Eugene P. Wang, DO
Joseph P. Sullivan, MD
Jason D. Peterman, PA-C
Kelli M. Brower, PA-C

HARBORSIDE Spine & Sports Center
WWW.HARBORSIDESSC.COM

2375 Summit Park Drive
Petoskey, MI 49770
Phone: 231-348-3283
Fax: 231-348-3331

Marital Status M D S W

Patient's Full Legal Name _____

Birthdate _____/_____/_____ Age _____ ☐ Male ☐ Female SS# _____-_____-_____

Home Phone ( ) _____ -_____ Cell ( ) _____ -_____ Work ( ) _____ -_____
☐ Preferred Contact Number ☐ Preferred Contact Number ☐ Preferred Contact Number

Mailing Address _____

City/State/Zip _____

Physical Address (if different from mailing) _____

E-mail Address _____

Emergency Contact/Relationship _____ Phone ( ) _____ -_____

Referring Physician _____ Phone ( ) _____ -_____

Primary Care Physician _____ Phone ( ) _____ -_____

Cardiologist _____ Phone ( ) _____ -_____

INSURANCE INFORMATION

***Please provide your drivers' license and insurance card at check-in**

Date of injury or onset of symptoms _____ Affected Area _____

Is this a work or auto-related injury that will be billed through worker's compensation or auto insurance? ☐ YES ☐ NO (Provide info. on back)

Primary Insurance _____ I am the policy holder: ☐ YES ☐ NO

Secondary Insurance _____ I am the policy holder: ☐ YES ☐ NO

(If no, please complete Policy Holder Information below)

Prescription Coverage _____

Policy Holder Information – to fill out if other than self

Relationship to the patient: ☐ Spouse ☐ Parent ☐ Other: _____

Name _____ Birthdate _____/_____/_____ SS# _____-_____-_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize Harborside Spine and Sports Center to release any information acquired in the course of my examination or treatment for billing purposes and/or reimbursement. Further, I authorize payment of the medical and/or surgical benefits directly to Harborside Spine and Sports Center for the services provided. I recognize and accept responsibility for any balance after payment of such benefits.

Patient or Guarantor Signature _____ Date _____

Patient's Full Legal Name _____ **Birthdate** _____/_____/_____

WORKERS COMPENSATION INSURANCE INFORMATION

Is this an open worker's compensation claim? ☐ YES ☐ NO

Insurance Company _____

Address _____
Street City State Zip

Adjustor or Contact Person _____ Phone ( ) _____ -_____

Claim # _____

Employer Name _____

Address _____

Phone ( ) _____ -_____ Contact Person _____

AUTO INSURANCE INFORMATION

Is this an open auto claim? ☐ YES ☐ NO

Insurance Company _____

Address _____
Street City State Zip

Adjustor or Contact Person _____ Phone ( ) _____ -_____

Claim #_____

I understand that if my worker's compensation or auto insurance does not pay for my services at Harborside Spine and Sports Center, I am fully responsible for my medical expenses.

Patient or Guarantor Signature _____ **Date** _____

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Patient Intake Questionnaire

Date of Visit _____/_____/_____

Name_____ Date of Birth _____/_____/_____ Age_____

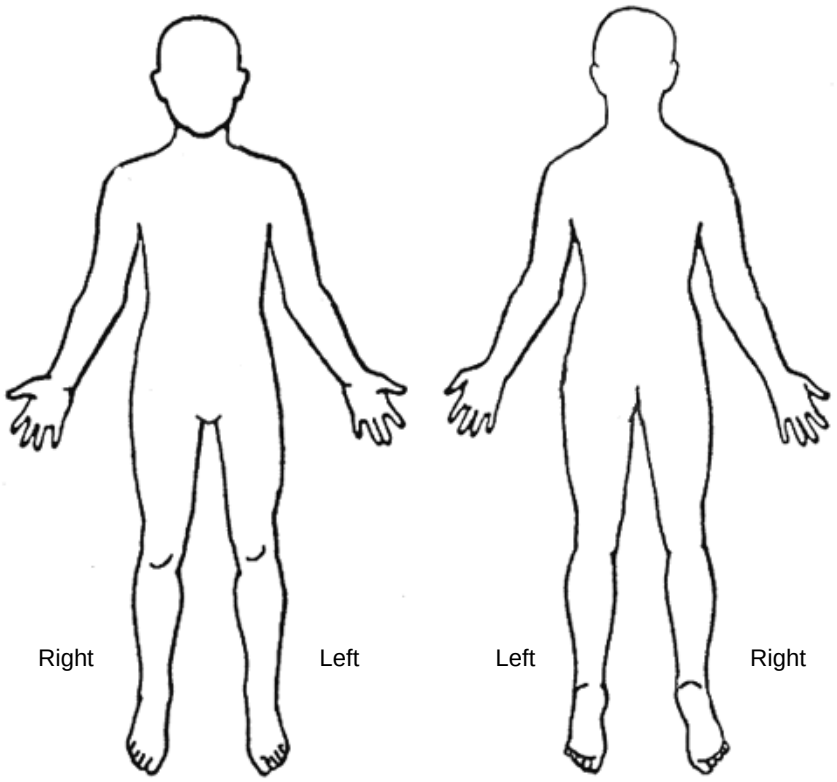
Are you ☐ **Right Handed** or ☐ **Left Handed**? Height_____ Weight_____

Is your problem the result of ☐ **personal injury** ☐ **car accident** ☐ **work** or ☐ **other**?

What problem(s) has/have brought you here today?_____

Where is your pain?
Please us the symbols to mark the areas of your body affected by the sensations listed.

Burning	X
Numbness	O
Stabbing	>
Ache	*
Pin/Needles	-



Describe your pain levels on a scale of 0-10.

0 = no pain
10 = worst pain

What is your **current** pain level?
0 1 2 3 4 5 6 7 8 9 10

What is your **average** pain level?
0 1 2 3 4 5 6 7 8 9 10

What is your **worst** pain level?
0 1 2 3 4 5 6 7 8 9 10

When did symptoms first appear?_____

Please list your medications and dosages:

Patient Name: _____

How often do your symptoms appear?
- ☐ Constant
- ☐ Intermittent
- ☐ This is the first episode
- ☐ Every few minutes
- ☐ Hourly
- ☐ Several times daily
- ☐ Once Weekly
- ☐ Several times weekly
- ☐ Several times a month
- ☐ Once monthly
- ☐ Every couple of months
- ☐ Other:_____

How long do your symptoms last?
- ☐ A few seconds
- ☐ Less than a minute
- ☐ ___ minutes
- ☐ ___ hours
- ☐ All day
- ☐ Varies
- ☐ Greater than 4 hours per episode

What makes your pain worse?
- ☐ No aggravating factors
- ☐ Walking
- ☐ Standing
- ☐ Performing daily chores
- ☐ Work activities
- ☐ Overhead movement
- ☐ Lifting objects
- ☐ Sitting
- ☐ Bending over
- ☐ Weather changes
- ☐ Movement
- ☐ Exertion
- ☐ Coughing
- ☐ Defecation
- ☐ Emotional stress
- ☐ Lack of sleep
- ☐ Sexual intercourse
- ☐ Urination
- ☐ Other: _____

What makes your pain better?
- ☐ No aggravating factors
- ☐ Rest
- ☐ Lying down, facing upwards
- ☐ Sitting
- ☐ Standing
- ☐ Sitting in a recliner
- ☐ Sleep
- ☐ Injections
- ☐ Pain medication
- ☐ Opiate pain medication
- ☐ Acetaminophen
- ☐ NSAIDs
- ☐ Physical Therapy
- ☐ Hot/cold compresses
- ☐ Acupuncture
- ☐ Stretching
- ☐ Exercising
- ☐ Use of a TENS unit
- ☐ Surgery
- ☐ Chiropractic adjustments
- ☐ Other:_____

Do you have any of the following symptoms? (Check if appropriate)

General
- ☐ Fever
- ☐ Infection
- ☐ History of cancer
- ☐ Sweats
- ☐ Chills
- ☐ Appetite loss
- ☐ Significant weight loss

Skin
- ☐ Rash
- ☐ Itching
- ☐ Hives

Hearing
- ☐ Ear pain
- ☐ Deafness
- ☐ Discharge
- ☐ Ringing in the ears

Vision
- ☐ Change in vision
- ☐ Eye pain
- ☐ Glasses
- ☐ Blindness
- ☐ Blurred vision
- ☐ Double vision
- ☐ Color blindness

Pulmonary
- ☐ Pneumonia
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Sore Throat
- ☐ Sinusitis
- ☐ Runny nose
- ☐ Allergies

Cardiovascular
- ☐ Pacemaker
- ☐ Chest pain
- ☐ Shortness of breath with exertion
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Varicose veins
- ☐ Sleep on extra pillows

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Dysphagia
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Difficulty controlling bowels

Genitourinary
- ☐ Loss of control of urine
- ☐ Urgency of urination
- ☐ Frequency of urination
- ☐ Blood in urine
- ☐ Increased urination at night
- ☐ Difficulty controlling urine
- ☐ Venereal disease
- ☐ Pelvic infection
- ☐ Painful menstruation
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Menopause
- ☐ Pregnant
- ☐ Difficulty with erections
- ☐ Last menstrual period ____/_____/_____

Orthopaedic
- ☐ Back pain
- ☐ Neck pain
- ☐ Sciatica
- ☐ Joint pain
- ☐ Joint laxity
- ☐ Dislocated joints
- ☐ Ruptured disc
- ☐ Scoliosis
- ☐ Kyphosis
- ☐ Osteoporosis
- ☐ Soft bones
- ☐ Bursitis
- ☐ Arthritis
- ☐ Joint infection/gout
- ☐ Torn cartilage
- ☐ Torn tendon
- ☐ Torn ligament
- ☐ Amputation
- ☐ Bone tumor
- ☐ Tendonitis
- ☐ Dislocated joint

Endocrine
- ☐ Thyroid enlargement
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Hyperthyroidism
- ☐ Intolerance to heat or cold

Hematologic & Immunologic
- ☐ Excessive bleeding
- ☐ Impaired Immune System
- ☐ Easy bruising
- ☐ Anemia
- ☐ Trouble clotting blood
- ☐ Iron deficiency
- ☐ Frequent bloody noses
- ☐ Swollen glands
- ☐ Chronic infection

Neurological
- ☐ Weakness
- ☐ Change in sensation
- ☐ Headaches
- ☐ Seizures
- ☐ Paralysis
- ☐ Balance problems
- ☐ Numbness
- ☐ Fainting
- ☐ Night cramps
- ☐ Weakness
- ☐ Memory loss
- ☐ Dizziness
- ☐ Coordination problems
- ☐ Tremor

Psychological
- ☐ Nervousness
- ☐ Anxiety
- ☐ Difficulty sleeping
- ☐ Depressed
- ☐ Suicide attempt
- ☐ Mood swings

Patient Name: _____

Have you had any of these tests within the last year for this problem?

Test	**Where?**	**When?**
MRI		
CAT Scan/Myelogram		
X-RAYS		
Bone Scan		
EMG/Nerve		
Conduction Study		

Have you ever had any of the following treatments for this problem?

	Previously Done?	**Did it help?**	**When?**	**Who performed them?**
Physical/Occupational Therapy	☐ YES ☐ NO	☐ YES ☐ NO		
Chiropractic/Manipulation	☐ YES ☐ NO	☐ YES ☐ NO		
Massage	☐ YES ☐ NO	☐ YES ☐ NO		
Acupuncture	☐ YES ☐ NO	☐ YES ☐ NO		
Trigger Point Injections	☐ YES ☐ NO	☐ YES ☐ NO		
Joint Injections	☐ YES ☐ NO	☐ YES ☐ NO		
Epidural Injections	☐ YES ☐ NO	☐ YES ☐ NO		
Other: _____	☐ YES ☐ NO	☐ YES ☐ NO		

Have you tried any of the following medications? (please check the ones you have tried)

NSAIDS:
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Celebrex
- ☐ Voltaren
- ☐ Toradol
- ☐ Relafen
- ☐ Other:_____

Opioids:
- ☐ Darvocet
- ☐ Vicodin
- ☐ Lortab
- ☐ Norco
- ☐ Oxycodone
- ☐ Oxycontin
- ☐ Morphine Sulfate IR
- ☐ MS Contin
- ☐ Kadian
- ☐ Avinza
- ☐ Dilaudid
- ☐ Duragesic patch
- ☐ Actiq
- ☐ Fentora
- ☐ Opana
- ☐ Percocet
- ☐ Methadone
- ☐ Other:_____

Muscle Relaxants:
- ☐ Flexeril
- ☐ Skelaxin
- ☐ Zanaflex
- ☐ Baclofen
- ☐ Valium
- ☐ SOMA
- ☐ Other:_____

Neuromodulators:
- ☐ Neurontin
- ☐ Lyrica
- ☐ Zonegran
- ☐ Nortriptyline
- ☐ Amitriptyline
- ☐ Ritalin
- ☐ Provigil
- ☐ Seroquel
- ☐ Xanax
- ☐ Ativan
- ☐ Klonopin
- ☐ Other:_____

Antidepressants:
- ☐ Cymbalta
- ☐ Paxil
- ☐ Lexapro
- ☐ Celexa
- ☐ Zoloft
- ☐ Prozac
- ☐ Effexor
- ☐ Remeron
- ☐ Wellbutrin
- ☐ Other:_____

Headache Medicines:
- ☐ Imitrex
- ☐ Frova
- ☐ Maxalt
- ☐ Amerge
- ☐ Zomig
- ☐ Axert
- ☐ Relpax
- ☐ Midrin
- ☐ Metoprolol
- ☐ Topamax
- ☐ Tegretol
- ☐ Other:_____

Sleeping Aids:
- ☐ Ambien
- ☐ Lunesta
- ☐ Trazadone
- ☐ Rozerem
- ☐ Prosom
- ☐ Other:_____

Miscellaneous:
- ☐ Tramadol
- ☐ Lidoderm patch
- ☐ Tylenol
- ☐ Tylenol #3
- ☐ Capsaicin cream
- ☐ Oral glucocorticoids ≥5mg/day of prednisone for ≥3 months (ever)
- ☐ Other:_____

Which of the above medications were effective in treating your symptoms?_____

_____

Have you seen any other physicians for this problem? Please list names.

_____ _____ _____

Did you have surgery for **this** problem?

Date	**Location**	**Type**	**Did it help?**
			☐ YES ☐ NO
			☐ YES ☐ NO

Patient Name: _____

PAST MEDICAL HISTORY

Have you ever had surgery for ***any*** reason?

Type of surgery	**When?**	**Where?**

Did you or do you have the problem?

- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Cancer: _____
- ☐ Carotid Artery Stenosis
- ☐ Cerebrovascular Accident
- ☐ Chronic Renal Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes: Type ____
- ☐ Fibromyalgia
- ☐ Fracture(s)
- ☐ GERD
- ☐ Headaches, migraine
- ☐ Headaches, tension
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Iron Deficiency Anemia
- ☐ Medication Noncompliance
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Sensory Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Radiculopathy – Neck/Back
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Spinal Arthritis
- ☐ Spinal Stenosis
- ☐ Transient Ischemic Attack
- ☐ Other:_____

If you have had any of the problems, please explain

_____

Please list all allergies ☐ No known allergies

Name	**Type of Reaction**

FAMILY HISTORY

Are there any diseases or conditions that run in your family?

Family Member(s) Affected	**Type of Condition**

SOCIAL HISTORY

What is your marital status? ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Living with significant other**

Do you live with someone who can take care of you? ☐ **Yes** ☐ **No**

How much schooling did you complete?

☐ **Less than high school** ☐ **Graduated from high school** ☐ **Some college** ☐ **Graduated from college** ☐ **Postgraduate education or degree**

What is your **current** work status?

☐ **Student** ☐ **Homemaker** ☐ **Laid off** ☐ **Disabled** ☐ **Other:** _____

☐ **Currently working** ☐ **Retired** ☐ **Unemployed** ☐ **Leave of absence**

If working, what is your job title?_____ If you are not working, when was your last day of work? _____

Patient Name: _____

Do you have an exercise routine? ☐ **Yes** ☐ **No**

If so, what do you do? Type _____ Duration _____ Times per week _____

Are you (on) or (planning to apply for) any of the following programs? ☐ **Social Security** ☐ **Disability** ☐ **Workers Compensation**

Are you experiencing any financial difficulties because of your injury? ☐ **None** ☐ **A Little** ☐ **Some** ☐ **A Lot**

Do you smoke or use other forms of tobacco? ☐ **Yes** ☐ **No** If you quit, how long ago did you quit? _____

How much do you smoke per day?_____ Have you been exposed to second-hand smoke? ☐ **Yes** ☐ **No**

How many years have you smoked or used tobacco products and/or been exposed to second-hand smoking? _____

When you awake in the morning, when do you smoke? ☐ **Immediately** ☐ **Within 1 hour** ☐ **Within 2-4 hours** ☐ **Within 5 or more hours**

What is your caffeine intake? (i.e., coffee, tea, chocolate soda, etc.) _____

Do you drink alcoholic beverages? ☐ **Yes** ☐ **No** How often? ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Yearly** ☐ **Occasionally**

What do you usually drink? ☐ **Beer** ☐ **Hard Liquor** ☐ **Wine**

Have you ever used alcohol to control your pain? ☐ **Yes** ☐ **No** Have you ever had a problem with alcohol or other drugs? ☐ **Yes** ☐ **No**

Did or does anyone related to you have a problem with alcohol or other drugs? ☐ **Yes** ☐ **No**

How often have you had trouble with thinking clearly or had memory problems? _____

How often have you had trouble controlling your anger (i.e., road rage, screaming, etc.) _____

How often have you felt that things are just too overwhelming that you can't handle them? _____

Harborside Spine & Sports Center
Consent to Treat, Release of Information, and Financial Policy

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider or assistant to examine and treat me. I understand that this could include medical treatment, lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of examination or treatment in this office.

RELEASE AND TRANSFER OF INFORMATION: I hereby authorize Harborside Spine and Sports Center (HSSC) to release to all insurance companies, third party payers (and to my employer if worker's compensation), and utilization review organizations, any medical or other necessary information for the purpose of obtaining authorization for medical services and for payment of my medical bills. I authorize HSSC to obtain and/or transfer clinical information about me to or from any other healthcare provider or health care agency including but not limited to physicians, hospitals, nursing homes, home care agencies and public health departments, in order to enhance the continuity of my care. I understand and agree that the information transfer will occur by means deemed most appropriate to the circumstances by HSSC including photocopy, electronic file transfer, fax, and computerized information systems.

NOTICE: I am notified, according to Michigan law, that as a patient of this practice, I may be tested for the presence of HIV or HIV antibody, Hepatitis C, and/or Hepatitis B without my consent in the event that any healthcare worker or other health facility employee sustains a percutaneous, mucous membrane or open wound exposure to my blood or body fluids. This test is permitted under Michigan law and is for my protection as well as the protection of the staff of HSSC.

HEALTH INSURANCE: It is my responsibility to provide the practice with current insurance information. I will be asked to show my insurance card(s) at my visit. If current information is not obtained at the time of service, it will become my responsibility to pay until current information is provided to the practice. It is my responsibility to notify HSSC of any patient information changes (i.e. address, name, insurance information, etc).

My insurance policy is a contract between me and my insurance company. HSSC participates with, and accepts assignment from, most major payers, except Medicaid. As a courtesy, HSSC will file my claims for me and provide information as necessary for proper billing of charges. However, HSSC will not become involved in disputes between me and my insurance carrier. **I am ultimately responsible for the timely payment of my account.**

ASSIGNMENT OF BENEFITS: I authorize all medical and/or surgical benefits to which I am entitled to be paid to HSSC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I realize that I am responsible for payment of co-pays, deductibles, and coinsurance as required by my insurance plan.

PAYMENTS: I will pay all co-pays, deductibles, and coinsurance at the time of service. Co-payments are due at the time I check in at the front desk **PRIOR** to being seen by the provider. Unless other arrangements are approved by HSSC in writing, the balance on my statement is due and payable when the statement is issued. I can pay with cash, check or credit card.

PAYMENT ARRANGEMENTS: In the event that my total balance due is more than I am able to pay, I will make reasonable payment arrangements. Please contact HSSC billing office or practice manager to make such arrangements.

PAST DUE BALANCE: If my account becomes past due, I understand that HSSC will take the necessary steps to collect this debt and cancel future appointments. If payment is not made on this account, collection efforts will begin. If no resolution can be made, my account will be turned over to a collection agency and I will be discharged from the practice.

RETURNED CHECKS: The charge for a returned check is $25 payable by cash or money order. HSSC will apply this to my account in addition to the insufficient funds amount. I will be placed on a "Cash Only" basis following any returned check.

MISSED APPOINTMENTS: I will keep my scheduled appointments. I will call 24-hours before my appointment to cancel or reschedule. Failing to provide proper notice of cancellation will result in a $50.00 missed appointment charge for office visits and $150.00 charge for a missed injection or EMG. This charge is my responsibility and it is not covered by insurance carriers. Missing appointments on more than one occasion may result in the discharge of my care.

FORM COMPLETION: Disability, FMLA, and other forms are often requested to be completed by the physician. Many of the forms require completion of detailed medical history questionnaires. In many instances, it may be necessary to schedule an appointment for an assessment by the physician.

PRIVACY PRACTICES: I have been offered or provided a copy of the HSSC Notice of Privacy Practices for my review.

I have read and agree to the terms listed above.

_____ _____/_____/_____
Printed Name Date of Birth

_____ _____/_____/_____
Signature of Patient or Guardian Date

Spouse, relative, friend, or caregiver to whom pertinent information may be disclosed:

Name: _____ Relationship: _____

I authorize the staff at HSSC to leave messages on my phone at: (_____)_____-_____