Jason A. Montone, D. O.
Spine & Scoliosis Surgery, Inc.

PATIENT REGISTRATION

Patient Name _____ SS# _____

Address _____ City _____ State _____ Email _____

Zip _____ Date of Birth _____ Age _____ Marital Status: S M W SEP D

Phone (____) _____ Cell (____) _____ Sex: M or F (circle)

Employer _____ Work Phone (____) _____

Name of Spouse _____ Date of Birth _____ SS# _____

Employer _____ Work Phone (____) _____

If Child: Responsible Party _____ SS#_____

Relationship to Child _____

Address _____ City _____ State _____

Zip _____ Phone (____) _____

We are required by federal standards to collect information on race and ethnicity.

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, Other _____

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Other _____ **Preferred Language:** _____

Preferred Pharmacy (Name, Address, Phone) _____

Primary Care Physician _____ **Phone** _____

INJURY INFORMATION

Employment Related? YES NO **Date of Injury** _____

MVA Related? YES NO **Date of Injury** _____

Accident or Other? YES NO **Date of Injury** _____

Primary Insurance Company _____ **ID#** _____
Group # _____ **Subscriber's Name** _____
Relationship to Patient _____ **Date of Birth** _____
Employer _____ **Address** _____
Secondary Insurance Company _____ **ID#** _____
Group # _____ **Subscriber's Name** _____
Relationship to Patient _____ **Date of Birth** _____
Employer _____ **Address** _____

EMERGENCY CONTACT INFORMATION

Name _____ **Relationship** _____
Phone (____) _____ **Cell/Work** (____) _____

* I certify the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay bills at the time of service unless other arrangements are made. I authorize my insurance claim to be paid directly to the clinic. I further understand my health care insurance carrier or payer of my health benefits may pay less than the actual bill for services, and that I am financially responsible for all charges whether or not paid by insurance.

Patient, Parent or Guardian Signature _____ **Date** _____

Jason Montone, D.O.
Spine & Scoliosis Surgery, Inc.
2790 Clay Edwards Drive, Suite 630
Kansas City, Missouri 64116

ASSIGNMENT OF BENEFITS

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and
(Name of Insurance Company)
assign directly to **Jason Montone DO.**, all medical benefits, if any, otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Jason Montone, DO,** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

PAIN DRAWING – VERY IMPORTANT

PATIENT S NAME _____ DATE _____

Show by marking and drawing on the front and back of the figures below where you are having any

Aching and or pain

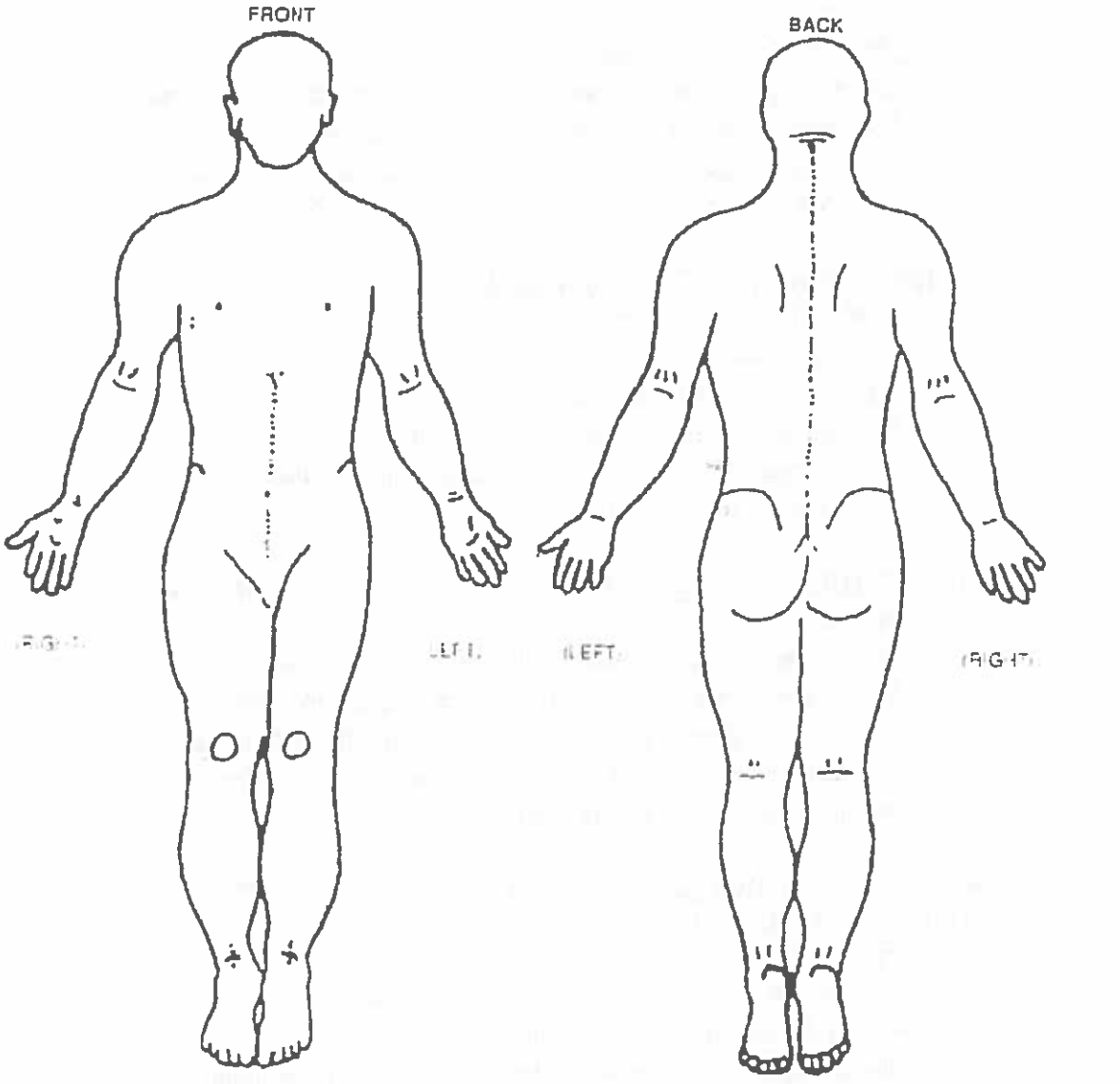
Numbness and/or tingling

Pins and or needles

Burning

Spasms and/or cramps

Draw arrows pointing where pain goes or shoots Show all areas involved



Please answer the following questions based on a 0-10 pain scale (0 is no pain at all and 10 is extremely severe pain):

1) How would you rate your pain when it is at its worst? (0-10)_____

2) How would you rate your pain when it is at its least? (0-10)_____

3) What is the average level of pain you have most of the time? (0-10)_____

Please answer the following 4 questions about your pain as best you can. We understand that this is difficult. Choose the responses that most closely describe your pain presently.

1. HOW OFTEN ARE YOU HAVING PAIN NOW? (√ One):
   _____No pain or rarely have pain now
   _____Occasional pain (about once or twice per year or so)
   _____Recurrent pain (a few or more days at least every month if not more)
   _____Frequent pain (a few or more days at least every few weeks if not more)
   _____Very frequent pain (every week or more often; almost every day)
   _____Pain every single day (is it constant? Yes _____ No _____)

2. WHEN HAVING PAIN, IS IT GENERALLY (√ One):
   _____A mild discomfort or less
   _____A dull pain, worse at times
   _____A harder aching pain, frequently worse at times
   _____A severe pain, even sharp and shooting at times
   _____A very severe pain, frequently sharp, shooting and disabling
   _____An extremely severe and disabling pain

3. HOW IS THE PAIN NOW LIMITING YOUR JOB OR HOUSEWORK? (√ One):
   _____Not limited in any way now
   _____Pain not bad enough to really limit me very much now
   _____Able to work with pain all the time by modifying my activities
   _____Must stop and limit activities, but able to work most of the time
   _____Frequently unable to work for several or more days at a time
   _____Unable to work at all, totally disabled by pain

4. HOW IS PAIN NOW LIMITING YOUR SOCIAL, RECREATIONAL AND OTHER ACTIVITIES? (√ One):
   _____Not limited in any way now
   _____Pain not bad enough to really limit me very much
   _____Able to do most things most of the time with pain
   _____Must modify activities to control pain and not do some things
   _____Must greatly limit activities to control pain and not do most things
   _____Unable to engage in any of these activities whatsoever due to pain

Spine & Scoliosis Surgery, Inc.

BACK AND LEG PAIN ASSESSMENT

Name_____ **Today's date**_____

Date of birth _____ **Primary insurance company**_____

How did you get referred to our office? _____

Have you ever had back surgery before? ☐ yes ☐ no

If yes then please indicate:

- Type of procedure_____
- Surgeon's name and Hospital_____
- Approximate date of surgery_____

Have you had back problems in the past? ☐ yes ☐ no **If so how long?**_____

How long has your current pain been present? _____

Does the pain wake you up at night? ☐ yes ☐ no

Which activities are affected by the pain? ☐ activities of daily living ☐ social activities ☐ work ☐ none

Describe your pain, use all that apply: ☐ mild ☐ moderate ☐ severe ☐ aching ☐ burning ☐ sharp ☐ stabbing ☐ dull ☐ throbbing ☐ spasms ☐cramping ☐ shooting ☐ electric shocks

How often is the pain present? ☐ rare ☐ occasional ☐ most of the time ☐ constant

- **Is the pain:** ☐ getting better ☐ getting worse ☐ staying about the same

What makes the pain better?_____

_____

What makes the pain worse? _____

_____

Have you seen a pain management doctor? ☐ yes ☐ no **If so, who?**_____

What previous treatments have you tried? (check all that apply)

☐ over the counter meds, please list _____

☐ home exercises ☐ physical therapy ☐ chiropractic ☐ bracing ☐ trigger point injections ☐ heat ☐ ice ☐ rest

☐ acupuncture ☐ epidurals, how many?_____ ☐ facet injections ☐ medial branch blocks ☐ inversion table

☐ radiofrequency ablation ☐ SI injection ☐ hip injection ☐ muscle relaxers ☐ time off work ☐ massage therapy

☐ pain medication, please list:_____

☐ other _____

Have you had any incontinence of Bladder? ☐ yes ☐ no **Bowel?** ☐ yes ☐ no

Was this pain caused from an injury? ☐ yes ☐ no **What was the approximate date?**_____

Please describe the injury:_____

_____

_____

Are you currently: ☐ employed ☐ retired ☐ disabled ☐ other, please explain_____

What is your occupation?_____

Are you off due to this pain? ☐ yes ☐ no **How long?**_____

Have you ever been diagnosed with any psychological illness, depression, anxiety, etc.? ☐ yes ☐ no

- If so please explain:_____

Please add any other information you think would be useful to the doctor: _____

_____

_____

_____

Medical History Questionnaire

Please list all medical problems (check all that apply):

☐ hepatitis C ☐ HIV ☐ heart attack ☐ anemia ☐ anxiety ☐ arrhythmia ☐ asthma ☐ prostate ☐ bipolar ☐ CHF
☐ coronary artery disease ☐ stroke ☐ Crohn's ☐ degenerative disc ☐ depression ☐ diabetes ☐ diverticulitis
☐ COPD ☐ seizures ☐ gall bladder ☐ glaucoma ☐ gout ☐ hearing loss ☐ hypertension ☐ hyperthyroid
☐ hypothyroid ☐ IBS ☐ kidney disease ☐ liver disease ☐ lung disease ☐ migraines ☐ obesity ☐ osteoporosis
☐ pancreatitis ☐ pneumonia ☐ rheumatoid arthritis ☐ sleep apnea ☐ tuberculosis ☐ bleeding disorders
☐ peripheral neuropathy ☐ ulcers ☐ reflux ☐ cellulitis
☐ cancer, please specify: _____ ☐ other _____

_____

What surgeries have you had? _____

_____

_____

What medications are you currently taking? _____

_____

_____

What medications are you allergic to? _____

Are you a current smoker? ☐ yes ☐ no **How many packs per day?**_____ **How long?**_____

Are you a former smoker? ☐ yes ☐ no **If yes date quit:** _____

Do you drink alcohol? ☐ yes ☐ no **How much?** ☐ rarely ☐ social ☐ every day ☐ other _____

List any medical problems that run in your family: _____

_____