ROCKY MOUNTAIN SPINE CLINIC, P.C.

Eric R. Jamrich, M.D. John R. Barker, M.D. Chad J. Prusmack, M.D. Michael W. Madsen, M.D.

Name ______________________________ Birthdate ________
Last First Middle Initial
SSN ________

Address ________________ Apt. # ____ City ________ State ____ Zip ______

Home Phone ( ) ________ **Work Phone** ( ) ________ **Cell Phone** ( ) ________

E-mail Address ________________ Preferred method of contact: ☐ Phone ☐ E-mail ☐ Text

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employer ________________ Occupation ________________

Employer's Address ________________ City ________ State ____ Zip ______

Employment Status ☐ Full-Time ☐ Part-Time ☐ Retired ☐ On Leave ☐ Other

In case of emergency contact ________________ Relationship ________
Home Phone ( ) ________ Work Phone ( ) ________ Cell Phone ( ) ________

REFERRING PHYSICIAN / COMPLETE NAME AND ADDRESS:

____

PCP (if different from Referring Physician) COMPLETE NAME AND ADDRESS

____

Pharmacy ________________ Phone ________

INSURANCE INFORMATION ~ We will need a copy of your insurance card(s).

Primary Insurance Address (Street/City/State) Employer

________ ________ ________

Group # ________ ID # ________ Policy Holder ☐ Self ☐ Spouse ☐ Parent/Guardian

Secondary Insurance Address (Street/City/State) Employer

________ ________ ________

Group # ________ ID # ________ Policy Holder ☐ Self ☐ Spouse ☐ Parent/Guardian

INSURED RESPONSIBLE PARTY INFORMATION – If other than self

Name ________ Relationship ________ Birthdate ________ SSN ________

Address (If different from patient) ________________

Home Phone ( ) ________ Work Phone ( ) ________ Employer ________

ACCIDENT INFORMATION

Is this a ☐ Work Comp or ☐ Motor Vehicle Accident? ☐ Yes ☐ No If YES, on what date did the injury occur? ________

Work Comp / Motor Vehicle Claim Number ________________

Adjuster's Name ________________

Phone Number ( ) ________ Fax Number ( ) ________

I authorize that payment of any insurance benefits for health care services be made directly to Rocky Mountain Spine Clinic, P.C. NOTE: If patient is a minor under the age of 18 years, these forms must be signed by parent or legal guardian. They cannot be signed by a minor.

________________________ ________
Signature of Patient, Parent or Legal Guardian Date

ROCKY MOUNTAIN SPINE CLINIC, P.C.
Two Year Update

NAME:______________________________ Date of Birth _______________ Today's Date _______________

What brings you in today? ____
____
____

How long ago did your symptoms begin?____

Is this new pain? Yes No If Yes, circle: Injury Accident Began slowly over time Began suddenly

Circle symptoms: Stabbing pain. Burning pain. Aching pain. Pins & needles. Numbness. Weakness.

Stiffness. Grinding or popping. Muscle spasms. Headaches. Bowel/bladder function loss.

Is the pain constant, or does it come and go?____

Have you had physical therapy? Did it help? ____

Have you had any injections for your problem?_______ If so, please describe:__________________
____

Have you had any of the following tests regarding your back or neck within the last year?

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG/nerve conduction studies

List all current medical problems:
____
____
____

List all medications you are currently taking with dosage and quantity:
____
____
____
____

RECENT SURGERIES SINCE LAST VISIT ~ Please list the surgery, the year, and any complications.
____
____
____

SOCIAL HISTORY
Do you currently smoke? ☐Yes ☐ No How many packs per day _______ for how long_________
Have you quit smoking? ☐Yes ☐ No When did you quit:_______________________________
Do you use marijuana? ☐Yes ☐ No ____

DOMINANT HAND: ☐ Right ☐ Left

Patient's Signature ______________________________ Date:________________________

Physician's Initials______________________________ Date:________________________