

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 A. MONTONE, D. O.
Spine & Scoliosis Surgery, Inc.
2750 Clay Edwards Drive, Suite 600
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 A. Montone, D. O.**, 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 A. Montone, D.O.**, 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 _____

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

Aching and/or pain: X X X X X X
X X X X X X
X X X X X X

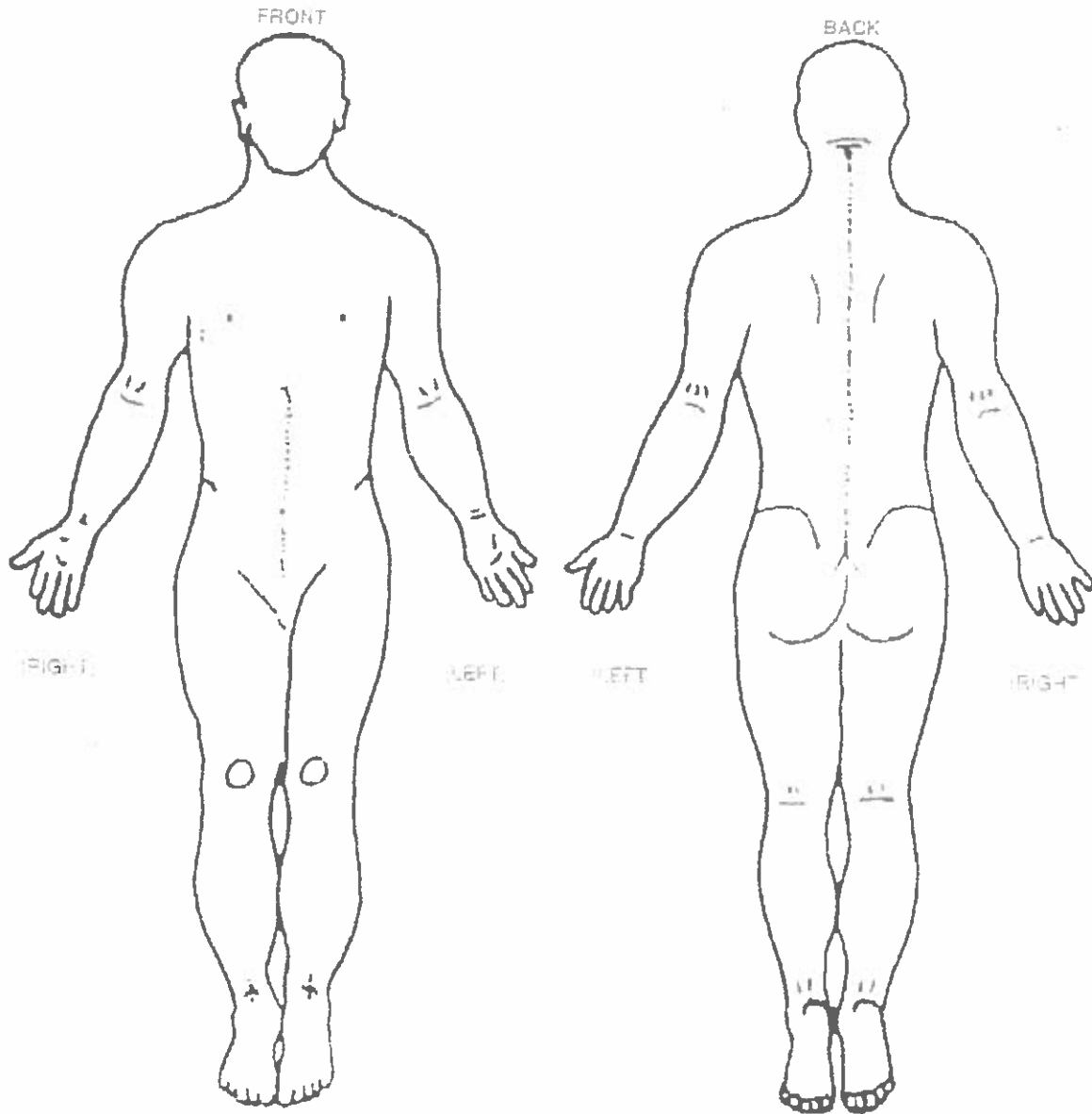
Numbness and/or tingling: O O O O O
O O O O O
O O O O O

Pins and/or needles: * * * * *
* * * * *
* * * * *

Burning: / / / / /
/ / / / /
/ / / / /

Spasms and/or cramps: Δ Δ Δ Δ Δ
Δ Δ Δ Δ Δ
Δ Δ Δ Δ Δ

Draw a line through the figure where pain goes or spreads. (Start at a less 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.

NECK AND ARM PAIN ASSESSMENT

Name _____ Today's date _____

Date of birth _____ Primary insurance company _____

How did you get referred to our office? _____

Have you ever had neck surgery before? yes no

If yes then please indicate:

- Type of procedure _____
- Surgeon's name and Hospital _____
- Approximate date of surgery _____

Have you had neck 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: _____