KEIPER SPINE PC

Glenn L. Keiper Jr. MD, Ralph G. Peterson PA-C
Jonathan D. Sherman MD, Jason A. Kocian PA-C
1410 Oak Street, Suite 200, Eugene, OR 97401
Phone: 541-485-2357 **Fax:** 541-485-2358

Date: _____

First, MI, Last Name: _____ **DOB:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

SSN: _____ **Email:** _____

Referring Provider: _____

Primary Care Provider: _____

Emergency Contact: _____ **Phone:** _____

Please mark the correct boxes below: (Answers are optional but KS is asked to report # of each to State of Oregon)

Ethnicity:

Hispanic ☐ Non-Hispanic ☐ Prefer not to list ☐

Race:

Caucasian ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other ☐

African American/Black ☐ American Indian ☐ Prefer Not To List ☐

Current Symptoms:

Please mark the boxes below that correlate with your symptoms

Back Pain: ☐ Neck Pain: ☐

Lower Extremities: Left Side: ☐ Right Side: ☐ Both: ☐
Numbness/Tingling: ☐ Weakness: ☐ Pain: ☐

Upper Extremities: Left Side: ☐ Right Side: ☐ Both: ☐
Numbness/Tingling: ☐ Weakness ☐ Pain: ☐

Other: _____

Diagnostic Studies And Conservative Treatments:

MRI
Where: _____ When: _____

X-Ray
Where: _____ When: _____

CT/CT Myelogram
Where: _____ When: _____

EMG/NCS
Where: _____ When: _____

Discogram
Where: _____ When: _____

Physical Therapy
Where: _____ When: _____

Epidural Steroid Injections
Where: _____ When: _____

Chiropratic Treatment
Where: _____ When: _____

Acupuncture

Where: When:

Other

Where: When:

Past Medical History:

Diagnosis	Managing Physician	Active/Inactive/Resolved?

Past Surgical History:

Type	Year

Family Medical History:

Problem	Relation
Spine Surgery	
Brain Tumors	
Cancer	
Diabetes	
Heart Disease	
Migraines	
Strokes	
Tuberculosis	

Social History:

Tobacco Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Alcohol Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Marijuana Use:

Never: ☐ Every Day: ☐ Some Day: ☐ Former: ☐

Marital Status:

Married: ☐ Single: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐

Domestic Partner: ☐

Occupation:

Employed: ☐ Unemployed: ☐ Retired: ☐ Disabled: ☐

Job Title:_____

Employer:_____

Allergies And Sensitivities:

(Please list all including drugs, foods, environmental, inhalants, insects, and plants)

Allergy or Sensitivity	Reaction

Medication List:

Medication	Dosage	SIG (how you take it)	Why You Are Taking

Review Of Systems:

Please check all that apply

- ☐ Night Sweats
  Notes:_____
- ☐ Fever
  Notes:_____
- ☐ Recent Weight Loss
  Notes:_____
- ☐ Eye Pain
  Notes:_____
- ☐ Swallowing Difficulty
  Notes:_____
- ☐ Sleep Apnea with C-PAP
  Notes:_____
- ☐ Irregular Heart Beat
  Notes:_____
- ☐ Chest Pain
  Notes:_____
- ☐ Shortness of Breath
  Notes:_____
- ☐ Constipation
  Notes:_____
- ☐ Abdominal Pain
  Notes:_____
- ☐ Bowel Incontinence
  Notes:_____
- ☐ Dysuria (painful urination)
  Notes:_____
- ☐ Urinary Incontinence
  Notes:_____
- ☐ Impotence
  Notes:_____
- ☐ Joint Pain
  Notes:_____
- ☐ Skin Cancer
  Notes:_____
- ☐ Depression
  Notes:_____

Review of Systems (cont'd):

- ☐ Anxiey
  Notes:_____
- ☐ Thyroid
  Notes:_____
- ☐ Diabetes
  Notes:_____
- ☐ Use of Blood Thinners
  Notes:_____
- ☐ Easy Bruising
  Notes:_____
- ☐ Free Bleeding
  Notes:_____
- ☐ History of Bleeding Disorder
  Notes:_____
- ☐ Easy Infection
  Notes:_____
- ☐ Headaches
  Notes:_____
- ☐ Dizziness
  Notes:_____
- ☐ Blackouts
  Notes:_____
- ☐ Convulsions
  Notes:_____
- ☐ Confusions
  Notes:_____
- ☐ Memory Problems
  Notes:_____
- ☐ Blurred Vision
  Notes:_____
- ☐ Clumsiness
  Notes:_____
- ☐ Loss of Balance
  Notes:_____
- ☐ Numbness
  Notes:_____
- ☐ Weakness
  Notes:_____

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICIES

(A NOTICE OF PRIVACY PRACTICE WILL BE OFFERED TO YOU DURING YOUR VISIT: OR YOU MAY REQUEST A COPY AT ANY TIME)

I have received a copy of this office's notice of privacy practices.

Please Print Name:_____

Signature:_____

Or Signature of Legal Representative:_____

Date:_____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I/We authorize medical service providers to release to KeiperSpine, PC, any medical, clinical or financial records required for my care. I/We also authorize KeiperSpine, PC release medical or financial records that may be required to ensure continuity of care to the other health providers, insurers, or contracted service providers. This includes but is not limited to my insurance company, rehabilitations services, Social Security Administration, and Workers Compensation.

Patient Name:_____

Patient Signature or Representative:_____

Date:_____

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Financial Agreement:
I understand that I may be responsible for the payment of service rendered if the services ar not covered by my insurance. KeiperSpine is a participating provider with most health plans. However, participation is subject to change. I understand it will be my responsibility to verify with my insurance carrier the plan participation status of KeiperSpine, PC prior to a sevice being rendered. Insurance will be according to the billing/payment guidelines of my primary insurance contract.

Payment Agreement:
Co-payment, deductibles, co-insurance, non-covered services (including pre-existing conditions), and services denied due to lack of referral are my responsibility.

Assignment of Insurance Benefits:
I assign medical benefits paid by my insurance carrier(s) to –

KEIPERSPINE, PC

For application to my bill. I acknowledge that I will be billed for charges not covered under my insurance policy as well as those portions indicated as my responsibility.

Additional Charges:
You may have additional medical services ordered by your physician, such as laboratory or radiology, for which you will be referred out of this clinic. If this occurs, you will receive a separate billing from the appropriate provider, for which you will be responsible.

Release of Information:
I authorize KeiperSpine, PC to furnish insurance company(s), employer, other payer(s) or their representatives any and all information required to process my claim. Special permission is necessary to release the following information: drug/alcohol abuse, mental health, or HIV related conditions.

Patient Name:_____DOB:_____

Signature of Patient/Guardian:_____Date:_____