The Sports & Spine Center
Jimmy D. Huebert, MD
Phn 503 691-2000 Fax 503 691-2001

PATIENT INFORMATION:

Name: _____Date of birth: _____ Sex: M ☐ F ☐
(First - Middle Initial - Last)

Nickname: _____ Driver's License #: _____SS#:_____

Address_____ Apt#:_____

City, State, Zip: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Phone: Home_____ Phone: Cell _____

Email Address_____

Preferred Method of contact (check one): Phone _____ Email _____ Other _____

May we leave confidential information on your voice mail? YES _____ NO _____

Primary Care Provider: _____

Referring Source/Provider: _____

EMPLOYMENT INFORMATION:

Employer: _____

Employer's Phone: _____

Occupation: _____
☐ Retired ☐ Unemployed ☐ Other

EMERGENCY CONTACTS:
Name: Relationship: Phone #:

_____

_____

_____

INSURANCE INFORMATION:

Primary Insurance Co: _____

ID#:_____

Group/Policy #:_____
Subscriber:
Name: _____

Phone: _____

Relationship to patient: _____

Date of Birth: _____ SS#_____

Secondary Insurance Co: _____

ID#:_____

Group/Policy #: _____
Subscriber:
Name: _____

Phone: _____

Relationship to patient: _____

Date of Birth_____ SS#_____

MVA or WORK RELATED INJURIES ONLY: _____

Insurance carrier name: _____ Address: _____

City, State, Zip: _____ Phone: _____

Claim #:_____ Date of injury: _____ Employer _____

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Financial Agreement and Release of Information
Please read and sign the following consents, releases, and agreements.

1. RELEASE OF INFORMATION: To obtain payment for services, the undersigned hereby authorizes the clinic to furnish from the patient's record, requested information or excerpts to any insurer, employer, or union which ·processes claims for the patient's care.

2. PAYMENT AGREEMENT: Billing of your insurance is done as a courtesy for you, but we hold you responsible for your account and to be financially responsible for charges not covered by insurance. Co-payments and Co-insurances are due at the time of your office visit. Accounts that are 90 days old are considered delinquent and a finance charge of $3.00 per month will be added to cover the cost of additional handling.

Consent to Release Health Information

As a patient of the Sports & Spine Center, PC., I understand that my health information may include information both created and received by the practice, which may be in the form of written or electronic records or spoken work, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses,
Treatments, procedures, prescriptions, and similar types of health-related information.
By my signature of that of my representative below, I agree and understand that the Sports & Spine Center, PC may use and disclose my health information for such typical purposes of:

1. *Treatment,* including: providing, coordinating, managing, making decisions about and planning for my care and treatment: referring to, consulting with, coordinating among and managing along with other healthcare providers for my care and treatment.
2. *Payment,* including determining my eligibility for health plan or insurance coverage and benefits, submitting bill to health plans, insurers and others who may be responsible to pay for some or all of my health care; and
3. *Health Care Operations,* including performing various office, administrative, and business functions that support the Sports & Spine Center efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

Patient's Signature: _____ Date: _____

Patient Name: _____ Date: _____

Guardian's Signature (if patient under 18): _____

Relation to Patient: _____

Signed By (Other than patient): _____

Please read and sign

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and authorize him to furnish information regarding my illness/injury to my insurance carrier.
I understand that I am responsible for any amount not paid for by my insurance.

_____ _____
Patient/Guardian Signature Date

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Date: _____

Health History:

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Male: Female:

What is the primary reason for your visit with the doctor today?

_____

_____

Latex Allergy Yes No
Drug Allergies Yes No Please list medications and reactions:

_____

_____

Medications

Please list any medications that you take on a regular basis. Include medication name, dose, and frequency.

_____

_____

_____

_____

_____

Past Medical History

Yes No

Do you have any medical problems?
Please list:

_____

_____

_____

_____

Have you ever had cancer? Yes No
If yes, what type?

_____

_____

Surgical History

Yes No

Have you ever had surgery?
Please list type and approximate date:

_____

_____

_____

_____

Family History

Any family history of the following?	Yes	No
Heart Disease	o	o
Arthritis	o	o
Cancer	o	o
Diabetes	o	o
Bleeding tendencies	o	o
Other: _____		

If answered yes, please list family member(s) relation to you:

_____
_____
_____
_____
_____
_____

Social History

	Yes	No
Do you drink alcohol?	o	o

If yes, how many drinks per week? _____

Have you ever used tobacco products?	o	o

How much/how long? _____

Have you stopped?	o	o

When did you stop? _____

Occupation _____

	Yes	No
Do you exercise?	o	o

How often? _____

Other activities _____

_____

	Yes	No
Do you/have used use recreational drugs?	o	o

Review of Systemsg

Do <u>you currently</u> have any of the following symptoms?

	Yes	No
Constitutional Symptoms		
Fever	o	o
Chills	o	o
Lethargy	o	o
Weight gain/ loss	o	o
Eyes		
Blurred vision	o	o
Double vision	o	o
Respiratory		
Wheezing	o	o
Frequent cough	o	o
Shortness of breath	o	o
Cardiovascular		
Chest pain	o	o
Rhythm problem	o	o
High blood pressure	o	o
Heart attack	o	o
Gastrointestinal		
Abdominal pain	o	o
Nausea / vomiting	o	o
Indigestion / heartburn	o	o
Neurological		
Dizzy spells	o	o
Numbness/ tingling	o	o
Endocrine		
Excessive thirst	o	o
Too hot/cold	o	o

	Yes	No
Hematological / Lymphatic		
Blood clotting problem	o	o
Easy bruising	o	o
Swollen nodes	o	o
Had a transfusion	o	o
History of Hepatitis	o	o
HIV / AIDS	o	o
Allergic / Immunologic		
Itchy eyes / nose	o	o
Runny nose	o	o
Pets in the home	o	o
Immune disorder	o	o

Pharmacy you prefer to use: _____

Location: _____

New Patient Work Sheet

Name:_____ Today's Date:_____

Ht:_____ Wt:_____ BP:_____ P:_____ R: _____ Date of Injury:_____

Why are you seeing the doctor today?: _____

What is your current pain level on a scale from **0** to **10** scale (10 being the worst)? _____

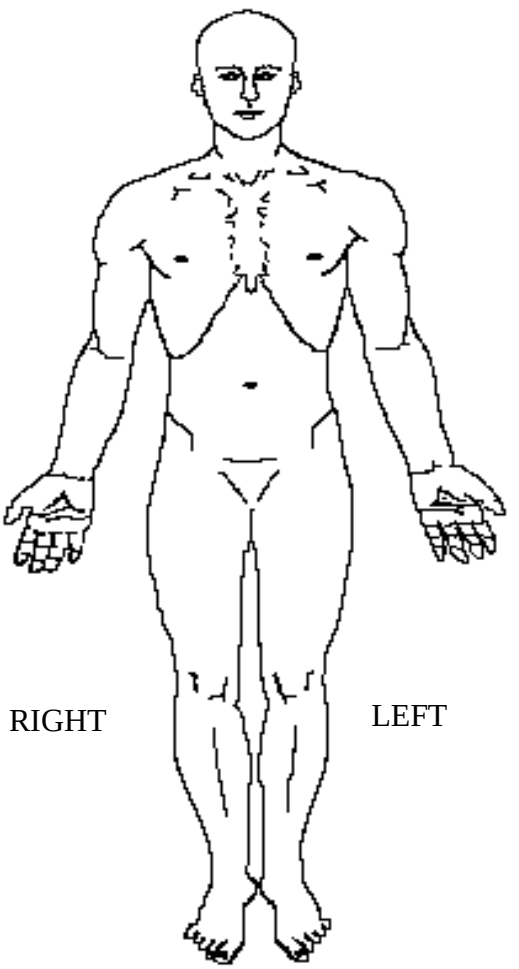
What % of your pain is located in the: Neck:_____ Shoulder:_____ Elbow/Arm:_____ Hand:_____

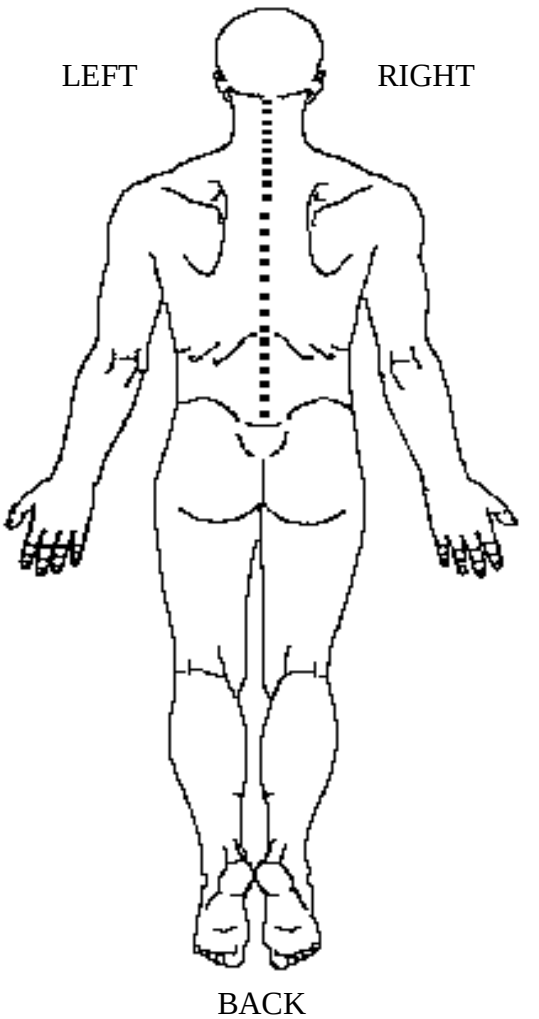
Back:_____ Hip: _____ Knee/Leg: _____ Foot: _____

Place a **single vertical line** across the line below to indicate your current pain level.

_____

0 (no pain) 10 (worst pain ever)





X-Rays:

MRI:

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I _____ give TSSC permission to disclose my medical
(printed name) information as noted below and to the persons I have listed below.

☐ All test results as it relates to MRI Scans – CT Scans – Xrays – Bone Scans – Lab tests – EMG tests – and all other information (including financial information) as it relates to your medical care from this office, to be left on my ANSWERING MACHINE.

☐ MRI♦CT♦Xray results ☐ Lab results ☐ Make/cancel appointments

☐ Pick up prescriptions ☐ Pick up medical records ☐ _____

1. _____
name relationship

2. _____
name relationship

3. _____
name relationship

4. _____
name relationship

_____ _____
Patient Signature Date

AUTHORIZE TO USE AND/OR DISCLOSE MEDICAL INFORMATION

NEW PATIENT VISIT		INJECTIONS-CPT		L	R	LUMBAR – DDD	M51.36
Expanded	99202	Bilateral -50				L – SPINE PAIN – LUMBAGO	M54.5
Detailed	99203	Lumbar selective ESI	64483			L – facet sydrome	M46.96
Comprehensive	99204	Additional level	64484-59			L – Bulging disc – Annular Tear	M51.26
Complex	99205	Caudal ESI	62323			Intervertebral disc disorder w/ radiculopathy	M51.17
FOLLOW UP VISIT		Thoracic selective ESI	64479			L – Spondylosis	M47.816
No Charge/Post Op	99024	Additional level	64480-59			L – Stress Fx	M43.06
Minimal (Non MD)	99211	Cervical ESI	62320			L – spinal stenosis	M48.06
Focused	99212	Lumbar Facet	64493			L – comp fx – S32.0105,.0205,.0305,.0405,.0505	S32.0005
Expanded	99213	Additional Level Lumbar Facet	64494-59			L – post lam syndr/Failed back syndr	M96.1
Detailed	99214	Cervical-Thoracic Facet	64490			L – strain, Acute	M54.5
		Additional Level C-T Facet	64491-59			L – Spondylolysis – listhesis	M43.16
BRACES-SPLINTS-SUPPLIES		Median Br N block – C-T-L	64450			Scoliosis	M41.86
Lumbar Corset brace	L0627	Blood patch-Lumbar	62273			L/T Radiculitis – Radiculopathy	M54.17
SI Joint belt	L0621	Inter-costal nerve block	64420			L – SCIATICA	M54.30
LSO Back brace	L0637	Sphenopalatine ganglion block	64505			L – Spine Schmorl Nodes	M51.46
TLSO Back brace	L0456	LUMBAR SYMPATHETIC	64520			OA-L Spine/Sacrum	M47.816
Thusane Soft Knee Brace		Stellate ganglion block	64510			SI Joint-HIP PAIN	M25.559
OA-Unloader Knee Brace		Carpal Tunnel injection	20526			COCCYX PAIN	M53.3
Carbon Fiber Shoe Inserts		Occipital nerve block	64405			Hip DJD / OA	M16.10
Thumb Spica		Supra-scapular nerve block	64418			SI Joint strain – Instability	M53.2x8
Tennis Elbow Strap		Digital nerve block	64455			Hip – Labral tear	M24.159
		Other Peripheral nerve block	64450			Trochanteric / Gluteal bursitis	M70.60
		SI Joint	27096			ITBF syndrome/Snapping Hip	M76.30
Dexamethasone – 4mg	J1100	Hip Joint	27093			T – DDD	M51.34
Depo-Medrol – 40mg	J1030	Small Joint/bursa (fingers-toes)	20604			T – Spine OA/Spondylosis	M47.814
Kenalog – 10mg	J3301	Med Jt/bursa (ankle-elbow-wrist)	20606			T – SPINE PAIN	M54.6
Celestone – 6mg	J0702	Large jt (hip-knee-shoulder)	20611			T – HNP	M51.34
		Tendon sheath – Ligament	20550			Intercostal Neuralgia	G58.0
Hyaluronic Acid (Hyalgan)		Trigger points (1 or 2 sites)	20552			T – Spinal stenosis	M48.04
		Trigger points (3 or more)	20553			Chest Wall pain	R07.89
Blood Patch	62273	LUMBAR DISCOGRAM	62290			C – DDD	M50.30
Surgical Tray	A4550	Median Nerve hydro-dissection	64721			C – Spinal Stenosis	M48.02
		Ulnar Nerve hydro-dissection	64718			C – Spondylosis/OA	M47.812
IV ANCEF NDC 0264-3103-11	96366	Other major peripheral nerves	64708			C – DDD w/ myelopathy	M50.00
IV Infusion medication	96374	NEUROLYSIS (Phenol, etc)	64640			C – SPINE PAIN	M54.2
IM Injection (specify medication)	96372	**SCS TRIAL**	**63650**			C –Gr Occ Neuralgia	M54.81
PHLEBOTOMY-Venopuncture	36415	KNEE PAIN	M25.569			C – HNP	M50.30
Bone Marrow Aspirate	38220	Knee – OA / DJD	M17.10			C – radiculitis/radiculopathy	M54.12
		Knee - Tenosynovitis	M76.891			Complex Migraine	G43.109
IMAGING		Chondromalacia	M94.269			Common Migraine	G43.009
MSKUS needle guidance	76942-59	Chondromalacia patellae	M22.40			Tension HA	G44.209
Fluoro needle positioning – Office	77003-59	Patellar dislocation/instability	M25.369			Chronic Tension HA	G44.229
Fluoro Disc Interpretation	72295-59	Pre-patellar bursitis	M70.40			SHOULDER PAIN	M25.519
Epidurogram	72275-59	Patellar Tendonitis	M76.50			Shoulder joint OA	M19.019
CONSCIOUS SEDATION	99152	Pes Anserine bursitis	M70.50			Rotator Cuff/Bicipital Tenosynovitis	M75.20
PRONOX VERSED ALPHA-STIM		ACL sprain	S83.519			Calcific Tendonitis	M75.30
		PCL sprain	S83.529			SLAP Tear – initial	S43.439A
BEAUTIFILL		Posterior-Lateral-Corner injury	M23.259			SLAP Tear - subsequent	S43.439D
		Medial Meniscus tear	S83.249			AC Joint disloc – initial-S43.50xA subseq-543.50xD	
ACCENT PRIME ACCUFIT		Lateral Meniscus tear	S83.289			AC Joint arthropathy	M19.019
		LCL sprain	S83.429			Adhesive Capulitis	M75.00
TED **SOPRANO**		MCL sprain	S83.419			Instability	M25.319
		Effusion	M25.469			Rotator Cuff Tear – Atraumatic	M75.110
ADIPOSE BMAC EXOSOMES		Osgood-Schlatter's	M92.50			Rotator cuff tear – Traumatic	S46.099
		Shin Splints-Initial encounter	T79.6xxA			ELBOW – UPPER ARM PAIN	M25.529
AMNIO PRP HAS A2M		Shin Splints-subs encounter	T79.6xxD			Lateral Epicondylitis	M77.10
		FOOT PAIN- SINUS TARSI	G57.50			Medial Epicondylitis	M77.00
PROLOTHERAPY Pre-PROLO		LEG PAIN	M79.606			Radial Ligament sprain S53.439D	S53.439A
		Ankle Sprain-initial	S93.499A			Ulnar Ligament sprain S53.449D	S53.449A
ALPHA STIM-AID ALPHA STIM-M		Ankle Sprain-subsequent	S93.499D			Unlar nerve entrapment/Subluxation	G56.20
		Ankle DJD / OA	M19.079			Olecranon Bursitis	M70.20
PEMF EPAT		Plantar Fasciitis	M72.2			WRIST – FOREARM PAIN	M25.539
		Mortons Neuroma	G57.60			HAND – MCP JOINT PAIN	M79.643
CBD+		Achilles Tendonosis – Bursitis	M65.869			FINGER PAIN	M79.646
		Stress Fx – foot – initial eval	M84.376A			Hand/Wrist OA	M19.039
TRANONT		Stress Fx – foot - subsequent	M84.376D			Wrist Synovitis	M65.839
		Ankle Instabilty	M25.979			Hand Synovitis	M65.849
PEPTIDES SOVAJ		Heel Pain/Stone Bruise	M79.673			TFCC – Scapho-lunate ligament tear	M24.149
		Sports Hernia	K43.9			Carpal Tunnel Syndrome	G56.00
syringes EtOH Sharps Container		Concussive syndrome – MTBI	S06.0x0			DeQuervain's	M65.4
		Peripheral Nerve Entrapments	G58.8			Trigger Finger	M65.30
CBD-1oz CBD-5oz CBD-Patch		PTSD	F43.1				

NAME:_____

DATE: _____ DOB:_____

PT ID#: _____

The Sports & Spine Center
7654 SW Mohawk Street
Tualatin, OR 97062

PAID AMOUNT $:_____

CoPAY – Co INS: _____

CASH CHECK Charge: MC VISA AMEX DISC HSA