Summit
Spine & Joint Centers

NAME: _____ DATE OF BIRTH: _____

PATIENT INFORMATION

GENDER:____M____F ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATIN RACE: ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐WHITE ☐BLACK OR AFRICAN AMERICA

EMAIL: _____MARITAL STATUS: _____MARRIED_____WIDOWED_____SINGLE

REFERRING PHYSICIAN: _____PRIMARY CARE PHYSICIAN:_____

EMERGENCY CONTACT: _____EMERGENCY PHONE#:_____

RESPONSIBLE PARTY INFORMATION

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

PHONE:_____SSN:_____RELATIONSHIP :_____

EMPLOYER:_____ EMPLOYER PHONE:_____

EMPLOYER ADDRESS:_____

INSURANCE INFORMATION

(DO NOT complete if you have already provided this information)

INSURANCE COMPANY:_____INS. PHONE:_____

INSURANCE ADDRESS:_____

INSURED ID #:_____ GROUP#:_____

MEDICAID #:_____ SECONDARY INSURANCE:_____

SECONDAY INS ID #:_____ SECONDARY INS GROUP #:_____

INSURED'S NAME:_____DATE OF BIRTH:_____

INSURED'S SSN:_____RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER:_____

NAME: _____ DATE OF BIRTH: _____

NEW PATIENT INTAKE

- Location of your pain: _____
- When did it start: _____
- What happened and when? (Car accident, falling down, nothing, etc.)

  _____
- Is your pain a result of a personal injury (car accident , slip and fall, etc) Yes No
  - If yes, is there an active case Yes No
  - Attorney Information
    - Name: _____
    - Phone Number: _____
    - Date of Injury: _____
- Is your pain constant or intermittent? _____
- From scale of 0 to 10, how bad is your pain today? (0=no pain and 10= severe pain) _____
- From scale of 0 to 10, what was your average pain score throughout the last 30 days? _____
- Where does your pain start? _____
- Where does it go? _____
- **Quality** of your pain(circle all that apply)

Numbness Pins & Needles Burning Aching Stabbing Shooting

- What **aggravates** your pain? (Circle all that apply)

Sitting Bending Walking Lying down Leaning forward

Leaning back Coughing/sneezing Climbing upstairs Going downstairs

- What makes your **pain better**? (Circle all that apply)

Sitting Bending Walking Lying down Leaning Forward Leaning Back Stretching Rest Heat

Cold Medication

If medication, which ones?

_____

- What treatments have you tried? (Circle all that apply)

Physical Therapy Chiropractor TENS Injections Massage Therapy Ibuprofen/Aleve/Motrin Hypnosis

Over-the-counter ointments (Ben-gay, Icy-Hot, Myoflex) Traction Braces Nerve Block Acupuncture

Biofeedback Ice/Heat Narcotics Religious Counseling Psychological Counseling Surgery

- Did any of the above treatments help? If so, which ones helped?

_____

NAME: _____ DATE OF BIRTH: _____

CURRENT MEDICATIONS

Please write current medications in the table below or provide list of medications to staff

PAST MEDICAL HISTORY

Please indicate if you have suffered any of the following medical conditions. Also, state the year when these occurred.

_____Pneumonia
_____Depression
_____Diabetes
_____Kidney stones
_____Gout
_____Asthma
_____Nervous breakdown
_____Thyroid
_____Kidney disease
_____Emphysema
_____High blood pressure
_____Cancer
_____Menopause
_____Hormone problems
_____Shingles
_____Heart disease/attack
_____Other blood abnormalities

_____Arthritis
_____Herpes infection
_____Insomnia
_____Heart failure
_____Stroke
_____Headaches/migraines
_____Gonorrhea
_____Lupus
_____Tuberculosis
_____Seizures/convulsions
_____Hepatitis
_____Gall bladder issues
_____Panic attacks
_____Rheumatic heart
_____Multiple sclerosis
_____Syphilis
_____Other venereal disease

_____Irregular heartbeats
_____Chronic skin disease
_____Jaundice
_____AIDS or HIV
_____Heart murmur
_____Peptic ulcer disease
_____Urinary infection
_____Liver disease
_____Fibromyalgia
_____Schizophrenia/bipolar
_____Peripheral vascular disease

Other: _____

_____

ALLERGIES

Please list all known allergies

_____

_____

Latex: YES NO Adhesive: YES NO Betadine: YES NO

Injection Dye: YES NO Steroids: YES NO Lidocaine/Marcaine: YES NO

NAME: _____ DATE OF BIRTH: _____

PAST SURGICAL HISTORY

Please list previous surgeries and the (month/year) they took place

Date (Month/Yr)	Type of Surgery

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father-diabetic, grandfather-heart disease).

Family Member	Disease, Illness, or Ailment

SOCIAL HISTORY

Do you smoke? YES NO HOW MANYPACK/DAY? _____ YEARS? _____

Drink alcohol? YES NO IF YES HOW MUCH?_____

Do you use any other drugs (Marijuana, Cocaine, etc)? YES NO

Marital status? SINGLE MARRIED DIVORCED WIDOWED

Do you live alone? YES NO IF NO, WHO DO YOU LIVE WITH?_____

Is there an ongoing lawsuit related to your visit today? YES NO

NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain at the bottom of this page.

Allergy/Immunology					
Congestion……	Yes	No	Enlarged/swollen lymph glands……	Yes	No
Ophthalmologic					
Blurred vision……	Yes	No	Itching and redness……	Yes	No
Diminished visual acuity……..	Yes	No	Eye pain……	Yes	No
ENT					
Difficulty swallowing……	Yes	No	Sore throat……	Yes	No
Dry mouth……..	Yes	No	Ringing in ears……	Yes	No
Endocrine					
Thyroid disease……	Yes	No	Heat/Cold Intolerance……	Yes	No
Respiratory					
Shortness of breath at rest……	Yes	No	Coughing……	Yes	No
Wheezing……..	Yes	No	Pain with inspiration……	Yes	No
Cardiovascular					
Chest pain at rest……	Yes	No	Palpitations……	Yes	No
Varicose veins……..	Yes	No	Orthopnea……..	Yes	No
Dizziness……...	Yes	No	Weight gain……	Yes	No
Gastrointestinal					
Hemorrhoids……	Yes	No	Change in bowel habits……...	Yes	No
Blood in stool……	Yes	No	Nausea……..	Yes	No
Constipation……..	Yes	No	Heartburn……...	Yes	No
Hematology					
Easy bruising……	Yes	No	Prolonged bleeding……..	Yes	No
Musculoskeletal					
Significant pain/stiffness……..	Yes	No	Joint stiffness……	Yes	No
Carpal tunnel……	Yes	No	Weakness……	Yes	No
Skin					
Itching……	Yes	No	Skin cancer……	Yes	No
Rashes……...	Yes	No	Skin lesions……...	Yes	No
Neurologic					
Dizziness……	Yes	No	Tingling/numbness……..	Yes	No
Seizures……	Yes	No	Tremor……	Yes	No
Psychiatric					
Anxiety……	Yes	No	Loss of appetite……	Yes	No
Depressed mood……..	Yes	No	Substance abuse……	Yes	No
Difficulty sleeping……	Yes	No	Suicidal thoughts……..	Yes	No

ADDITIONAL NOTES

_____

_____

NAME: _____ DATE OF BIRTH: _____

HIPAA Acknowledgement and Consent Form

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 this information can and will be used to:

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

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care organizations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it's bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Printed Name	Date of Birth
Signature of Patient	Date
Legal Representative	Relationship to Patient

Summit Spine & Joint Centers, LLC 455 Philip Boulevard, Building 100, Suite 140 Lawrenceville, GA 30046

NAME: _____ DATE OF BIRTH: _____

Controlled Substance Agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases controlled substances are used as a therapeutic option in the management of chronic pain and related anxiety and depression which is strictly regulated by both stated and federal agencies. This agreement is a tool to protect both you and the physician by establishing guideline, within the laws, for proper controlled substance use. The words “we” and “our” refer to the facility and the words “I”, “you”, “your”, “me”, or “my” refer to you, the patient.

1. I understand that chronic opioid therapy has been associated with not only addiction and abuse but also multiple medical problems including the suppression of endocrine function resulting in low hormonal levels in men and women which may affect mood, stamina, sexual desire, and physical and sexual performance.
2. For female patients, if I plan to become pregnant or believe that I have become pregnant while taking this medication, I am aware that, should I carry the baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I will immediately call my obstetrician and this office to inform them of my pregnancy. I am also aware that opioids may cause a birth defect even though it is extremely rare.
3. I have been informed that long term and/or high doses of pain medications may also cause increased levels of pain known as opioid induced hyperalgesia (pain medicine causing more pain) where simple touch will be predicted as pain and pain gradually increases in intensity and also the location with hurting all over the body. I understand that opioid induced hyperalgesia is a normal expected result of using these medicines for a long period of time. This is only treated with addition of non-steroidal anti-inflammatory drugs such as Advil, Ibuprofen, etc. or by reducing or stopping opioids. I understand that I should not operate any heavy machinery while under the influence of narcotics.
4. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine uses is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.
5. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment, reduce the dose, or stop it.
6. I: All controlled substances must come from the physician whose signature appears below or during his/her absence, by the covering physician unless specific authorization is obtained for an exception.
7. I understand that I must tell the physician whose signature appears below or during his/her absence the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death.
8. I may not seek prescriptions or controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician’s knowledge.
9. I also understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician or his/her staff or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
10. All controlled substances must be obtained at the same pharmacy when possible. Should the need arise to change pharmacies, our office must be informed.

NAME: _____ DATE OF BIRTH: _____

11. You may not share, sell, or otherwise permit others, including your spouse or family members, to have access to any controlled substances that you have been prescribed.
12. Early refills will not be given; all patients will be seen every 30 days to receive refills on medications. Renewals are based upon keeping scheduled appointments ONLY during working hours. Please DO NOT make excessive phone calls for prescriptions on early refills and do not phone for refills after hours or on weekends. Summit Spine & Joint Centers, LLC have hours of operation between 8:30 am and 5:00 pm on Monday through Friday. Medication refill requests made via telephone have 24 BUSINESS HOURS to be returned.
13. Unannounced pill counts (random or planned) urine or serum adherence monitoring may be requested from you and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from the facility and its physicians and staff.
14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or during his/her absence by the covering physician, as set forth in Section 2 above. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances (e.g. alcohol and prescription drugs), which impairs my driving ability may result in DUI charges.
15. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen, it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told the authorities is not enough.
16. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol) refills on controlled substances will not be given.
17. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted
18. I also understand that the prescribing physician has permission to discuss all diagnostic and treatment details, including medications, with dispensing pharmacists, other professionals who provide your healthcare, or appropriate drug and law enforcement agencies for the purposes of maintaining accountability.
19. I am aware that it is a felony in Georgia for a patient to fail to disclose to his physician that he has received a controlled substance of a similar therapeutic use from another practitioner.
20. I affirm that I have full right and power to sign and to be bound by this agreement, that I have read it and understood and accept all of its terms.

My signature below acknowledges that I have read and received the Controlled Substance Agreement and the policies concerning prescription of dependence producing drugs.

Patient's Full Name	Date
Patient's Signature	Date
Supervising Provider Signature	Date
Witness	Date

NAME: _____ DATE OF BIRTH: _____

Clinic Policies

Initials _____Payment is due at the time services are rendered. I understand that if I have insurance that I am the responsible party, and that having insurance does not guarantee payment of the services rendered to me. I authorize submission of my claim to the insurance company listed above**.**

Initials _____If you are unable to make an appointment please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment you will be charged a NO SHOW fee of $15 for an office visit and $25 for a procedure. Frequent NO SHOWS may result in a release from the practice**.**

Initials _____Permission for treatment: I hereby authorize physician and assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations of treatments that may be ordered to be performed by the clinical personnel. I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature Date

***Please list the name of any person you wish to release your personal medical records/medical information to:

Name: **Relationship:**

Name: **Relationship**

Name: **Relationship:** **.**

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Summit
Spine & Joint Centers

Amit Patel, M.D.
Steven T. Nguyen, M.D.
Srinand Mandyam, M.D.
An Do, M.D.
Jose Mathew, D.O.
Celine Mathew, D.O.
Chad Lee, M.D.

Scott Linacre, P.A.
Dalandra Belcher, N.P.
Deborah Wilkens, N.P.
Mekinnah Currie, N.P.
Chinyere Okonkwo, N.P.

Faxed Medical Records Request

Date:_____ Fax: _____

Provider:_____ Attention: _____

Phone: _____

Please fax records ASAP

Patient Name:_____ DOB:_____

At your earliest convenience, please fax over the following information:

- All treatment records including the 1st office note
- Procedure notes (if applicable)
- Imaging reports in raper format (X-rays, MRIs, CT scans)
- Most recent lab work / urine drug screen results (the last three if applicable)
  Medication record
- Dismissal / Discharge letter (if applicable)
- Mental health / substance Abuse
- Other (specify):

  _____

Please fax the information to 770-962-3643.

Patient Signature:_____Date: _____

By signing above, I authorize the named health care provider to release the information or records to Georgia Pain and Wellness Center via facsimile or by mail and I understand that this authorization will expire one year from the date of the signature above

455 Philip Blvd,
Suite 140
Lawrenceville, GA 30046

3970 Five Forks Trickum Road
Suite A
Lilburn, GA 30047

484 Irvine Court,
Suite 110
Decatur, GA 30030

1200 Bald Ridge Marina Road,
Suite 150,
Cumming, GA 30041

466 Green Street
Gainesville, GA 30501

3905 Johns Creek Court,
Suite 200
Johns Creek, GA 30024

5900 Hillandale Drive,
Suite 320
Lithonia, GA 30058

100 Liberty Blvd
Suite 210
Canton, GA 30501

1255 Friendship Road,
Suite 150
Braselton, GA 30517

If you have any questions, please call us at 770-962-3642