Surgeries/ Serious Illnesses.	When?	Hospital, City, State

MEDICATIONS (PLEASE INCLUDE NON-PRESCRIPTION ALSO)

DRUG NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN

PHARMACY_____ **Phone (___)**_____

Address_____ **City**_____

ALLERGIES

_____

_____

Patient's Social History:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation	Dominant Hand
□ Single	□ Never	□ Never	□ Spouse	□ Right
□ Married	□ Occasional	□ Previously, but quit	□ With Family	□ Left
□ Divorced	□ Moderate	□ Currently	□ Alone	
□ Widowed	□ Daily	□ Other	□ Other _____	
□ Separated		_____Packs per Day		

Family Medical History:

	Age	Conditions or Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Review of Systems: Please check any personal history below.

General
□ Change in weight, unexplained
□ Joint stiffness or swelling
□ Fever

HEENT
□ Headaches
□ Dizziness
□ Blurred vision
□ Double vision
□ Ringing of ears
□ Hearing difficulties

Respiratory
□ Shortness of breath w/ exertion
□ Cough
□ Bloody sputum
□ Wheezing

Cardiovascular
□ Chest pain
□ Palpitations
□ High blood pressure
□ Shortness of breath at night

Gastrointestinal
□ Abdominal pain
□ Nausea or □ Vomiting
□ Constipation or □ Diarrhea
□ Loss of appetite
□ Bloody or tarry stools
□ Unexplained weight change
□ Coughing up blood

Genitourinary
□ Frequent urination
□ Urgency, or □ Hesitancy
□ Bloody urine
□ Kidney stone
□ Frequent urinary tract infection

Endocrine
□ Excessive urination at night
□ Palpations or nervousness

Hematologic Allergic / Immunologic
□ Anemia
□ Enlarged lymph nodes
□ Easy bruising

Rheumatologic
□ Arthritis or □ Joint pain
□ Swollen warm joints
□ Morning stiffness

Neurologic
□ Numbness
□ Weakness
□ Seizures

Breast
□ Masses
□ Tenderness
□ Nipple discharge

Skin
□ Rashes
□ New skin lesions
□ Change in size or color of moles

Allergic Immunologic
List food/environmental allergies

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary service I may need.

_____ _____

Patient Signature **Date**

NAME: _____ DATE: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

Do you have neck pain? YES NO

Does it radiate into your arms? YES NO

Which arm? LEFT RIGHT BOTH

How far does the pain radiate? _____

Is there any numbness associated with your Pain? YES NO

Have you ever had neck Surgery? YES NO

If so, When? _____ Where? _____

Do you have low back pain? YES NO

How long have you had back pain? _____

Is this the result of an injury? YES NO

If so, what type of injury? _____

_____

Does your pain radiate to your legs? YES NO

Which Leg? LEFT RIGHT BOTH

How far does the pain radiate? _____

Does the pain increase with standing or sitting? YES NO

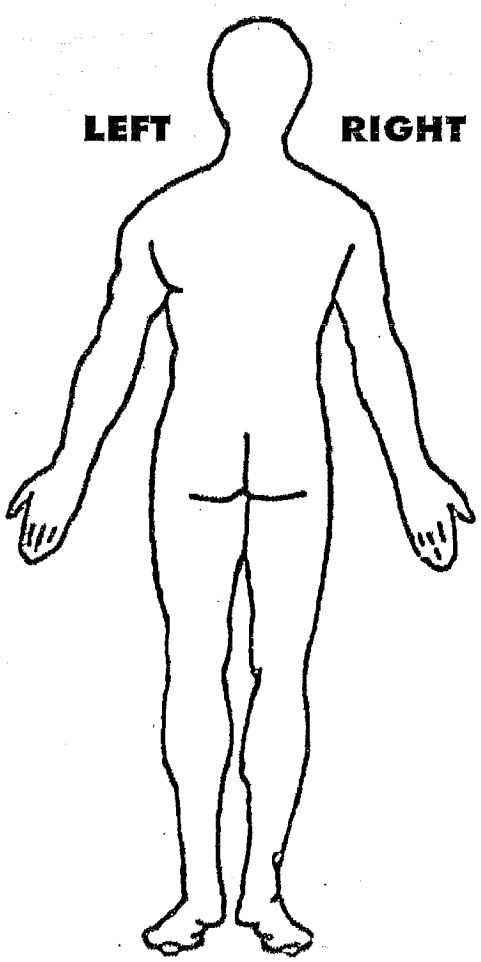
Is there numbness associated with your pain? YES NO

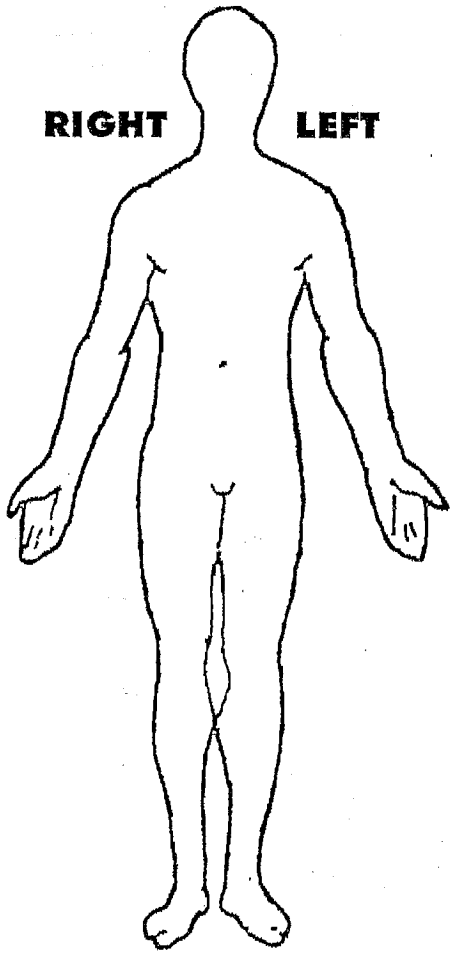
Have you ever had back surgery? YES NO

If so, When? _____ Where? _____

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. MARK ALL AREAS.

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING	OTHER
□□□□□	=========	oooooooooo	xxxxxxxxx	/////////	*****





Spinal and Neurological Surgery of South MS, PLLC

Victor T. Bazzone, MD Eric J. Graham, MD Michelle Graham, NP-C

IMPORTANT INFORMATION YOU MUST READ & UNDERSTAND

WORKER'S COMP PATIENTS

You must keep up with your visits for your mileage reports. This is your responsibility. If you need a printout for this, there will be a $10.00 charge and we will only go back 1 year from the date you are requesting the information. We will only authorize mileage for visits to this office and any facility we can verify that we sent you to. If we are unable to verify, then we cannot approve it. **Initial:** _____

FMLA OR DISABILITY FORMS

There will be a charge that must be paid at the time of pick up. It is the patient's responsibility to pick up the form and send it to the facility. We will not fax them. The charge begins at $20.00 and depending on the length of the form, could be more. We will let you know what the charge is once it is complete. We receive numerous forms daily so you **must** allow our office up to **15 days** to have the form filled out. We will be happy to supply you with one copy. If you need additional copies, there will be a charge of $1.00 per page. **Initial:** _____

BCBS PATIENTS

If Dr. Bazzone is your treating physician, please note that he is out of network for BCBS (with the exception of BCBS AHS State Insurance). If you wish to be treated by him, you will need to verify that you have Out of Network benefits. Your deductable and out of pocket may be higher with an out of network physician. At each visit you will be asked to sign a Non Network Written Direction of Payment for BCBS to allow them to send us the payment and EOB for your visit. If however BCBS sends the check and/or EOB to you, it will be necessary for you to bring it to us so that we can apply it to your account and adjust your account accordingly. This must be brought to us within **3 business days**. If this is not done, you will be responsible for the entire balance without any discounts, which must be paid within 30 days to avoid collections &/or further legal action.

Initial: _____

If Dr. Graham is your treating physician and you have surgery, Dr. Bazzone may assist. You need to be aware that Dr. Bazzone is out of network for BCBS (with the exception of BCBS AHS State Insurance). We will file the charges for the assistant surgeon however, as long as you have Out of Network benefits, we will treat you as if in network for this service only. You will be asked to sign a Non Network Written Direction of Payment for BCBS to allow them to send us the payment and EOB for your surgery. If however BCBS sends the check and/or EOB to you, it will be necessary for you to bring it to us so that we can apply it to your account and adjust your account accordingly. This must be brought to us within 3 business days. If this is not done, you will be responsible for the entire balance without any discounts, which must be paid within 30 days to avoid collections &/or further legal action. **Initial:** _____

DUE TO CHANGES MANDATED BY THE FEDERAL GOVERNMENT WE MUST INFORCE THE FOLLOWING

PRESCRIPTION REQUESTS

You must call in your prescription request at least **48 hours** prior to running out and you must give our office **48 hours** to return your call if the prescription will or will not be filled. **THERE IS NO NEED TO CALL OUR OFFICE AGAIN BEFORE THE 48 HOURS HAVE PASSED!!**

IT WILL BE MANDITORY FOR YOU TO COME IN FOR AN OFFICE VISIT EVERY TIME YOU RECEIVE A REFILL ON YOUR NARCOTIC MEDICATION. NO ONE ELSE CAN PICK UP YOUR NARCOTIC MEDICATION. **Initial:** _____

THIS MUST BE SCHEDULED ON A DAY THAT YOUR DOCTOR IS HERE. THE GOVERNMENT REQUIRES THAT YOUR DOCTOR HAND NARCOTIC MEDICATION TO YOU PERSONALLY. **Initial:** _____

YOU MAY BE REQUIRED TO HAVE A URINE DRUG SCREEN AT ANY VISIT. **Initial:** _____

YOU MAY BE REQUIRED TO BRING YOUR MEDICATION WITH YOU TO THESE VISITS TO BE COUNTED. **Initial:** _____

THIS WILL BE AN OFFICE VISIT AND YOUR COPAY WILL APPLY. **Initial:** _____

My initials above and signature below indicate that I have read and completely understand all the above statements.

_____ _____

Patient Signature/Responsible Party **Date**

Bayou Bernard Professional Building
15190 Community Road, Suite 300
Gulfport, MS 39503
Phone: (228) 831-2229 · Fax: (228) 831-9991

Spinal & Neurological Surgery of South MS

15190 Community Rd., Suite 300
Gulfport, MS 39503
Telephone (228) 831-2229 Fax (228) 539-8313

Dear Patient

Dr. Eric J. Graham serves as a consultant from time to time for medical device companies, including those that manufacture instruments and implants used in spine surgery. His consulting arrangements adhere to AdvaMed policies and do not influence clinical decision making for product use. In addition, Dr. Eric J. Graham is an investor-shareholder in medical technology companies, physician-owned hospitals, surgery centers, imaging facilities, spinal implant manufacturing companies, and physical therapy facilities. These investments do not influence clinical decision making, product use or serve as inducement for referrals.

By signing this you have been made aware of this.

_____ _____

Patient Signature / Responsible Party Witness

Copy given to patient _____ _____

Initials Date

SF-36 ™ Health Survey

Instructions for completing the questionnaire: Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully checking the box that best represents your response.

Patient Name: _____

SSN#: _____ Date: _____

Person helping to complete this form: _____

1. In general, would you say your health is:
   □ Excellent □ Very good □ Fair □ Poor

2. Compared to one year ago, how would you rate your health in general now?
   □ Much better now than a year ago
   □ Somewhat better now than a year ago
   □ About the same as one year ago
   □ Somewhat worse now than one year ago
   □ Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
   a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   c. Lifting or carrying groceries.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   d. Climbing several flights of stairs.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   e. Climbing one flight of stairs.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   f. Bending, kneeling or stooping.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   g. Walking more than one mile.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   h. Walking several blocks.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   i. Walking one block.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all
   j. Bathing or dressing yourself.
      □ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
   a. Cut down the amount of time you spend on work or other activities? □ Yes □ No
   b. Accomplished less than you would like? □ Yes □ No
   c. Where limited in the kind of work or other activities? □ Yes □ No
   d. Had difficulty performing the work or other activities (i.e. took extra time)? □ Yes □ No

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
   a. Cut down the amount of time you spent on work or other activities? □ Yes □ No
   b. Accomplished less than you would like? □ Yes □ No
   c. Didn't do work or other activities as carefully as usual? □ Yes □ No

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with your family, friends, neighbors or groups?
   □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

7. How much bodily pain have you had during the past 4 weeks?
   □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
   □ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.
   a. Did you feel full of pep?
      □ All the time □ Most of the time □ A good bit of the time
      □ Some of the time □ A little of the time □ None of the time

   b. Have you been a very nervous person?
      □ All the time □ Most of the time □ A good bit of the time
      □ Some of the time □ A little of the time □ None of the time

   c. Have you felt so down in the dumps nothing could cheer you up?
      □ All the time □ Most of the time □ A good bit of the time
      □ Some of the time □ A little of the time □ None of the time

   d. Have you felt calm and peaceful?
      □ All the time □ Most of the time □ A good bit of the time
      □ Some of the time □ A little of the time □ None of the time

   e. Did you have a lot of energy?
      □ All the time □ Most of the time □ A good bit of the time
      □ Some of the time □ A little of the time □ None of the time

   f. Have you felt downhearted and blue?

□ All the time □ Most of the time □ A good bit of the time
□ Some of the time □ A little of the time □ None of the time

g. Did you feel worn out?
□ All the time □ Most of the time □ A good bit of the time
□ Some of the time □ A little of the time □ None of the time

h. Have you been a happy person?
□ All the time □ Most of the time □ A good bit of the time
□ Some of the time □ A little of the time □ None of the time

i. Did you feel tired?
□ All the time □ Most of the time □ A good bit of the time
□ Some of the time □ A little of the time □ None of the time

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?
□ All the time □ Most of the time □ A good bit of the time
□ Some of the time □ A little of the time □ None of the time

11. How TRUE or FALSE is each of the following statements for you?
a. I seem to get sick a little easier than other people
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

b. I am as healthy as anybody I know
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

c. I expect my health to get worse
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

d. My health is excellent
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

Oswestry Index Questionnaire

This questionnaire is designed to help us better understand how your back pain affects your ability to manage everyday- lift activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present-day situation.

Section 1 – Pain Intensity
- ☐ My pain is mild to moderate. I do not need pain killers.
- ☐ The pain is bad, but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

Section 2 – Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weight without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if items are conveniently positioned, (i.e.: on a table)
- ☐ I can lift only very little weights.

Section 4 – Walking
- ☐ I can walk as far as I wish
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from waking more than ¼ mile.
- ☐ I can walk only if I use a cane or crutches.
- ☐ I am in bet or in a chair for most of every day.

Section 5 – Sitting
- ☐ I can sit in any chair for as long as I like
- ☐ I can sit in my favorite chair only, but for as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I sleep well but only when taking medication.
- ☐ Even when I take medication, I sleep less than 6 hours.
- ☐ Even when I take medication, I sleep less than 4 hours.
- ☐ Even when I take medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Lift
- ☐ Social life is normal and causes me no extra pain.
- ☐ Social life is normal, but increases the degree of pain.
- ☐ Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Changing Degree of Pain
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates, but overall is definitely getting better
- ☐ My pain seems to be getting better, but improvement is Slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening

Section 10 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to necessary journeys under ½ hour.
- ☐ Pain prevents traveling except to the doctor/hospital.

_____ _____

Patient Name Date

Score _____ [50] Benchmark -5 = _____