J. Michael Calhoun, M.D., P.A.

Surgery of the Spinal Cord and Peripheral Nerves

4020 Richards Road, Suite I

North Little Rock, AR 72117

# New Patient Information

| First Name | Mid. Initial | Last Name | Date of Birth | Age | Social Security No. |
|---|---|---|---|---|---|
| | | | | | |

| Street Address | City, State | Zip Code | Home Phone No. |
|---|---|---|---|
| | | | ( ) |

| Patient Employer | Occupation | Business Phone No. |
|---|---|---|
| | | ( ) |

| Employer's Address | City, State | Zip Code |
|---|---|---|
| | | |

| Spouse's Name | Employer's Name &Address | Business Phone No. |
|---|---|---|
| | | ( ) |

| Spouse's Social Security No. | Spouse's Date of Birth | Nearest Relative & Address |
|---|---|---|
| | | |

| Person, other than a relative, to contact in case of emergency | Street Address, City, State & Zip Code | Phone No. |
|---|---|---|
| | | ( ) |

| Primary Care Doctor | Street Address, City, State & Zip Code | Phone No. |
|---|---|---|
| | | ( ) |

Specific Problems

Email Address

## Please Read and Complete in Full

Insurance Information is this related to: ☐ Worker's Compensation ☐ Motor Vehicle Accident

| Name of Primary Ins. Carrier: | Identification No. | Group No. | |
|---|---|---|---|
| | | | |

| Name of Policy Holder | Mail Claim form to: |
|---|---|
| | |

| Name of Secondary Ins. Carrier | Identification No. | Group No. | |
|---|---|---|---|
| | | | |

| Name of Policy Holder | Mail Claim form to: |
|---|---|
| | |

I authorize release of any information relating to this claim. I understand and acknowledge that I am primarily responsible for these medical fees in the event there is no insurance coverage. If the patient is a minor, I hereby understand, acknowledge and agree that I am responsible for payment of his or her medical bills. I hereby authorize payment directly to the below named physician of the group insurance benefits otherwise payable to me.

****HIPPA****

We will use and disclose your protected health information for treatment, payment and healthcare operations. We request that you read our notice of privacy practices. Additional copies are located in your Providers waiting area.

I have received a copy and agree to J. Michael Calhoun, M.D., P.A.'s notice of privacy practices.

# Patient Visit Questionnaire

Please complete prior to examination by physician

Patient Name_____

Date of Birth_____

Spinal Problem

| | |
|---|---|
| Neck pain | Low back Pain |
| Neck pain with right arm pain | Low back pain with left leg pain |
| Neck pain with left arm pain | Low back pain with right leg pain |
| Neck pain and both arm pain | Low back pain with both leg pain |

First Noticed_____

Is this due to an Accident or Injury Yes No

Date of accident/injury_____

Physician seen for this problem_____

Treatment for neck/back pain thus far

Physical Therapy

Steroid injections

Chiropractic treatment

Anti Inflammatory medication therapy

Please list any **Medications**

_____

_____

## Medication Allergies

_____

## Past Medical History

**Diabetes** Yes No

**High Blood Pressure** Yes No

**Heart Problems** Yes No

If yes please provide **Cardiologist Name** _____Phone_____

**Lung Problems** Yes No

If yes please provide **Pulmonologist Name** _____Phone_____

**Digestive disorders** Yes No

**Bleeding disorders** Yes No

**Cancer** Yes No

If yes please provide **Oncologist Name** _____Phone_____

**Have you been seen for Pain Management** **Y or N**

**Pain Management Physician Name**_____

Any illnesses not listed above_____
Any diseases which run in families (if yes explain)_____

_____

**Review of Systems**

**General**
Fever, chills or sweat  Loss of Appetite  Fatigue  Unexpected Weight Loss

**Eyes**
Blurred Vision  Eye Pain/irritation  Failing Vision

**Ears/Nose/Throat**
Ringing in ears  Decreased hearing  Difficulty Swallowing  Sinus/Congestion

**Cardiovascular**
Chest Pain  Fainting Spells  Palpitations (fast, irregular heart)

**Respiratory**
Shortness of breath  Chronic Wheezing  Coughing up blood  Chronic cough

**Gastrointestinal**
Nausea/vomiting  Diarrhea  Constipation  Chronic Abdominal Pain

**Skin**
Rash  Itching  Suspicious moles or abnormalities

**Psychological**
Depressed  Memory Loss  Difficulty concentrating  Phobias/fears

**Social**
**Race**

**Previous Surgeries**_____

_____

| | | | |
|---|---|---|---|
| **Do you have a pacemaker?** | Yes | No | |
| **Are you claustrophobic?** | Yes | No | |
| **Do you have any metal in your body?** | Yes | No | |
| **Do you smoke?** | Yes | No | Packs per day? _____ |
| **Do you drink alcohol?** | Yes | No | |

**Height** ____ **Weight**____

Patient Signature_____

Date_____

J. Michael Calhoun, M.D., P.A.
Surgery of the Spinal Cord and Peripheral Nerves
4020 Richards Rd., Suite 1
North Little Rock, AR 72117
Phone 501-353-2123 Fax 501-771-4672

Patient Name_____ Date_____

## PHARMACY AND PRESCRIPTIONS

In order to better serve you, our patients, we are utilizing an Electronic Prescription program to send your prescriptions directly to your pharmacy. In order to more efficiently process your prescriptions, please provide us with your primary pharmacy's information. We ask that you call your pharmacy for all refills not the office as this will only delay your prescription.

If you utilize a mail order pharmacy for long-term medications, please provide us with both your mail order pharmacy information and a local pharmacy you use as well. If your pharmacy participates, we will electronically send your prescription directly to them. If they do not participate, we will continue to call in your prescriptions for you.

Some medications can only be accepted by the pharmacy as a written prescription signed by your physician. If that is the case, we will still give you a signed prescription that you will need to take to your pharmacy.

## PRIMARY PHARMACY

Pharmacy Name: _____

Address: _____

City: State: Zip: _____

Phone #: (  ) _____ ☐ Mail Order (3-month) ☐ Local Pharmacy ☐ Both

## SECONDARY PHARMACY

Pharmacy Name: _____

Address: _____

City: State: Zip: _____

Phone #: (  ) _____ ☐ Mail Order (3-month) ☐ Local Pharmacy ☐ Both

NOTES:

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# NOTICE OF PRIVACY PRACTICES

## As Required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We will use and disclose your protected health information for treatment, payment and healthcare operations. We request that you read our notice of privacy practices. Additional copies are located in your provider's waiting area.

I have received a copy and agree to J. Michael Calhoun, M.D., P.A.'s notice of privacy practices.

Signature: _____ Date: _____

## Authorization for Release of Medical Information/Records

I hereby authorize use or disclosure of the named individual's health information described below:

Patient Name: _____ Date of Birth: _____
Social Security #: _____ Daytime Phone# _____ Cell Phone # _____
**Email Address** _____

**Please Release the Following:**

_X_ Problem List
_X_ Progress Notes
_X_ History/Physical Exam
_X_ Lab Reports
_X_ Immunizations
_X_ Itemized Statement
_X_ X-Ray Reports
_X_ X-Ray Films
_X_ EKG Reports
_X_ Other Diagnostic Reports (Specify)
_X_ Other (Specify)

**Purpose or Need for Use or Disclosure:**

Continued Patient Care
Attorney/Legal
Disability Determination
Insurance Claim/Application
Other (Specify)

I authorize J. Michael Calhoun, MD (and representative thereof) to release and/or obtain any health information listed above to continue treatment or to assist in filing claims to the insurance companies, my referring physician, family physician and any physician to whom I may be referred. I agree this authorization will remain in effect until canceled by me in writing or on date entered here _____. I authorize payment of benefits directly to Dr J. Michael Calhoun for services rendered and understand that I am responsible for any charges that are denied by my carrier. (If my coverage is with an HMO, I will assume responsibility for obtaining a referral form and/or number from my primary care physician and will be responsible for payment of services denied by my failure to obtain the referral. I am aware that this referral form is required prior to being examined.) I give my permission to be contacted or a message left at the phone numbers above regarding my appointment and/or treatment. I also give permission to discuss my medical care with a family member such as spouse or any other relative as I designate. If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year from the signature date.

_____
Name of family member

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
I will not hold J. Michael Calhoun, MD liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

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Due to recent changes by the DEA and Arkansas State Medical Board concerning pain medication refills; we are forced to make the following changes to our medication policy. If a patient is under the guidance of a pain management physician, we will not prescribe any medications at any time for that patient. The patient will need to continue receiving their prescriptions from that physician. If a patient is undergoing surgery and is not currently seeing a pain management physician, we will prescribe pain medications for two months after surgery only. There will be little or no exceptions to this policy.