The Spine and Sports Center
EdCheril Benny, MD

NEW PATIENT QUESTIONNAIRE

Today's Date:

Name:_____ Date of Birth:_____ Age:_____ Sex: _____

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

Preferred Pharmacy:_____Phone#:_____

PAST MEDICAL HISTORY

HISTORY OF:

HYPERTENSION:_____

DIABETES:_____

HEART DISEASE:_____

STROKE:_____

SEIZURES:_____

MENINGITIS:_____

MIGRAINES:_____

PAST SURGICAL HISTORY

HEAD:_____

SPINE:_____

FAMILY HISTORY

MIGRAINE:_____

SEIZURES:_____

STROKE:_____

MEDICATIONS AND ALLERGIES

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:

_____

_____

SOCIAL HISTORY

Do you drink alcohol?_____
How much alcohol do you usually drink per week? _____
Have you been a cigarette smoker in the past 5 years?_____
Currently, do you smoke? If yes, how much per day _____

OB/GYN HISTORY (FEMALES ONLY)

LAST MENSTRUAL PERIOD:_____

CURRENTLY USING CONTRACEPTION:_____ TYPE:_____

CURRENTLY PREGNANT:_____ POSSIBILITY OF PREGNANCY:_____

The Spine & 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) _____

Home Phone _____ E-mail Address _____

Work Phone _____ Fax _____ Cell Phone _____

Date of Birth _____ Social Sec. # _____Sex □ M □ F

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 _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Insurance Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Insurance Address _____ City, State, Zip _____

Policy I.D. _____ Group # _____ Member # _____

Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ _____

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 & 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 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 is sold or merged with another organization, your health information/record will become the property of the new owner.

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 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 amend your protected health information. Please be advised, however, that Center for Spine, Sports and Rehabilitation Excellence 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.

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 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 is required by law to comply with this Notice.

Center for Spine, Sports and Rehabilitation Excellence 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 at (713) 590-2700.

COMPLAINTS

Complaints about your privacy rights, or how Center for Spine, Sports, and Rehabilitation Excellence here has handled your health information should be directed to Center for Spine, Sports and Rehabilitation Excellence at (713) 590-2700. If Center for Spine, Sports and Rehabilitation Excellence 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 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

BENOY BENNY, M.D.
EDCHERIL BENNY, M.D.
BRIAN LIEM, M.D.
MILES KILROY, M.D.

Galleria -2100 West Loop South #150 - Houston, Texas 77027
Sugarland- 1111 HWY 6 South, # 145 - SugarLand, Texas 77478
Willowbrook- 18220 Tomball Parkway #335 – Houston, Texas 77070
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	___ Operative report	___ Pathology report
___ EEG, EKG	___ 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)