



PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birth Date: _____

Signature: _____

Date: _____



AZ Integrated Neuro Spine & Pain

COMMUNICATION AUTHORIZATION

Patient Name: _____ DOB: _____

What number(s) may we contact you at? May we leave a message?

Yes No

Yes No

Is there anyone other than yourself that you authorize AZI to speak with on behalf of your medical care? If so please list below:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Do you authorize AZI to communicate with your Pharmacy?

Yes No

Local Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

Mail Order Pharmacy: _____ Phone: _____

May we communicate with you via Email?

Yes No

Email: _____

Patient Signature _____ Date: _____



CONFIDENTIAL BILLING INFORMATION

You were referred to us by: _____

Your primary care physician is: _____

Patient Name: _____
Last First Middle

Address: _____
Address City State ZIP

Phone: _____ Cell: _____

Age: _____ Birth Date: _____ Sex: Male Female

Marital Status: _____ Social Security #: _____

Employer: _____ Business Phone: _____

Employer Address: _____

Parent/Spouse's Name: _____ Parent/Spouse's SS#: _____

Parent/Spouse's Birth Date _____

Parent/Spouse's Employer: _____ Business Phone: _____

Student: Yes No Full Time Part Time

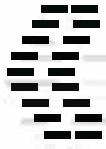
School Name: _____

Emergency Contact - other than a relative in the same home:

Name: _____

Address: _____

Phone: _____



AZ Integrated Neuro Spine & Pain

Patient's Name: _____ Date: _____

I hereby authorize my insurance company to make direct payment to:

AZ Integrated Neuro Spine & Pain

And I understand I am financially responsible for any co-payments, deductibles, coinsurance and all charges which are considered to be not a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.

I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signed: _____

RELEASE OF INFORMATION:

I hereby authorize release of medical information to my referring physician and/or to any other physicians who have been or may become involved in my medical care. I also authorize release of information that may be necessary in the processing of any insurance claims.

Signature: _____ Date: _____

A photostatic copy of this authorization shall be considered as effective and valid as the original



PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE

1. Constitutional:	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
	<input type="checkbox"/> Chills			

2. Eyes:	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Pain
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3. ENT:	<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Jaw Pain
	<input type="checkbox"/> Jaw Popping/Clicking			

4. Cardiovascular:	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Passing Out	<input type="checkbox"/> Chest Pain/Pressure	
	<input type="checkbox"/> Palpitations			

5. Respiratory:	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing		
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6. Gastrointestinal:	<input type="checkbox"/> Belly Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea		

7. Genitourinary:	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Urinary Retention Or Urgency		
	<input type="checkbox"/> Urinary Incontinence			

8. Musculoskeletal:	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Mid Or Lower-back Pain		
	<input type="checkbox"/> Sore Muscles	<input type="checkbox"/> Cramps		

9. Integument:	<input type="checkbox"/> Skin Ulcerations	<input type="checkbox"/> New Rashes	<input type="checkbox"/> Hair Loss	
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10. Cardiovascular:	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Depression	
	<input type="checkbox"/> Visual or Auditory Hallucinations			

10. Hematology/ Lymphatic:	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Recurrent Infections	
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AZ Integrated Neuro Spine & Pain

PAST MEDICAL HISTORY: (All illnesses diagnosed, controlled or not)

- | | |
|-----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |

OPERATIONS: (Please list all, even minor ones such as tonsillectomy)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

ALLERGIES: (For example: IV contrast dye, penicillin, latex, etc.)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

MEDICATIONS: (Including supplements and herbs)

	Dose	Times per day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

(Continue on the back of page if necessary)



AZ Integrated Neuro Spine & Pain

Personal and Social History:

Are you presently working? Yes No Occupation: _____

If disabled:

Date of disability began: _____

Cause of disability: _____

Highest level of education: _____

How many steps to the entrance of your home? _____

How many floors in your home? _____

Have you ever smoked? Yes No

Do you currently smoke? Yes No How long: _____ How much: _____

If you quit, what year did you quit? _____ How long did you smoke?: _____

Do you drink alcohol? Yes No Weekly amount? _____

Caffeinated? Yes No

Do you drink soda? Yes No Weekly amount? _____

Caffeinated? Yes No

Have you used illegal drug? Yes No If yes, what? _____

Family History: Please circle all diseases anyone in your family has

- Stroke TIA Seizures/Epilepsy Headaches/Migraine Multiple Sclerosis
- Heart Disease Diabetes Hypertension High Cholesterol Cancer

Other neurological disease (please explain):

Do any diseases run in your family? _____



PLEASE FILL-OUT FAMILY MEMBER HEALTH INFORMATION BELOW:

	Age	Living	Medical issues (if deceased please state cause)
Father:	_____	<input type="checkbox"/>	_____
Mother	_____	<input type="checkbox"/>	_____
Brother(s)	_____	<input type="checkbox"/>	_____
Sisters(s)	_____	<input type="checkbox"/>	_____
Son(s)	_____	<input type="checkbox"/>	_____
Daughter(s)	_____	<input type="checkbox"/>	_____