Performance Spine

Robert L Kimber, MD

12337 Ashley Dr.
Suite F
Gulfport, MS 39503
(228) 284-2370

PATIENT REGISTRATION

PATIENT INFORMATION

Referring Physician _____ Primary Physician _____

Pain Management Physician _____

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ___/___/___ Sex M ☐ F ☐ Social Security Number _____

Street Address _____

City _____ State _____ Zip _____

Home Phone (___) _____ Cell Phone (___) _____ Emergency Phone (___) _____

Employer Name _____ Employer Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

If patient is a student, please indicate school attending _____

Marital Status: Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated ☐

PATIENT'S SPOUSE

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ___/___/___ Sex M ☐ F ☐ Social Security Number _____

Employer Name _____ Employer Phone (___) _____

Employer Address _____ City _____ State _____ Zip _____

EMERGENCY INFORMATION (Please list the name of someone who does not live with you to contact in case of emergency)

Name _____ Phone (___) _____

Address _____ City _____ State _____ Zip _____

VISIT INFORMATION

Was this a result of an accident or injury? Yes ☐ No ☐

Is this visit today work related? Yes ☐ No ☐ If yes, date of injury ___/___/___ Employer _____

Is there litigation pending? Yes ☐ No ☐ If yes, lawyer's name _____

Is this visit today related to an auto accident? Yes ☐ No ☐

WE DO NOT FILE 3RD PARTY INSURANCE. YOU MUST PAY FOR YOUR VISIT IN FULL AT TIME OF SERVICE

_____ _____

Patient Signature (Parent or Legal Guardian if Minor) Date

INSURANCE INFORMATION

Primary Insurance Name _____ Phone Number _____

Insurer Address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured SSN _____

Insured DOB ___/___/___ Sex M ☐ F ☐ Insured Phone Number _____

Policy # _____ Group # _____ Effective Date ___/___/___

Insured's Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

SECONDARY INSURANCE INFORMATION

Sec Insurance Name _____ Phone Number _____

Insurer Address _____ City _____ State _____ Zip _____

Name of Insured _____ Insured SSN _____

Insured DOB ___/___/___ Sex M ☐ F ☐ Insured Phone Number _____

Policy # _____ Group # _____ Effective Date ___/___/___

Insured's Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

GUARANTOR INFORMATION

Guarantor's Name _____ **Date of Birth** ___/___/___

Guarantor's Billing Address _____

City _____ **State** _____ **Zip** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review the notice before signing this consent. As provided in the notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from our office by writing 12337 Ashley Dr, Suite F, Gulfport, MS 39503.

You have the right to request that Dr. Robert Kimber restrict how protected information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to such restriction, but if we do, are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about your treatment and health care operations (including HIV testing and drug and alcohol screening, if applicable.) You have the right to refuse signing this consent and the right to revoke this consent in writing, except when we have already made disclosures in reliance to your prior consent. This consent will expire two years from the date below.

_____ _____

Patient Signature (Parent or Legal Guardian if Minor) Date

I am responsible for payment of services rendered to me by this clinic. (If the patient is under 18, the parent or legal guardian assumes responsibility of all charges.) Full payment is due at the time of service. I understand that if my account should ever require action by collection agency or attorney in order to insure payment, the fees charged by these agents may be added to the balance due on the account. I authorize Performance Spine and all employees and other personnel of/or associated with Performance Spine to have access to my existing and future medical records and copies thereof in connection with all medical services or treatment under confidentiality which I may now or hereafter receive from the staff.

I hereby also authorize payment of medical benefits to Performance Spine for all services provided to me. I authorize the physician to release any information acquired in the course of my treatment to process insurance claims, workers compensation claims, or any other agent that has been involved in my medical treatment. I also permit release of medical information to continue the process of care on my behalf. All other releases will require a release of information form to be completed.

I hereby acknowledge and agree to accept the policies as stated above.

_____ _____

Patient Signature (Parent or Legal Guardian if Minor) Date

Patient Name _____ Age ____ Date of Birth ____/____/____

Chief Complaint _____

Past Medical History

Have you ever had any of the following? Please check all pertinent boxes.

☐ AIDS or HIV+	☐ Anemia	☐ Arthritis	☐ Asthma
☐ Back Trouble	☐ Bladder Infection	☐ Bleeding Tendency	☐ Blood Transfusion
☐ Bronchitis	☐ Chickenpox	☐ Diabetes	☐ Epilepsy/Seizures
☐ Glaucoma	☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure
☐ Kidney Disease	☐ Low Blood Pressure	☐ Measles	☐ Mitral Valve Prolapse
☐ Mumps	☐ Pneumonia	☐ Polio	☐ Scarlet Fever
☐ Small Pox	☐ Stroke	☐ Tuberculosis	☐ Ulcer
☐ Venereal Disease	☐ Whooping Cough	☐ Other_____	☐ Other_____

Past Surgical History

Please list previous Surgeries	When	Hospital, City, State

Medications (Please include non-prescription also)

Drug Name	Dosage	Frequency	Prescribing Physician

Allergies

Patient's Social History

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Use of Alcohol
- ☐ Never
- ☐ Rarely
- ☐ Moderate
- ☐ Daily

Use of Tobacco
- ☐ Never
- ☐ Previously, but quit
- ☐ Currently
- ☐ Other

_____Packs per day

Living Situation
- ☐ With Family
- ☐ With Friends
- ☐ Alone

Dominant Hand
- ☐ Right
- ☐ Left

Family Medical History

	Age	Conditions or Diseases	If deceased, cause of death
Father			
Mother			
Sibling			
Sibling			

Review of Systems: Please check any personal history below

General
- ☐ Change in weight, unexplained
- ☐ Joint stiffness or swelling
- ☐ Fever

HEENT
- ☐ Headaches
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Double vision
- ☐ Ringing of ears
- ☐ Hearing difficulties

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Blurred vision
- ☐ Bloody sputum
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure
- ☐ Shortness of breath at night

General
- ☐ Abdominal pain
- ☐ Nausea or vomiting
- ☐ Constipation or diarrhea
- ☐ Loss of appetite
- ☐ Bloody or tarry stools
- ☐ Unexplained weight change
- ☐ Coughing blood

Genitourinary
- ☐ Frequent urination
- ☐ Urgency or hesitancy
- ☐ Bloody urine
- ☐ Kidney stone
- ☐ Frequent urinary tract infection

Endocrine
- ☐ Excessive urination at night
- ☐ Palpitations or nervousness

Hematologic
- ☐ Anemia
- ☐ Enlarged lymph nodes
- ☐ Easy bruising

Rheumatologic
- ☐ Arthritis or joint pain
- ☐ Swollen warm joints
- ☐ Morning stiffness

Neurologic
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures

Breast
- ☐ Masses
- ☐ Tenderness
- ☐ Nipple discharge

Skin
- ☐ Rashes
- ☐ New skin lesions
- ☐ Change in size or color of moles

Allergic/Immunologic

List food/environmental allergies

_____

_____

What treatments have you had for your symptoms?
- ☐ Over the counter pain medication
- ☐ Non-narcotic prescription medication
- ☐ Narcotic pain medication
- ☐ Physical therapy
- ☐ Chiropractic treatment
- ☐ Injections

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary service I may need.

_____ _____

Patient Signature (Parent or Legal Guardian if Minor) Date

Name _____ Date ___/___/___

Age _____ Height _____ Weight _____

How long have the symptoms been present? _____

How severe is your pain? 1-10 (least to worst) _____

Circle all that apply:

Numbness Tingling Weakness Pain

Does the pain interfere with: Work Activities Wakes you up at night Affects bladder control

If you have pain, is it mostly:

Where is the pain?

Back (Upper or Lower) Buttock Hip Groin Thigh Knee Shin Calf

Right, Left, or Both:

Neck _____ Shoulder _____ Upper Arm _____ Elbow _____ Forearm _____ Wrist _____

Hand _____ Palm _____ Thumb _____ Index Finger _____ Small Finger _____

What makes your pain worse? _____

What makes your pain better? _____

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. MARK ALL AREAS.

ACHING	NUMBNESS	PINS & NEEDLES	BURNING	STABBING	OTHER
□□□□□	═══	ooooo	xxxxx	/////	*****