WELCOME TO OUR OFFICE

Douglas Blaty, DO
850 W. Ironwood Dr., Suite 300
Coeur d'Alene, ID 83814
208-667-1376
FAX # 208-292-0873

DATE OF APPOINTMENT _____

(PLEASE PRINT)

PATIENT'S LAST NAME:	PATIENT'S SOC. SEC. NO:
PATIENT'S FIRST NAME:	PATIENT'S EMPLOYER:
MIDDLE INITIAL:	PATIENT'S WORK PHONE:
ADDRESS:	PATIENT'S BIRTHDATE:
	AGE: SEX: □ MALE □ FEMALE
CITY, STATE:	MARITAL STATUS: □ S □ M □ W □ D
ZIP:	**PHYSICIAN** REQUESTING THIS CONSULT:
HOME PHONE NUMBER:	
CELL PHONE NUMBER:	**FAMILY PHYSICIAN**:
E-MAIL ADDRESS:	

SPOUSE'S NAME OR PARENT NAME IF MINOR:	
SPOUSE'S OR PARENT EMPLOYER:	SPOUSE'S OR PARENT WORK PHONE:
SPOUSE'S OR PARENT SS#:	SPOUSE'S OR PARENTS DATE OF BIRTH :

SOMEONE TO NOTIFY IN CASE OF EMERGENCY, OTHER THAN SPOUSE OR PARENT

NAME: **PHONE:**

COMPLETE THIS SECTION FOR WORKERS COMPENSATION INJURY ONLY

DATE OF INJURY:	WORKERS COMP. CLAIM NO:
NAME OF WORKERS COMP. INSURANCE:	
ADDRESS OF WORKERS COMP:	
EMPLOYER AT THE TIME OF INJURY:	
CLAIM REP: PHONE:	FAX:

INSURANCE INFORMATION

DO YOU HAVE MEDICAL INSURANCE? □ YES □ NO

IF NO INSURANCE, HOW DO YOU PLAN TO PAY? □ CASH □ CHECK □ CREDIT CARD

I. PRIMARY INSURANCE	II. SECONDARY INSURANCE
INSURANCE NAME:	INSURANCE NAME:
ADDRESS:	ADDRESS:
PHONE NO:	PHONE NO:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
GROUP NO:	GROUP NO:
POLICY NO:	POLICY NO:

COMPLETE THE FOLLOWING **ONLY** IF THIS IS AN ACCIDENT INJURY:

NATURE OF INJURY: _____

DATE OF INJURY: _____

Inland Northwest Spine and Neurosurgery, PLLC

DOUGLAS BLATY, DO
850 W. Ironwood Dr., Suite 300
Coeur d'Alene, ID 83814
208-667-1376
Fax 208-292-0873

Welcome to Inland Northwest Spine and Neurosurgery

The distinguishing aspects of our practice have always been prompt and excellent neurosurgical care delivered in a caring and compassionate manner. Your health and peace of mind are important to us at Inland Northwest Spine and Neurosurgery. If you have any questions, contact our office to schedule an appointment to discuss your neurosurgical health concerns. We care about you as a patient and look forward to seeing you.

IMPORTANT OFFICE POLICIES AND PROCEDURES

APPOINTMENTS

We make every effort to remain on schedule; therefore, you must arrive on time. Please arrive **30 minutes** early for your first appointment to complete paperwork. If you fail to arrive on time for an appointment, you will likely be rescheduled for a later date. Your consideration of a **48-hour notice** of cancellation is greatly appreciated so that we may utilize that time for other patients. Not notifying the office within 48 hours will result in a $50.00 charge.

X-RAYS

If you have had x-rays or other diagnostic imaging studies from sources outside of the Spokane, Washington or North Idaho area, it is your responsibility to bring a CD or hard copy of films with you to your appointment. Failure to arrive without the necessary studies may result in an additional cost to you for x-rays taken in our office, further imaging, or even rescheduling the clinic visit.

FINANCIAL INFORMATION

The financial cost of services rendered is the responsibility of the patient and/or guarantor regardless of insurance coverage. Please bring **insurance cards** along with **picture ID** to your appointment. Insurance co-payments are due at the time of your visit.

Idaho Workers' Compensation Insurance is accepted in general. You must provide our office with the following information at the time of your first appointment:

- ☐ Name and address of employer's insurance carrier.
- ☐ Exact date of your injury with a brief description.
- ☐ Insurance claim number.

This information is the only way that we can bill the Workers' Compensation Insurance. Your employer can assist you in obtaining this information. You may otherwise need to be rescheduled or be required to self-pay until such information is received.

Motor vehicle accidents, liability action, and/or litigation against a third party are not acceptable reasons for delay in payment. A deposit will be required if surgery is recommended. Payment arrangements must be made in advance of surgery scheduling. If you would like an estimate of cost for your visit, please call our office at 208-667-1376 x-25.

I agree to the above terms and conditions.

_____ _____

Patient Signature **Date**

I hereby authorize and agree by initialing the following items.

INSURANCE/ MEDICARE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance or Medicare benefits be made either to me or on my behalf to Inland Northwest Spine and Neurosurgery, PLLC for any services rendered to myself/dependent. I authorize any holder of medical information about me to release to the insurance company or CMS (Centers for Medicare and Medicaid Services, formerly known as HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that I am fully responsible for any amount not covered by my insurance. All accounts are due in full within 90 days of service unless arrangements have been made.

_____ _____

Patient Signature **Date**

PRESCRIPTIONS/REFILLS

Narcotic medications and other prescriptions will be provided by our office in the immediate postoperative period only (usually for no more than four weeks after surgery). Chronic pain requiring more protracted courses of narcotics is best managed by a specialist trained to deal with chronic pain, or by your primary care physician. It is very important to note that prescriptions will be provided during normal office hours. We do not fill prescriptions after 4:00 PM, weekends, or holidays. Please allow **48 hours** for prescription approvals. Please be advised that **we do not replace lost or stolen prescriptions**. Some pharmacies are now offering e-prescribing. Please be advised that a feature of e-prescribing is the electronic exchange of prescription data between physician practices and pharmacies, which can potentially improve the efficiency of the prescribing process and reduce medication errors.

I understand and accept the terms of INSN Prescription Policy.

_____

Initials

NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges he/she may obtain a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

_____

Initials

ASSIGNMENT OF PROCEEDS

I grant and assign to the physician any and all proceeds from any settlement or court determination related to injuries for which the physician has treated me. This assignment shall not exceed the amount of the physician's unpaid services and/or expenses. In consideration for the physician's examination and treatment, I agree to all promises set forth above and further agree to pay physician at the time of billing for all services rendered and for all costs and losses caused by any failure to pay this commercial transaction in a timely manner. I further agree that all the information and promises stated above are freely given with the knowledge that I am granting the physician substantial rights in the event that I fail to pay for his services in a timely manner.

In witness of my agreement with the physician, Bret A. Dirks, MD.

_____ _____

Signature **Date**

Patient Name: _____ Date: _____

What is the reason for seeking spine care today? _____

How long have you had this problem? _____

How did your symptoms start? ☐ Suddenly ☐ Gradually ☐ Chronic/recurrent

Did any of the following contribute to your current spine problem?

□ Spine deformity
□ Fall/trauma
□ Work injury
□ Motor vehicle accident
□ House/yard work
□ Sports/leisure
□ Stress
□ Other

Have you had spine surgery in the past? □ Yes □ No **If yes, date of surgery**: _____

Type of procedure _____ **Surgeon:** _____

What activities/positions make symptoms worse?

□ Sitting
□ Standing
□ Walking
□ Lying down
□ Bending
□ Lifting
□ Coughing/sneezing
□ Sleep postures
□ Getting in/out of bed
□ Getting in/out of chair
□ Driving
□ Computer work
□ Stair climbing
□ Neck movements
□ Arm movements
□ First morning symptoms
□ End of day symptoms
□ Other _____

What activities/positions/interventions make symptoms better?

□ Lying down
□ Sitting
□ Walking
□ Bending forward
□ Exercise
□ Changing positions
□ Reclined positions
□ Ice
□ Heat
□ Medications
□ Better as day progresses
□ Other _____

What treatment have you tried?

□ Physical therapy
□ Chiropractic
□ Injections
□ Anti-inflammatory medication
□ Narcotics
□ Bracing/back support
□ Pain clinic
□ Exercise program
□ Surgery
□ Acupuncture
□ Other _____

Of these treatments, what has been helpful? _____

Imaging studies you have completed in the past 1-2 years:

□ X-ray
□ MRI
□ CT
□ Myelogram
□ EMG
□ Discogram

Facility imaging was performed: _____

Medical History (Check all that apply)

□ Anesthesia problem
□ ADD/ADHD
□ Alcoholism
□ Anemia
□ Anxiety
□ Arthritis (rheumatoid/osteo)
□ Asthma
□ Atrial fib
□ Benign prostatic hypertrophy
□ Bleeding disorder
□ Bipolar disorder
□ Chronic pain
□ COPD
□ Coronary artery disease
□ Cancer type _____
□ Deep vein thrombosis
□ Depression
□ Diabetes
□ GERD
□ HIV/aids
□ Hypercholesterolemia
□ Hypertension
□ Fibromyalgia
□ Kidney disease
□ Liver disease
□ Migraine
□ Myocardial infarction
□ Osteoporosis/osteopenia
□ Parkinson's
□ Pulmonary embolism
□ Seizure disorder
□ Sleep apnea
□ Stomach ulcer
□ Stroke (CVA)
□ Substance abuse
□ Thyroid disease
□ Tuberculosis
□ Other _____
□ Other _____
□ Other _____

Surgical History (Check all that apply)

□ Angioplasty
□ Appendectomy
□ Bowel resection
□ Cardiac stents
□ Coronary artery bypass
□ C-section
□ Defibrillator/pacemaker
□ Carpal tunnel release
□ Cataract
□ Gall bladder surgery
□ Elbow surgery
□ Gastric bypass
□ Hernia repair
□ Hip replacement
□ Hysterectomy
□ Knee replacement
□ Knee arthroscopy
□ Mastectomy
□ Thyroidectomy
□ Shoulder surgery
□ Other _____
□ Other _____
□ Other _____

Current Medications and Dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies and Reactions

_____ _____ _____

_____ _____ _____

Family Medical History (check all that apply and list affected family member ie. Mother, father, grandparent, sibling)

□ Anesthesia complication _____
□ Bleeding disorder _____
□ Cancer _____
□ Depression _____
□ Diabetes _____
□ Heart disease _____
□ Hypertension _____
□ Osteoporosis _____
□ Scoliosis _____
□ Spine disorder/deformity _____
□ Stroke _____
□ Suicide _____

Social History

Do you use nicotine products? □ Yes □ No If yes, how much and what form? _____

Do you drink alcohol? □ Yes □ No If yes, how much and how often? _____

Do you exercise? □ Yes □ No If yes, how much and how often? _____

Review of Systems (check all that apply in the last 3 months)

General:
□ Fever
□ Chills
□ Night sweats
□ Unintended weight loss
□ Fatigue

Eyes/Ears:
□ Double vision
□ Glasses/contacts
□ Ringing in ears
□ Hearing loss

Nose/Oral:
□ Sinus infection
□ Hoarseness
□ Difficulty swallowing

Gastrointestinal:
□ Changes in appetite
□ Heartburn
□ Constipation

Cardiac:
□ Chest pain
□ Racing heart beats
□ Skipping heart beats

Psychological:
□ Anxiety
□ Depressed mood
□ Mood swings

Respiratory:
□ Excessive snoring
□ Shortness of breath with little exertion
□ Exposure to tuberculosis

Skin:
□ Rashes
□ Sores
□ Hairy patches
□ Changes in nail/hair
□ Easy bruising

Genitourinary:
□ Urine frequency
□ Unable to empty bladder
□ Incontinence

Neurological:
□ Headaches
□ Confusion
□ Loss of balance
□ Numbness
□ Tingling

Musculoskeletal:
□ Joint pain
□ Stiffness
□ Swelling
□ Gout
□ Atrophy

Heme/Lymphatic:
□ Easy bleeding
□ Transfusion reaction
□ Persistent infections
□ Latex allergy