The Spine and Sports Center

NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____

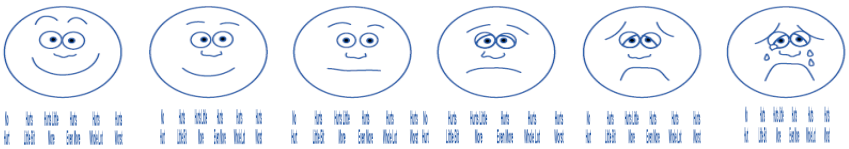
Date of Birth:_____ Age:_____ Sex: _____

Primary Physician's Name & Address	Referring Physician's Name & Address

QUESTIONS ABOUT MY *CURRENT* PROBLEM

1. Where is your pain? _____
2. When did your current pain problem begin? _____
3. How did it happen?

4. Generally speaking, are your symptoms getting better, worse or the same**?** _____
5. <u>Circle the number between 0 and 10 to indicate your level of pain in this last week:</u>

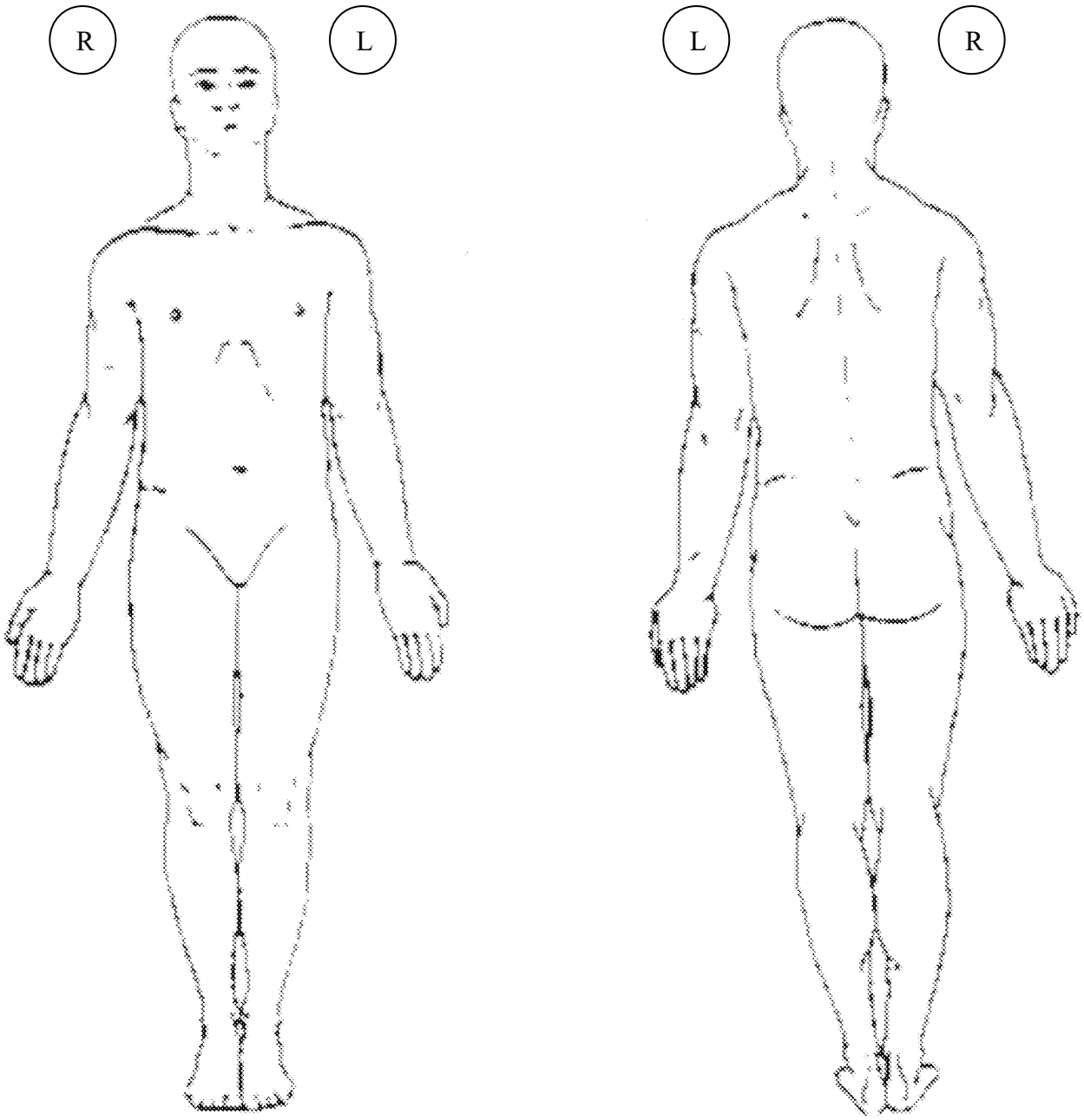


When it felt the worst this week	0	1	2	3	4	5	6	7	8	9	10
When it felt the best this week	0	1	2	3	4	5	6	7	8	9	10
Average for the week	0	1	2	3	4	5	6	7	8	9	10

6. What makes your pain worse?_____
7. What makes your pain better?_____
8. Describe the quality of your pain (aching, throbbing, burning, stabbing, etc) ?
9. What 4 things can you not do that is limited because of the pain?

a. _____ b. _____ c. _____ d. _____

Mark the areas on the body where you feel your normal pain/numbness/tingling



FRONT

BACK

TREATMENT HISTORY

Check (√) all treatments you have received for this problem:

- □ **Medication:**
  - **Name of Medications?** _____
  - **For how long?**_____
- □ **Physical Therapy, Occupational Therapy, Manipulation and/or other Chiropractic Treatment.**
  - **When?**_____
  - **For how long?**_____
- □ Injections or Nerve Blocks.
  - Do you know what injections were done?_____
  - Did they help? And for how long?_____
- □ Surgery? If yes, what? _____
- □ OTHER THINGS TRIED:

FUNCTIONAL STATUS:

□ yes □ no Do you have trouble getting to sleep because of pain

□ yes □ no Do you exercise? If yes how often _____

DIAGNOSTIC TESTS THAT YOU HAVE DONE FOR YOUR PROBLEM:

Test	*When done?*	*What hospital/clinic?*	*Findings*
X-Ray (What body part?)	_____	_____	_____
CT (CAT Scan)	_____	_____	_____
MRI	_____	_____	_____
EMG	_____	_____	_____
Other tests	_____	_____	_____

MEDICATIONS I AM ***CURRENTLY TAKING*** FOR ANY REASON (including non-prescription drugs)

Drug Name	Dose	How Often	For Pain Meds Only - - Does it help?
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know
			□ yes □ no □ don't know

LIST ALL KNOWN ALLERGIES:

MEDICAL HEALTH HISTORY

CHECK ALL THAT APPLY

□ yes □ no Tumors or Cancer? If yes, what type?
□ yes □ no Any infections in the last year? If yes, what**?**_____
□ yes □ no Epilepsy?
□ yes □ no Treated for headaches?
□ yes □ no Head injury with loss of consciousness?
□ yes □ no Thyroid problem
□ yes □ no Treated for a psychiatric disorder?
□ yes □ no Circulatory problems?
□ yes □ no Do you have a history of stroke?
□ yes □ no Heart problem? If yes, describe:
□ yes □ no Aortic aneurysm?
□ yes □ no Currently do you have high blood pressure?
□ yes □ no Do you have high cholesterol? If yes, what is it?
□ yes □ no Are you diabetic? If yes, are you insulin dependent? □ yes □ no
□ yes □ no History of respiratory disorders? (Asthma, Emphysema)
□ yes □ no Intestinal disorder?
□ yes □ no Gastrointestinal reflux? (GERD)
□ yes □ no AIDS or related diseases (HIV positive)?
□ yes □ no Hepatitis?
□ yes □ no Any disease of the nerves or muscles? If so, what _____
□ yes □ no Arthritis? What type_____
□ yes □ no Gout?
□ yes □ no Any injuries to other bones or joints?
□ yes □ no History of serious injury
□ yes □ no Do you have any other health problems not mentioned above?
If yes, please explain:
□ yes □ no Have you ever been hospitalized? _____

LIST ANY SURGERIES:

THINGS THAT I AM *CURRENTLY EXPERIENCING*

CONSTITUTIONAL

Y N Fever
Y N Recent Changes in Weight
Y N Chills
Y N Headache

EYES

Y N Change in Vision
Y N Wears Corrective Lenses

EARS

Y N Loss of hearing
Y N Earache

NOSE, MOUTH, THROAT

Y N Nosebleeds (Epistaxis)
Y N Tooth/Teeth Pain

OTOLARYNGEAL

Y N Hoarseness
Y N Gums

CARDIOVASCULAR

Y N Chest Pain
Y N Leg Pain with Exercise (Leg Claudication)
Y N Ankle Edema

RESPIRATORY

Y N Shortness of Breath
_____ Cough Worse in the Morning

PULMONARY

Y N Cough

GASTROINESTINAL

Y N Difficulty Swallowing
Y N Nausea
Y N Abdominal Pain
Y N Bowel Incontinence
Y N Decrease Appetite
Y N Belching (Eructation)
Y N Vomiting
Y N Diarrhea
Y N Constipation

GENITOURINARY (Men and Women)

Y N Urinary Frequency
Y N Burning Sensation during Urination
Y N Urinary Hesistancy
Y N Urinary Incontinence

GENITOURINARY (Women ONLY)

Y N Irregular Periods

FEMALE GU

Y N Spotting Between Periods
Y N Vaginal Discharge

HEMATOLOGIC

Y N Easy Bruising Tendency

NEUROLOGICAL

Y N Convulsions
Y N Fainting (Syncope)

PSYCHOLOGICAL/PSYCHIATRIC

Y N Sleep Disturbances

INTEGUMENTARY/SKIN

Y N Rash

FAMILY HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT FAMILY MEMBERS HAVE HAD

□ yes □ no Any blood relatives who have had a heart attack before age 55?
□ yes □ no Disabling back pain?
□ yes □ no Disability from work for other reasons?
□ yes □ no Arthritis
□ yes □ no Muscle or nerve disease. If so, what_____
Cancers
Rheumatological conditions
□ yes □ no Any other disease which might affect your treatment?
Please list:_____

SOCIAL HISTORY

Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated

Who do you live with? □ Alone □ Children (Ages_____)
□ Spouse □ Parents
□ Significant Other □ Friends or Relatives □ Other_____

Which part of town do you live? _____

How much alcohol do you usually drink per week? _____

□ yes □ no Have you been treated for drug or alcohol abuse?
□ yes □ no Do you use street drugs?
□ yes □ no Have you been a cigarette smoker in the past 5 years?
□ yes □ no Currently, do you smoke? If yes, how much per day _____

Aside from your current problem, what are the most stressful things in your life

WORK HISTORY

Do you currently work? □ full time □ part time □ no – why not?

If yes, where –

Job Title (current):_____

Employer / Company _____

Address:_____

Length of employment: Years_____ Months_____

Is your current problem work related? □ yes □ no

Do you believe this problem is caused by your work? □ yes □ no

Are you out of work because of this problem? □ no □ yes – Since what date?

Are you on physician ordered work restrictions because of this problem? □ yes □ no

If yes, please list restrictions:_____

FINANCIAL/LEGAL HISTORY

Are currently receiving compensation for your pain problem? □ yes □ no

Are you involved in any legal action (e.g. court case) related to your pain? □ yes □ no

ANYTHING ELSE YOU WISH TO SHARE WITH THE DOCTOR

The Spine and Sports Center

PATIENT PRIVACY FORM

First Name_____ Middle Initial _____ Last Name_____

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

Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOURE OF YOUR HEALTH CARE INFORMATION

TREATMENT – We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care options.

PAYMENT – We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS' COMPENSATION – We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES – We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH – As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS – We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT – We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS – We may disclose your health information to coroners or medical examiners.

ORGAN DONATION – We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH – We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY – It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES – We may disclose your health information for military, national security, prisoner and government benefits purposes.

CHANGE OF OWNERSHIP – In the event that Center for Spine, Sports, and Rehabilitation Excellence, dba The Spine and Sports Center is sold or merged with another organization, your health information/record will become the property of the new owner.

HEALTHCARE OPERATION -We may use or disclose health information about you to support the programs and activities of Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center such as quality and service improvement; health care delivery review; staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements.
Additionally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restriction on certain uses an disclosures of your health information. Please be advised, however, that Center for Spine, Sports, and Rehabilitation Excellence dba The Spine and Sports Center is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center amend your protected health information. Please be advised, however, that Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason (s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protect health information made by Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Center for Spine, Sports, and Rehabilitation Excellence dba The Spine and Sports Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Center for Spine, Sports, and Rehabilitation Excellence dba The Spine and Sports Center is required by law to comply with this Notice.

Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if

you want more information about your privacy rights, please contact Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center at (713) 590-2700.

COMPLAINTS

Complaints about your privacy rights, or how Center for Spine, Sports, and Rehabilitation Excellence dba The Spine and Sports Center here has handled your health information should be directed to Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center at (713) 590-2700. If Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to :

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, TX 20201

This notice is effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Center for Spine, Sports and Rehabilitation Excellence dba The Spine and Sports Center with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Signature: _____ Date: _____

The Spine and Sports Center

PATIENT INFORMATION *(PLEASE PRINT)*

First Name_____ Middle Initial _____ Last Name_____
Home Address _____
City _____ State _____ Zip _____
Billing Address (if different) _____
Work Address (if different) _____
Primary Phone _____ E-mail Address _____
Work Phone _____ Fax _____ Cell Phone _____
Date of Birth _____ Social Sec. # _____Sex □ M □ F
Ethnicity _____ Race_____ Primary Language_____
Marital Status □ S □ M □ D □ W □ Other _____ How did you hear about us?_____
Primary Care Physician _____ Referring Physician_____
Employer _____ Employer Phone_____
Emergency contact _____ Relationship _____ Phone _____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.
AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.
Patient Signature: _____ Date: _____

The Spine and Sports Center

Effective Immediately

24 Hour Cancellation Policy

There is a $25.00 cancellation fee for any appointment that is not cancelled or rescheduled more than 24 hours in advance. We regret having to implement this policy but find it necessary at this point. Thanks in advance for your understanding.

Print Name:_____ Date:_____

Signed Name: _____

THE SPINE AND SPORTS CENTER

BENOY BENNY, M.D.
EDCHERIL BENNY, M.D.
MARY VUONG, PA-C
Galleria -2100 West Loop South #150 - Houston, Texas 77027
Sugarland- 1111 HWY 6 South, # 145 - SugarLand, Texas 77478
Willowbrook- 14405 Walters Rd, #100 – Houston, Texas 77014
Katy- 21700 Kingsland Blvd., #102 – Katy, Texas 77450
Phone: 713.590.2700 Fax: 713.590.2702

RE: Records Release Authority

Patient name:_____

Previous Name (s):_____

I authorize The Spine and Sports Center to: ___ receive ___ release to the below Person/Agency:

_____
Name of Person or Agency

_____
Address

_____
City, State Zip

_____ _____
Telephone Fax

The following information: Please check off all that apply

___ Consultation report	___ EEG, EKG	___ Pathology report
___ Operative report	___ Discharge summary	___ Emergency record
___ Radiology reports	___ Lab reports	___ Progress Reports
___ History & Physical	___ Demographics information	

__Entire records except: _____

_____

_____ _____
(Date of Request) (Patient's Signature)

_____ _____
(Patient Date of Birth) (Address)

_____
(City, State, Zip Code)

THE SPINE AND SPORTS CENTER
BENOY BENNY, M.D.
EDCHERIL BENNY M.D.
MARY VUONG, PA-C

713-590-2700 office
713-590-2702 fax

Pharmacy Update Form

We are currently updating our records so we can electronically send your prescriptions. To expedite your office visit please fill out the following information:

Date_____

Patient Name_____

Pharmacy Name_____

Pharmacy Address_____

City_____ Zip Code_____

Pharmacy Phone Number (_____)_____

Thank you for your cooperation:

The Spine and Sports Center

Physician Disclosure of Financial Interest

Dear Patient:

As your physician, it is my duty to do everything I can to provide you with the highest quality of care. While I will provide services to you through my practice, it is possible that you will also require treatment, services or medical products from third parties. It is possible that I will recommend you obtain such treatment services or products from specific providers or entities. Any such recommendation will be based entirely and exclusively on what I believe to be in your best interest as my patient.

The purpose of this document is to inform you that as a member of the business community I have financial interests and other relationships with a number of entities that work in the field of healthcare. In an effort to be as transparent as possible, I want to disclose to you all such relationships (see below).

Please be aware that you have the right to be treated by and at any healthcare entity of your choice. The physician-patient relationship that exists between us will not be affected, nor will you be treated differently, if you choose to obtain any such items or services from another healthcare provider or entity.

Facilities/Entities in which Dr. Benny has a Financial Interest or other Relationship*

Entity Name	Type of Relationship
Center for Spine, Sports & Rehabilitation Excellence (DBA The Spine and Sports Center)	Ownership
Methodist Hospital, Sugar Land	Medical Staff
Pharmco	Ownership
Methodist Hospital, Willowbrook	Medical Staff
St. Luke's Hospital Medical Center	Medical Staff
Premier Performance Physical Therapy	Ownership
St. Luke's Hospital Sugar Land	Medical Staff
Elite Center for Minimally Invasive Surgery	Ownership
Houston Orthopedic and Spine Hospital	Medical Staff
ESA Labs	Ownership
Oakbend Hospital	Medical Staff
Elite Hospital Management, LLC (managing Hospital for Surgical Excellence)	Ownership

*A Medical Staff or Faculty relationship does not imply any conflict of interest, as Dr. Benny does not stand to benefit financially in such a relationship.

By signing below, you, or your legal representative, acknowledge that

(i) this disclosure has been made in advance of the date of the service;

(ii) you recognize the Dr. Benny has a financial relationship or other affiliation with the listed entities/facilities;

(iii) you are aware of your freedom to choose a facility or entity through which to receive the referred item or service; and

(iv) Dr. Benny has not required you to receive any item or service through a facility/entity in which he has a financial interest or other affiliation.

Date: _____

_____ Signature of Patient

_____ Print Name of Patient

_____ Signature of Parent/Guardian (if applicable)

_____ Print Name of Parent/Guardian (if applicable)