



Idaho Joint & Spine, PC

___NEW PATIENT
___INFO CHANGE

DATE: _____

PATIENT INFORMATION

(This information is regarding the person who is seeing the doctor)

Patient Name: _____

Address: _____

City, State, & Zip: _____

Date of Birth: _____ **Age:** _____ **Sex:** _____

Marital Status: _____ **Spouse's Name:** _____

Social Security Number: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Reminder Preference (Pick 1): Text Phone
*By selecting text, you agree that we can send text messages regarding appointments. Please reply "Y" to each message to confirm.

Preferred Pharmacy: _____

Employer: _____

Employer's Phone #: _____

Primary Care Provider (PCP): _____

Do you want your records sent to your PCP? YES NO

Policy Holder Info OR Responsible Party MYSELF
(If someone other than patient is responsible for the bill we will need the following)

Relationship to Patient: Spouse Parent Other

Name: _____

Date of Birth: _____

Address: _____

City, State, & Zip: _____

Home Phone: _____

Cell Phone: _____

Employer: _____

Employer Address: _____

Social Security Number: _____

NEAREST RELATIVE INFORMATION
(This information will be used when we are unable to contact the patient.)

Name: _____

Relationship to Patient: _____

Phone Number: _____

Referred By: _____

INSURANCE INFORMATION

Please select one: Health Insurance Worker's Comp* Auto Accident* Self

* Is this visit due to: Injury on the job? ___/___/___ date of injury Automobile accident ___/___/___ date of injury

Primary Insurance: _____ **Policy Number** _____

Secondary Insurance: _____ **Policy Number** _____

Worker's Comp Insurance Company: _____ **Claim Number** _____

Worker's Comp Adjuster: _____ **Phone:** _____

Liabile Insurance Company Name: _____ **Claim Number** _____

Attorney: _____ **Phone:** _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services of Idaho Joint & Spine, PC and hereby authorize payment directly to Idaho Joint & Spine, PC. I accept responsibility for payment of any charges not paid for or accepted by my insurance.

_____ **Date** _____ **Patient (If not the patient, please indicate legal relationship)**

I have reviewed this office's NOTICE OF PRIVACY PRACTICES which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

_____ **Date** _____ **Patient (If not the patient, please indicate legal relationship)**

Office Use Only: Insurance Cards Copied ID Copied Practice Fusion AMD



Idaho Joint and Spine

Dr. James Whitaker, D.O. Physical Medicine and Rehabilitation
1760 N Mitchell St, Boise, ID 83704 (208) 322-5922 ph (208) 576-6932 fax

FINANCIAL POLICIES

Thank you for choosing to involve us in your healthcare. We are committed to providing you with quality healthcare. Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Thus, this policy is designed to outline our financial policies. Please read it, ask any questions you may have, and sign the bottom of the form. Additional questions can be addressed to our office manager, Sarah, at (208) 322-5922 or info@idahojointandspine.com. If you would like a copy, please let us know.

- Missed and Cancelled less than 24-hour appointments.** Appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **\$40.00 fee**. We understand that situations arise in which you must cancel your appointment. It is requested that **if you must cancel your appointment you provide more than 24-hour notice**. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. The Cancellation and "No Show" fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. It is our policy that after three (3) "No Show" appointments or cancellations less than 24 hours during a 12-month period then we reserve the right to discharge you from our practice.
- Late Arrival.** Your time is valuable. In order to respect your time and that of other patients, we ask that you **arrive 5 minutes early**. If you are more than 5 minutes late, we may not be able to keep your appointment slot and you may have to reschedule. If this happens, you may be subject to the fees. If you are regularly late to appointments then we reserve the right to discharge you from our practice.
- Massage Appointments.** Massage Therapy appointments which are cancelled with less than 24-hour notification or "No Show" will be subject to a **\$40.00 fee** and fall under #1 above.
- Insurance.** We participate in most insurance plans, including Medicare and Medicaid (Idaho). If you are insured by a plan we do not participate with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment is expected in full each visit until we can verify your coverage. Knowing your insurance coverage is your responsibility. We will attempt to assist in verifying benefits and coverage, but this is not a guarantee. Please contact your insurance company with any questions you may have regarding your coverage.
- Co-payments, Co-insurances, and Deductibles.** All co-payments, co-insurances, and deductible amounts must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect these amounts from patients can be considered fraud and violate our contracts. Please help us in upholding the law and keeping our insurance contracts by paying your portions at each visit.
- Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit.
- Proof of insurance.** All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license or valid legal ID and current valid insurance to provide proof of insurance. If you fail to provide us with correct information in a timely manner, you may be responsible for the balance of your claim. If the coverage you provide is not valid, you will be responsible for the balance.
- Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Please be aware that if your insurance company requires a referral to see a specialist and it is your responsibility to ensure that happens.
- Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Please sign that you have read, understand and agree to this Financial Policy.

Patient Name (Please Print)

Date of birth

Signature of Patient or Patient Representative

Date



Idaho Joint and Spine

Dr. James Whitaker, D.O.

Physical Medicine and Rehabilitation
1760 N Mitchell St, Boise, ID 83704
(208) 322-5922 ph (208) 576-6932 fax

NEW PATIENT QUESTIONNAIRE

Printed Name: _____

DOB: _____ Age: _____ Gender: _____

INFORMATION ABOUT YOUR PRESENT INJURY OR CONDITION

1. What are your symptoms? _____

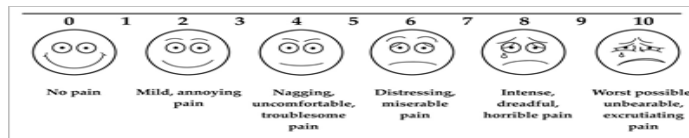
2. When and how did your symptoms begin? _____

3. What makes your symptoms worse? _____

4. What makes your symptoms better? _____

5. If you have had any treatments for your symptoms, what were they and when? _____

6. Using the pain scale below, rate your current pain level using a scale 0-10: _____



7. What number best describes your pain on average in the past week?

0	1	2	3	4	5	6	7	8	9	10		
No Pain											Pain as bad as you can imagine	
8. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0	1	2	3	4	5	6	7	8	9	10		
Does not interfere											Completely interferes	
9. What number best describes how, during the past week, pain has interfered with your general activity?

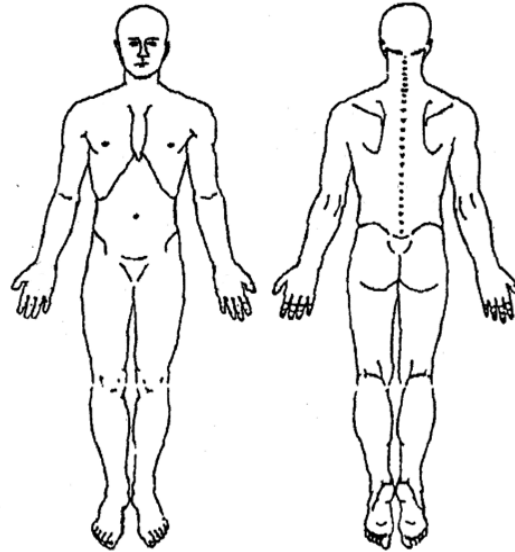
0	1	2	3	4	5	6	7	8	9	10		
Does not interfere											Completely interferes	

Please continue to the next page.

For Office Use Only: PEG Score: _____

10. Using the symbols given below, mark the areas on your body where you feel the described sensation. Include all affected areas.

- Aching:** Δ Δ Δ Δ
Numbness: =====
Pins & Needles: ○ ○ ○ ○ ○
Burning: X X X
Stabbing: // // // //
Other:



11. Have you recently had or do you **now** have: **NONE of the Below**

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Fever or Chills | <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Change in Vision | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Change in Hearing | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Gum Trouble |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Neck Lumps | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abnormal Heartbeat |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Bowel Control | <input type="checkbox"/> Loss of Bladder Control | <input type="checkbox"/> Difficulty Urinating |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Hives | <input type="checkbox"/> Rash | <input type="checkbox"/> Backache |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Recent Falls | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Poor Sleep |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Large Lymph Nodes | <input type="checkbox"/> Hair Change/Loss | <input type="checkbox"/> Increased Appetite |

12. Do you use any of the following? **NONE of the Below**

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Artificial Limb |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Splint | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Other _____ | | |

13. Do you need assistance with any the following: **NONE of the Below**

- | | | | |
|--------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Bathing | <input type="checkbox"/> Caring for hair | <input type="checkbox"/> Shaving |
| <input type="checkbox"/> Yard Work | <input type="checkbox"/> Eating | <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Using the toilet |
| <input type="checkbox"/> Housework | <input type="checkbox"/> Shopping | <input type="checkbox"/> Walking | <input type="checkbox"/> Driving a Car |
| <input type="checkbox"/> Other _____ | | | |

Please continue to the next page.

14. What medical conditions do you have? (Check all that apply.) **NONE of the Below**

- Head Trauma Diabetes Hearing Problems DVT
- Heart Attack COPD Asthma GERD
- Arthritis Gout Psoriasis Seizures
- Stroke Depression Thyroid Disease Vision Problems
- Cancer Fractures High Blood Pressure Kidney Problems
- Liver Problems Osteoporosis Pregnant (Currently) Previous C-Section
- Sleep Apnea Fibromyalgia Irritable Bowel Chronic Fatigue Syndrome
- Other:** _____

15. What surgeries or hospitalizations have you had? **NONE**

What _____ When _____

What _____ When _____

What _____ When _____

16. Have you had any previous injuries? Yes No

If YES, what was injured and when did it occur? _____

17. What Medications do you take? **NONE**

Name of Medication	Dosage / Amount	Frequency / How Often?

18. Do you have any allergies? Yes No If yes, please list below.

Please continue to the next page.

TELL US ABOUT YOURSELF:

19. Right Handed? or Left Handed?

20. Marital Status: Married Single Separated Divorced Widowed

21. Highest Education Level? _____

22. Current or Most Recent Employment (Company, Location, Position, How long?)

23. Do you use tobacco? Yes No

If Yes, how many packs per day? _____ For how many years? _____

24. Have you ever used tobacco? Yes No If Yes, when did you quit? _____

25. Do you consume alcohol? Yes No

If Yes, how much? _____ How often? _____

26. Do you or did you use illicit drugs? Yes No

If Yes, what type? _____ How often or When? _____

27. What are your hobbies and interests? _____

28. What medical problems run in your family? _____

29. Any other information you feel the physician needs to know. _____

**** I attest that this information is true and accurate to the best of my knowledge.***

PATIENT SIGNATURE _____ **DATE** _____

DOCTOR SIGNATURE _____ **DATE** _____