



Shawn Dalton-Bethea, MD

Diplomate ABPM, ABPMR

Interventional Spine & Musculoskeletal Disorders Management

520 Maple Avenue, Suite A • Reidsville, North Carolina 27320

Office 336-349-5050 • Fax 336-349-5056

www.pssspa.com

PLEASE PRINT AND FILL OUT COMPLETELY

Patient Information:

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone () _____ Work Phone() _____ Cell() _____

Can a detailed message be left at any of the above #'s? (Circle one) Yes No

If yes, please specify which number _____

Email Address: _____

Social Security _____ - _____ - _____ DOB _____ Sex (circle one) Male Female

Employment Status (circle one) Full-Time Part-Time Retired Unemployed Legally Disabled Student

Name of Employer (or school if student) _____

Primary Physician: _____ Location _____

Referring Physician: _____ Location _____

If **Self -Referral**, who or what was the source?

Pharmacy _____ Location _____ Phone _____

Spouse Information:

Name _____ Date of Birth _____

Emergency Contact:

Name _____

Relationship _____ Contact Number() _____



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Work Related Injury? (Circle one) Yes No If Yes, Date of Injury_____

Worker's Compensation Adjuster _____

Case Manager _____ Contact Number _____

Is this the result of an auto accident? (Circle one) Yes No

Do you have an attorney? (Circle one) Yes No

If yes, Name _____ Contact number _____

****If yes, please be aware that Performance Spine and Sports Specialists, P.A. DOES NOT accept or bill Third Party Liability. The charges for services rendered by our facility are YOUR financial responsibility.**

****Please be prepared to present your insurance card/s for verification purposes.**

****I authorize Performance Spine and Sports Specialists, P.A. to release all information in the course of my treatment to my insurance company for claims purposes.**

***By signing below, you agree that the above information is accurate to the best of your knowledge. You also accept financial responsibility for services rendered by Performance Spine and Sports Specialists, P.A. that are not covered by your insurance or worker's comp claim.**

Signature _____ Date _____

Name _____ DOB _____

Referral Source: _____

Pharmacy Name & Telephone Number: _____

Chief Complaint/Symptoms: (Example: low back and/or leg pain, neck pain, etc.)

Describe your symptoms: (Example: Ache, burn, stab, numbness, etc.)

When did your symptoms start? _____

What makes your pain worse?

What makes your pain better?

Have you seen other physicians for this problem? If yes, who?

What treatments have you had for this condition? (Examples: epidurals, physical therapy, chiropractic, acupuncture, trigger point injections, etc.)

Which treatments helped?

Medications tried in the past for this problem:

Past Medical History: (e.g. High Blood Pressure, Diabetes, Heart Problems, Breathing Problems, Ulcers, Glaucoma, Cataracts, High Cholesterol, Cancer, Fractures, etc.)

Name _____ DOB _____

Past Surgical History: (e.g. neck or back surgery, fracture repairs, heart surgery, etc.)

Current Medications: (You may attach a copy of your medications. Please list **ALL** medications including prescription, non-prescription, vitamins and supplements)

Medication

Allergies: _____

Food Allergies: _____

Are you allergic to any of the following- X-Ray dye, Shellfish or Iodine? If yes, circle which one

Family History: ___Diabetes ___Heart Disease ___Disc Problems ___Cancer ___Arthritis ___Thyroid

Social History: ___Single ___Married ___Divorced ___Widowed **Children:** ___Yes ___No

Education (years and degree): _____

Do you work? _____ Where do your work? _____

What do you do on your job? _____

Full Time, Part Time, or Modified Duty (circle the one that applies to you)

If on disability,how long and WHY? _____

Living Status: ___Alone ___With_____

Hobbies/Sports/Other Activities: _____

Do you smoke? _____ If yes, how many packs per day? _____

Do you drink alcoholic beverages? _____ If yes, how much per week? _____

Do you have a PERSONAL or FAMILY history of substance abuse (e.g. marijuana, cocaine, heroin, meth, alcohol)? _____ If yes, is this a CURRENT problem? _____ If yes, please explain

Do you have a history of physical and/or sexual abuse? _____ If yes, have you sought treatment? _____

Do you have problems with: ___Weight loss ___Weight gain ___Eyes/Ears ___Heart ___Lungs

___Bowel ___Bladder ___Headache ___Skin ___Stroke ___Balance Problems ___Depression

___Bleeding Disorder ___Anemia ___Ulcer Disease

Diagnostic Studies Performed: ___X-Ray ___MRI ___EMG ___CT/Bone Scan _____Other

Name: _____ DOB: _____ Date: _____ Acct# _____

Current Pain Medication -- Must Be Completed

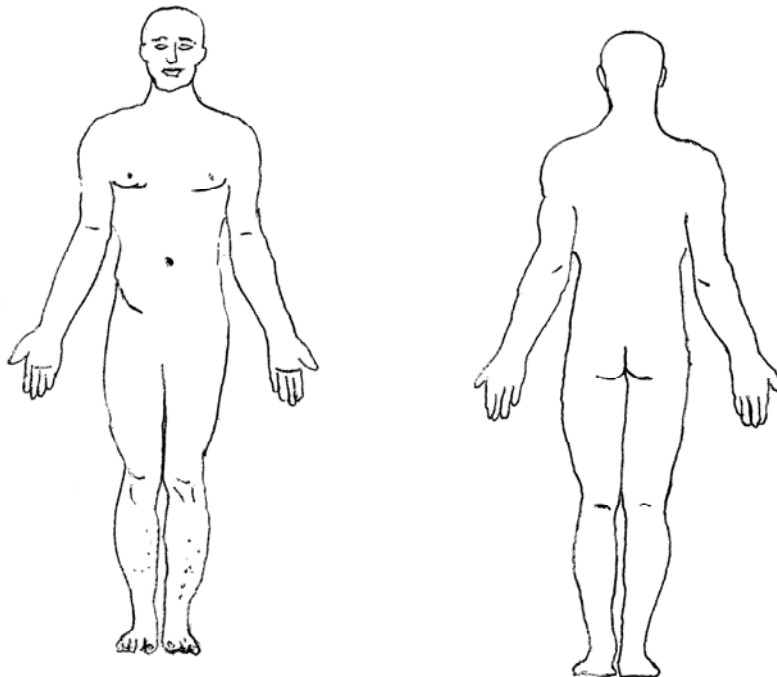
Other Medications:

PAIN DRAWING

INSTRUCTIONS:

Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the right side of the neck, etc.) Please indicate which sensations you feel by referring to the key below.

//// Stabbing	XXXX Burning	OOOO Pins & Needles	==== Numbness	++++ Aching
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Pain Level: 0 1 2 3 4 5 6 7 8 9 10

(Circle your current pain level)

- 0 No pain
- 1 Mild pain; you are aware of it, but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication to tolerate
- 4-5 More severe pain; you begin to feel antisocial
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain; worst pain you've ever felt

What relieves your pain: _____

What worsens you pain: _____

Any questions for the doctor: _____



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PATIENT CORRESPONDENCE

The way that we communicate in our current time is quite different than 15-20 years ago. No longer do we rely on telephone and fax, but we communicate through e-mail, instant messaging, text messaging, Facebook, Twitter, etc. The NC Medical Board strongly cautions medical providers and their staff to be very clear with the route of communication with patients. Medical providers and staff must be careful when receiving correspondence from patients outside of the normal channels of office communication.

The proper channels of communication with the Performance Spine and Sports Specialists team are the following:

Call 336-349-5050 between 7:30 AM and 4:00 PM Monday through Thursday

Kanitha, CPhT, extension 01*

Gail, Office Manager, CMA extension 05*

Karanja, EMT-P, CMA extension 03

Traci, RT-R extension 04

*Please address billing questions specifically with Gail or Kanitha. Otherwise, all other patient questions may be answered by all team members.

Fax: 336-349-5056

Office e-mail:

appointments@pssspa.com

billing@pssspa.com (do not send sensitive information, such as credit card numbers)

info@pssspa.com

injections@pssspa.com

referrals@pssspa.com

Medication refills: Please be mindful that medications are not refilled after 4 PM, on Fridays, weekends, or holidays. Ask your pharmacy to send a fax OR **preferably an electronic refill renewal request**. **Not all medications** are legally allowed to be faxed or submitted electronically. For those medications, please be sure that you call our office 3-4 days in advance so that the prescription may be mailed to you.

Please do not hesitate to contact our office if you have any questions regarding this policy.

Signature _____ Date _____

Witness _____ Date _____

****Visit us on Facebook!****

*****Please DO NOT post sensitive information on Facebook*****



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**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Names of individual persons permitted to access my medical information:

1. _____

2. _____

3. _____

Patient Name (please print) _____ DOB _____

Signature of Patient or Representative _____ Date _____

Witness _____ Date _____



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MEDICAL RECORDS ACCESS

Name: _____ DOB _____

By signing below I acknowledge that I have received information explaining who has access to my medical information/records. I understand that if I have questions regarding this information, I may contact Gail Revis, Office Manager, CMA at Performance Spine and Sports Specialists, P.A. I may also contact the state Health and Human Services division.

Signature: _____ Date: _____

POA or Responsible Party: _____

Witness: _____ Date: _____