SAN JOSE NEUROSPINE

Adebukola Onibokun, M.D.
Main clinic: 3425 S. Bascom Avenue, Suite I • Campbell, CA 95008
Satellite clinic: 3351 El Camino Real, Suite 200 • Atherton, CA 94027
www.SanJoseNeurospine.com • **P:** 408-377-3331

YOUR MEDICAL HISTORY page 1

1 Patient information

Chart #_____

Today's Date _____

Referring Doctor _____

Last Name _____ First Name _____ MI ___

Date of Birth (M/D/Y) _____ Age _____

Sex (M/F) _____ Height _____ Weight _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2 Your symptoms

Are your symptoms mostly in back, neck or elsewhere? _____

How long have you had these symptoms?

☐ ≤ 6 weeks ☐ ≥ 7 - 12 weeks ☐ 4 months or more

Do you have pain radiating past your knee or elbow? ☐ Yes ☐ No

Does your leg or arm ever go numb? ☐ Yes ☐ No

Have you lost bowel or bladder control? ☐ Yes ☐ No

The pain is: ☐ Constant ☐ It comes & goes

Does your pain wake you up at night? ☐ Yes ☐ No

What things makes the pain better? (rest, ice, heat, pills) _____

What makes the pain worse? (sitting, standing, lifting) _____

Do you have pain that radiates into the arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

Lost any control over bowel or bladder functions? ☐ Yes ☐ No

(If yes, describe) _____

Any weakness or numbness in an arm or leg? ☐ Yes ☐ No

(If yes, describe) _____

How long can you: _____ Sit _____ Stand _____ Walk

Is your pain the result of a: ☐ Fall ☐ Auto accident ☐ Other (list) _____

3 Current status

Is there a law suit pending on problem? ☐ Yes ☐ No

Which of the following describes you currently?

☐ Working; if yes: ☐ Full duties ☐ Limited

☐ Not working because of back or neck problem

☐ Not working because of another health problem

☐ Homemaker, retired or unemployed

How long have you been at that job? _____

Does your job require lifting, standing, sitting? ☐ Yes ☐ No

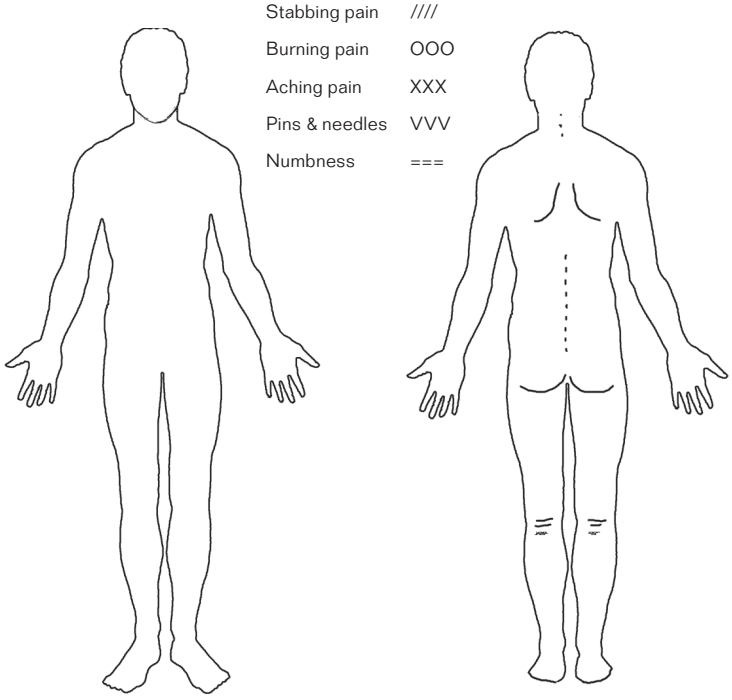
Employer at time of injury _____

4 Your pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

FRONT BACK

Stabbing pain	////
Burning pain	OOO
Aching pain	XXX
Pins & needles	VVV
Numbness	===



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain.

1 2 3 4 5 6 7 8 9 10

no pain extreme pain

Signature _____ Date _____

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5 Previous treatments & tests

Name of the doctor that treated you FIRST for this problem and the city. _____

What treatments did you have? _____

What tests have you had? ☐ CT scan ☐ MRI ☐ X-ray ☐ EMG
☐ Other (list) _____

Did you have any injections for your problem? ☐ Yes ☐ No
(If yes, describe) _____

Did these injections help? ☐ Yes ☐ No
(If yes, describe) _____

Did you have previous back or neck surgery? ☐ Yes ☐ No
(If yes, describe) _____

List any other PREVIOUS SURGERIES you had, and dates: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No
(If yes, describe) _____

Did you have physical therapy before for your problem? ☐ Yes ☐ No
(If yes, describe) _____

Did this therapy help? ☐ Yes ☐ No
(If yes, describe) _____

Do you do any special exercises for your back or neck? ☐ Yes ☐ No
(If yes, describe) _____

List any medications you are taking: _____

What other medications have you tried? _____

What do you hope we can accomplish today? _____

What other concerns do you have? _____

6 Your health

List any ALLERGIES you have to medications, foods, etc. _____

Do you have any adverse reactions to anesthesia? ☐ Yes ☐ No
(If yes, describe) _____

Do you smoke? ☐ Yes ☐ No (If yes, how many packs a day?) _____

Do you drink alcohol? ☐ Yes ☐ No (If yes, how many days a week?) _____

Do you have any of the following medical problems:

AIDS/HIV	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Recently, have you had...	
Heart problems	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Weight loss	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No
Migraines/headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Muscle diseases	☐ Yes ☐ No	Worse pain at night	☐ Yes ☐ No
Swollen ankles	☐ Yes ☐ No	Night sweats	☐ Yes ☐ No

Other problems: _____

7 Your family history

Do any family members have a history of:

Back/neck problems	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Arthritis or joint pain	☐ Yes ☐ No	Migraines/headaches	☐ Yes ☐ No
Bleeding disorders	☐ Yes ☐ No	Muscle diseases	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Stomach problems	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No

Other problems? _____

Signature _____ Date _____

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PERSONAL INFORMATION

1 Patient information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Personal Phone # _____ Work Phone # _____

Social Security # _____ Medicare # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____

Occupation (If retired, list prior occupation) _____

_____

Employer's Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Telephone # _____

Name of Personal Doctor _____

City _____ State _____

2 Person responsible for payment

(Leave blank if same as patient)

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Personal Phone # _____ Work Phone # _____

Social Security # _____

Date of Birth (M/D/Y) _____ Age _____ Sex (M/F) _____

Occupation (If retired, list prior occupation) _____

_____

Employer's Address _____

City _____ State _____ Zip _____

Is this visit due to a Workers Comp or Third Party Injury? ☐ Yes ☐ No

If YES: Company Name _____ Company Phone # _____

Claim # _____ Date of Injury _____

3 How did you hear of us?

☐ Friend/Relative ☐ Newspaper/Magazine ☐ Yellow pages ☐ Internet ☐ Insurance directory ☐ Referral - Dr. name _____

4 Insurance information

Primary Insurance _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Telephone # _____

Name of Policy Holder _____

Secondary Insurance _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

Insurance Telephone # _____

Name of Policy Holder _____

Signature _____ Date _____

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CONSENT FORM

1 Financial agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the physicians seen in this clinic of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to see the doctor, I will be responsible for the bill at the time of service.

Patient Name _____

Signature of responsible party _____

Today's Date _____

2 Consent for minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature _____ Date _____

Relationship to patient _____

3 Notice of privacy practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature _____ Date _____

If not signed by the patient, please indicate the relationship between the signee and the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

For office use only

Date received _____ Copayment _____

Authorization required ☐ Yes ☐ No Processed by _____

Practice follow-up ☐ Yes ☐ No Date of follow-up _____

Complete the following only if the patient refuses to sign the acknowledgement

Efforts to obtain _____

Reason for refusal _____

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WORK-RELATED INJURY REPORT FORM

1 Universal injury or accident statement

Last Name _____ First Name _____ MI _____ Today's Date _____

Please complete the following statement. Most insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Dateofinjury_____

Place where injury occurred (work, home, parking lot, car, friend's house, etc.) _____

2 Please describe how the injury or accident occurred

_____

_____

_____

3 Work related injury

Was the injury work related? ☐ Yes ☐ No (If yes, complete this section)

Name of Employer _____

Telephone # _____

Employer's Address _____

City _____ State _____ Zip _____

Workman's Compensation Carrier _____

Policy # _____ Group # _____

Claims Address _____

City _____ State _____ Zip _____

4 Third party liability settlement

Is there a possible third party liability settlement? (e.g., auto, homeowners, property)

☐ Yes ☐ No (If yes, complete this section)

Name of Insurance _____

Telephone # _____

Adjuster's Name (if known)_____

Telephone # _____

5 Authorization

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient Name (or signature of responsible party) _____ Today's Date _____

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PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. 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.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have that right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have received a copy of this Privacy Policy.

Patient Name (printed): _____ Signature: _____ Date: _____

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OUR PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will not provide pain prescriptions or pain prescription refills during the weekend which begins each Friday at noon and ends the following Monday at 8:30 a.m.

The goal of our spine center is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. So you may need to see the physician or the physician assistant to make these arrangements. Please call at least two days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs sufficient time to review your request for refill.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. Consequently, it is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade or give it away. If your medication is damaged, stolen or lost you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics. (Example include, Vicodin, Percocet, Oxycontin & Codeine)
2. Non-Steroidal Anti-Inflammatory drugs, “NSAIDS”. (Example include, Motrin, Celebrexx & Naprosyn)
3. Non-narcotic and other Pain Medicine. (Example include, Ultram or Darvocet)
4. Muscle Relaxants. (Example include, Flexeril or Soma)

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EMAIL AND TEXT POLICY

I, _____(patient) hereby voluntarily provide my email and cell telephone number to San Jose Neurospine.

I agree to permit San Jose Neurospine and their authorized representative(s), to communicate with me by email and text message with respect to the medical claims submitted to my insurance company and with respect to any balances due to San Jose Neurospine for balances not covered by insurance, coinsurance, deductibles, or any other balance deemed patient responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify San Jose Neurospine in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to San Jose Neurospine. There are no hardware or software requirements needed to receive email communication from the Practice or their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

San Jose Neurospine and their authorized representative(s), will not sell, share, or rent your email address or any other personal information collected on this consent.

Email: _____

Cell Phone: _____

Signature: _____