

Welcome to the South Coast Spine Center

PATIENT INFORMATION for the practice of DAVID A. PROPST, D.O.

OFFICE PHONE: 949-218-9990

OFFICE FAX: 949-218-9991

OFFICE ADDRESS: 26732 Crown Valley Parkway, Suite 541
Mission Viejo, CA 92691

OFFICE HOURS: 9:00 AM- 5:00 PM Monday – Friday

Evaluation of patients with a spine related problem is a lengthy procedure. Please allow two hours for your initial appointment. So that we can answer all your questions, write them down ahead of time and bring them with you.

Please be sure to complete the comprehensive “new patient form” prior to arrival at the Spine Center or allow 30 minutes extra to fill out these forms in the office. This information packet is an in depth questionnaire of your medical history and every section is to be completed. All of this information is pertinent to your condition. Many of the questions can be answered with a simple “yes” or “no”. If you have any questions, please let us know so we can help expedite the process.

X-Rays and other Special Tests:

If you have had X-Rays, MRI's, CT Scan's, Myelograms or other studies within the last 2 years, please arrange to pick them up from the facility they were performed at and bring them with you. We prefer the films with the report. Often, the report alone does not adequately describe the pathology and visually reviewing the film is helpful. Failure to provide all the previous studies will delay our ability to determine your diagnosis and develop a treatment plan for you.

Pain Medication Policy:

Narcotic pain medication is limited to surgical patients. Dr. Propst does not expect pain medication to be needed longer than three (3) months following surgery. Patients that require chronic narcotics need to have that medication managed by their Primary Care Physician or Pain Management Specialist.

Medication Refill Policy:

Please allow 48 hours for refill requests to be honored. Have your pharmacy number available or have the pharmacist call.

No refills will be filled after 5:00 PM on weekdays, nor anytime in weekends. This includes long holiday weekends. Please check your supply and plan accordingly.



Reconstructive Spinal Surgery/Orthopedic Surgery
David A. Propst, D.O.
Board Certified-Fellowship Trained Spinal Surgeon

PATIENTS' INFORMATION - PLEASE PRINT

Date: ___/___/___

Legal Last Name: ___ Patient First Name: ___ MI: ___
Address: ___ City: ___, CA Zip Code: ___
Home Phone: ___ Cell Phone: ___
Occupation: ___ Work Phone: ___
DOB: ___/___/___ M/F (circle one) SSN #: ___
Emergency Contact: ___ Relationship: ___
Phone: ___
Whom may we thank for referring you to this office: ___

PRIMARY INSURANCE (Please circle all that apply)

MEDICARE MEDI-CAL PPO/PRIVATE HMO WORK COMP SELF-PAY
Co-pay: \$ ___ (Co payments are due at the time of service)
Date of Injury: ___ Work Related: Yes/No Auto: Yes/No
MHAP Referring Physician: ___
(First and Last name of referring physician)
Insurance Name: ___ Insurance Phone: ___
Billing Address: ___
Insured Subscriber's Name: ___ DOB: ___/___/___
SSN#: ___ - ___ - ___ ID#: ___ Group #: ___ Effective Date: ___
Employer: ___
Employer's Address: ___ Phone: ___
Relationship of Patient to Insured/Subscriber: Self Father Mother Child Other:

SECONDARY INSURANCE

Insurance Name & Billing Address: ___
Insured Subscriber: ___ DOB: ___/___/___
ID#: ___/___/___ Group #: ___ Effective Date: ___

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize South Coast Spine Center to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I authorize them to furnish information to insurance carriers concerning this illness and/or injury. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the doctor in accordance with California Insurance code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

SUBSCRIBER/INSURED SIGNATURE: _____ DATE: _____



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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to David A. Propst, D.O. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physicians or suppliers agree to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____

Printed Name: _____

Medicare Number: _____

Mailing Address: _____



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I understand that South Coast Spine Center does not accept Medi-Cal or Cal- Optima and that I am responsible for payment for the treatment I have received.

Patient Name: _____

Signature: _____

Date: _____



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AUTHORIZATION FOR DIRECT PAY

Authorization to pay physician: David A. Propst, D.O.

I hereby authorize payment directly to David A. Propst, D.O. for surgical and medical benefits, if any, otherwise payable to me for his services as described on attached claim.

Signature of Insured

Date

Authorization to release information

I hereby authorize David A. Propst, D.O. to release any information needed for billing purposes. This authorization shall remain valid for one year from the date of signing unless revoked in writing.

Signature of Insured

Date

Billing your insurance company is a courtesy to you as our patient, not a contract for payment. All patients are responsible to pay their deductible, co-payment and co-benefit at the time of service.



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ADVANCE HEALTH CARE DIRECTIVE

Dear Patient,

As your physician, we are required to ask any patient over the age of 18, if they have an existing Advance Health Care Directive, so that we can incorporate the information into your medical record. You are not required to give us this information, but we are required to ask. Please complete this form, and return to the receptionist. Thank you.

PATIENT NAME: _____ SSN: _____

PATIENT SIGNATURE: _____ DATE: _____

- | | | | |
|----|--|-----------------------|----|
| 1. | I decline to answer these questions | Yes | No |
| 2. | Do you have an Advance Health Care Directive? | Yes | No |
| 3. | If Yes, please indicate which type of Directive. | | |
| | Durable Power of Attorney for Health Care | <input type="radio"/> | |
| | California Natural Death Act | <input type="radio"/> | |
| | Living Health Care Will | <input type="radio"/> | |
| | Other: _____ | <input type="radio"/> | |
| 4. | Will you bring a copy of your Directive? | Yes | No |

Internal Office Use Only

Type of Health Care Directive Received:		Date Received:
Durable Power of Attorney for Health Care	<input type="radio"/>	_____
California Natural Death Act	<input type="radio"/>	_____
Living Health Care Will	<input type="radio"/>	_____
Other: _____	<input type="radio"/>	_____

CALIFORNIA NATURAL DEATH ACT

SUMMARY AND GUIDELINES FOR PHYSICIANS

Any person who is at least 18 years of age and of sound mind may sign a Natural Death Act Declaration. A valid Declaration must be signed by the declarant (patient) and by two qualified witnesses. If a declarant is physically unable to sign a Declaration, the law provides that another person may sign for the declarant "at the declarant's direction and in the declarant's presence." The provision of health services or insurance cannot be conditioned on whether a person has or has not signed a Declaration.

When a Declaration Becomes Effective

A Declaration becomes effective when all of the following three conditions are met: (1) the Declaration is communicated to the attending physician; (2) the declarant is diagnosed and certified in writing to be in a terminal or permanent unconscious condition by the attending physician *and* a second physician who has personally examined the patient; and (3) the declarant is no longer able to make decisions about the administration of life-sustaining treatment. If the declarant is pregnant and this is known to the physician, the Declaration may *not* be given effect during the pregnancy.

Obligations of Health Care Providers

The California Natural Death Act imposes several obligations on health care providers presented with a Declaration:

1. A copy of the Declaration must be placed in the patient's medical record.
2. A health care provider who is furnished a copy of a Declaration and is unwilling to comply with it must immediately inform the patient of this fact. A provider who is unwilling to comply with the Act must take "all reasonable steps as promptly as practicable to transfer care of the declarant to another physician or health care provider who is willing to do so."
3. Upon determining that a patient is in a terminal or permanent unconscious condition (defined as irreversible coma or persistent vegetative state), an attending physician who knows of a Declaration must record the determination and the terms of the Declaration in the patient's medical record. If a copy of the Declaration has not already been placed in the medical record, it must be filed in the record at this time.
4. When a Declaration is revoked and the revocation is communicated to an attending physician or other health care provider by the declarant or a witness to the revocation, the physician or other health care provider shall make the revocation a part of the declarant's medical record.
5. Comfort care and treatment for the alleviation of pain must be provided, regardless of whether life-sustaining treatment has been withheld or withdrawn.
6. The Natural Death Act does not require or authorize health care providers to take any action contrary to reasonable medical standards, and does not override other provisions of the law that prohibit mercy killing, assisted suicide, or an affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

Immunities

The Natural Death Act provides broad immunities from civil and criminal prosecution, professional disciplinary action, and administrative or other sanction to health care providers who withhold or withdraw life-sustaining treatment pursuant to a Declaration, provided they act in accordance with reasonable medical standards and believe in good faith that their action is consistent with the Act and the desires expressed in a Declaration. Health care providers may presume that a Declaration is valid in the absence of knowledge to the contrary, and are not liable for acting on a Declaration in absence of knowledge of its revocation. Death resulting from the withholding or withdrawal of a life-sustaining treatment in accordance with the Act does not constitute a suicide or homicide.

Additional Information

For additional information about the California Natural Death Act, see *Guide to Advance Directives* published by the California Medical Association. For ordering information, write to CMA Publications at P.O. Box 7690, San Francisco, CA 94120-7690 or call 1-800-882-1-CMA.

NAME: _____ AGE: _____ SEX: _____

HEIGHT _____ WEIGHT _____ RT OR LF HAND _____

INSTRUCTIONS: Please answer each question by circling the correct answer or filing in the blank. Write N/A if not applicable to you.

HISTORY

Did your first symptoms begin after an injury? YES NO

Date and place of injury? _____

Activity which lead to injury _____

Did the injury occur at work or is it work related? YES NO

Employer's name: _____

Employer's address: _____

Employer's phone: _____

Did you have spinal problems or pain before this injury? YES NO

Describe: _____

If your FIRST symptoms began without an injury, on what date did they begin?

Do you recall any activity with preempted the onset of pain?

CURRENT SYMPTOMS

Do you have pain YES NO
Name all areas of your body where pain exists: _____

Which one area is worse? _____

Do you have weakness? YES NO

Do you have numbness YES NO

Do you have tingling, pins and needles, or other uncomfortable sensations YES NO

Do you have clumsiness, or in coordination when you:

Walk YES NO

Run YES NO

Use your hands/fingers YES NO

Do you have problems with balance? YES NO

Do you have problems with or recent changes in bowel habits? YES NO

Do you have problems with or recent changes in bladder habits? YES NO

Do you have sexual difficulties? YES NO

Do your symptoms cause you to be depressed? YES NO

Do your symptoms cause insomnia or difficulty sleeping? YES NO

CURRENT TREATMENTS

Within the past three months have you had:

MEDICINE Type? Amt/day? How long?

Narcotic Pain Medicine? YES NO _____

Muscle Relaxants? YES NO _____

Sleeping Pills? YES NO _____

Anti-Inflammatory Meds? YES NO _____

PHYSICAL THERAPY YES NO

Prescribed by whom? _____ visits per week _____

How many weeks? _____ visits missed _____

Location? _____

Active exercise YES NO Modalities (heat/ice) YES NO

Stretching YES NO TENS Unit YES NO

Back School YES NO Home exercise program YES NO

Pool Therapy YES NO Manual Therapy YES NO

ORTHODIC

YES NO

Soft Neck Collar YES NO Soft Corset YES NO

Hard Neck Collar YES NO Hard Brace YES NO

PAIN MANAGEMENT

YES NO

Out patient or Inpatient? _____

Name of Facility: _____

Location: _____

Phone: _____

Did your ability to cope with your symptoms improve?

INJECTIONS

YES NO

Neck injections (i.e. Epidural steroids, facet blocks) YES NO

How many times? _____ Did they provide relief? YES NO

For how long? _____

CHIROPRACTIC TREATMENTS

YES NO

Name of Chiropractor _____

Location: _____

Phone: _____

How many visits? _____ Did they provide relief? YES NO

CURRENT WORK STATUS

Fulltime, Part Time, or Not Working
Full duty or Modified Duty?

Are you currently working? YES NO

How long have you been off work? _____ Date of last employment _____

Name of last employer? _____ Location _____

Do you consider your symptoms to be work related? YES NO

Has a Worker's Compensation board determined your symptoms are work related? YES NO

Which State Board? _____ When: _____

Has your claim been settled? YES NO

Do you have a permanent disability rating? YES NO

When? _____ Where? _____ What percent? _____

ALLERGIES

Do you have allergies YES NO
Please describe:
Medications/drugs: _____
Food: _____
Environmental agents (pollen, pets, etc): _____
Diagnostic test agents (myograms, IVP, etc): _____
Numbing agents (Novocain, xylocaine, marcaine): _____
Tape (surgical dressing): _____

MEDICATIONS

List all of the medications that you take other than previously listed for your back or neck (e.g. blood pressure medication)

Medicine	Dose	Tabs/Caps	Times each day	Reasons

SURGICAL HISTORY

List all previous operations on your NECK OR BACK:

Type of Operation	Date	Surgeon	Hospital	Location

List all other operations you may have had on other areas of your body (i.e., gall bladder, tonsils, appendix, etc.)

Type of Operation	Date	Surgeon	Hospital	Location

Have you ever had a problem with anesthesia? Describe: _____	YES NO
Has anyone in your family ever had a problem with anesthesia? Describe: _____	YES NO
Have you ever had a problem during or after surgery? Describe: _____	YES NO
Have you ever had bleeding complications during or after surgery or dental procedure? Describe: _____	YES NO

MEDICAL HISTORY

Indicate ALL of your medical problems, conditions, diseases, and other disorders.

Cancer	YES	NO	Dialysis	YES	NO
Leukemia	YES	NO	Bladder problems	YES	NO
Lymphoma	YES	NO	History of Infections	YES	NO
Chemotherapy	YES	NO	Tuberculosis (TB)	YES	NO
Radiation Therapy	YES	NO	Pneumonia/Lung Inf.	YES	NO
High blood pressure	YES	NO	Urinary infections	YES	NO
Heart problems	YES	NO	Skin infections	YES	NO
Congestive heart failure	YES	NO	Hepatitis	YES	NO
Heart Murmur	YES	NO	HIV/AIDS	YES	NO
Heart Valve Problem	YES	NO	Birth Defect	YES	NO
Irregular Heartbeat	YES	NO	Inherited Conditions	YES	NO
Myocardial (heart attack)	YES	NO	Mental/Psychiatric	YES	NO
Lung Problem/Breathing	YES	NO	Degenerative Arthritis	YES	NO
Asthma	YES	NO	Rheumatoid Arthritis	YES	NO
Emphysema	YES	NO	Ankylosing Spondylitis	YES	NO
Pulmonary Embolus (clot)	YES	NO	Artificial replacement (joint surgery)	YES	NO
Seizures	YES	NO			
Stroke	YES	NO			
Endocrine problems	YES	NO	Vaginal/Uterus/Ovary problems	YES	NO
Thyroid problems	YES	NO	Penis/Scrotum/Testicle problem	YES	NO
Bleeding problems	YES	NO	Prostate problem	YES	NO
Sickle Cell disease	YES	NO			
Anemia	YES	NO			
Poor circulation	YES	NO			
Blood clots	YES	NO			

PROBLEMS WITH:

Esophagus/swallowing	YES	NO	Eyes	YES	NO
Stomach Problems/Ulcer	YES	NO	Ears	YES	NO
Liver problems/cirrhosis	YES	NO	Nose	YES	NO
Diabetes	YES	NO	Mouth/teeth	YES	NO
Intestine/Colon problem	YES	NO	Tongue	YES	NO
Rectrum/Anus problem	YES	NO	Throat/Voice	YES	NO
Kidney problems	YES	NO	Other problems	YES	NO

Are you taking steroid medication?	YES	NO
Are you taking nonsteroidal anti-inflammatory drugs (NSAIDS)?	YES	NO
Are you taking COUMANDIN/WARFARIN?	YES	NO

FAMILY HISTORY

	<u>Age if living</u>	<u>Medical condition</u>	<u>Deceased</u>	<u>Age at death</u>	<u>Cause of death</u>
Father	_____	_____	YES NO	_____	_____
Mother	_____	_____	YES NO	_____	_____
Brother(s)	_____	_____	YES NO	_____	_____
	_____	_____	YES NO	_____	_____
Sister(s)	_____	_____	YES NO	_____	_____
	_____	_____	YES NO	_____	_____
Child(ren)	_____	_____	YES NO	_____	_____
	(M/F)	_____	YES NO	_____	_____
(M/F)	_____	_____	YES NO	_____	_____
(M/F)	_____	_____	YES NO	_____	_____

Any medical problems with extended family (grandparents, uncles, aunts, cousins, grandchildren, great grandchildren)? YES NO

Describe: _____

OTHER HISTORY

Please list last 3 employers:

<u>Employer</u>	<u>Location</u>	<u>Occupation</u>	<u>Dates</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current marital status: _____

How many times have you been married? _____

Highest level of education? _____

Interests/Hobbies? _____

MEDICAL RISK FACTORS

In the past have you ever used:

	<u>Cigarettes</u>		<u>Cigars</u>		<u>Pipes</u>		<u>Chew</u>		<u>Other tobacco</u>	
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
No./day	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
No. years	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Which of the above are you currently using? _____

Alcohol Beer YES NO Bottles per day/week _____

Wine YES NO Glasses per day/week _____

Liquor YES NO Drinks per day/week _____

Illicit Drugs YES NO Type: _____

REVIEW OF SYSTEMS

Neurological

Periods of unconsciousness	YES	NO
Temporary episodes of leg Weakness	YES	NO
Temporary episodes of arm Weakness	YES	NO
Changes of smell	YES	NO
Changes in taste	YES	NO
Tremors	YES	NO
Gait disturbances	YES	NO
Blurred vision	YES	NO
Hearing loss	YES	NO
Temporary episodes of Blindness	YES	NO
Headaches	YES	NO

Musculoskeletal

Swelling in small joints Of hands	YES	NO
Pain in small joints of Hands and feet	YES	NO
Pain in large joints	YES	NO
Swelling in large joints	YES	NO
Fractures	YES	NO
Morning stiffness	YES	NO
Great toe pain	YES	NO
Muscle cramps	YES	NO
Calf pain with walking	YES	NO
Muscle wasting	YES	NO

Gastrointestinal

Swallowing difficulty	YES	NO
Heartburn	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Vomiting blood	YES	NO
Black/Tarry stools	YES	NO
Abdominal pain	YES	NO
Jaundice	YES	NO
Blood in stool	YES	NO
Diarrhea	YES	NO
Loss of appetite	YES	NO
Constipation	YES	NO

Cardiovascular

Shortness of breath	YES	NO
Palpitations	YES	NO
Chest pain on exertion	YES	NO
Resting chest pain	YES	NO
Ankle swelling	YES	NO
Chest tightness	YES	NO
Sleep on 3 or more pillows	YES	NO

Breast

Masses	YES	NO
Nipple discharge	YES	NO
Axillary nodes	YES	NO

Respiratory

Chronic cough	YES	NO
Wheezing	YES	NO
Pain with breathing	YES	NO
Coughing blood	YES	NO
Productive cough	YES	NO

?

Urinary frequency	YES	NO
Urinary urgency	YES	NO
Inability to urinate	YES	NO
Dribbling	YES	NO
Increase in amount of urine	YES	NO
Stones	YES	NO
Discharge	YES	NO
Venereal disease	YES	NO
Pelvic pain	YES	NO
Painful intercourse	YES	NO
Blood in urine	YES	NO

Constitutional Symptoms

Fever	YES	NO
Chills	YES	NO
Sweats (day/night)	YES	NO
Weight change (loss/gain)	YES	NO

PAIN DRAWING

Mark these drawings using the symbols that best describe your pain

Numbness ----- Aches ^^^^^^^^^^^^^^^^^^^ Pins and Needles 00000000

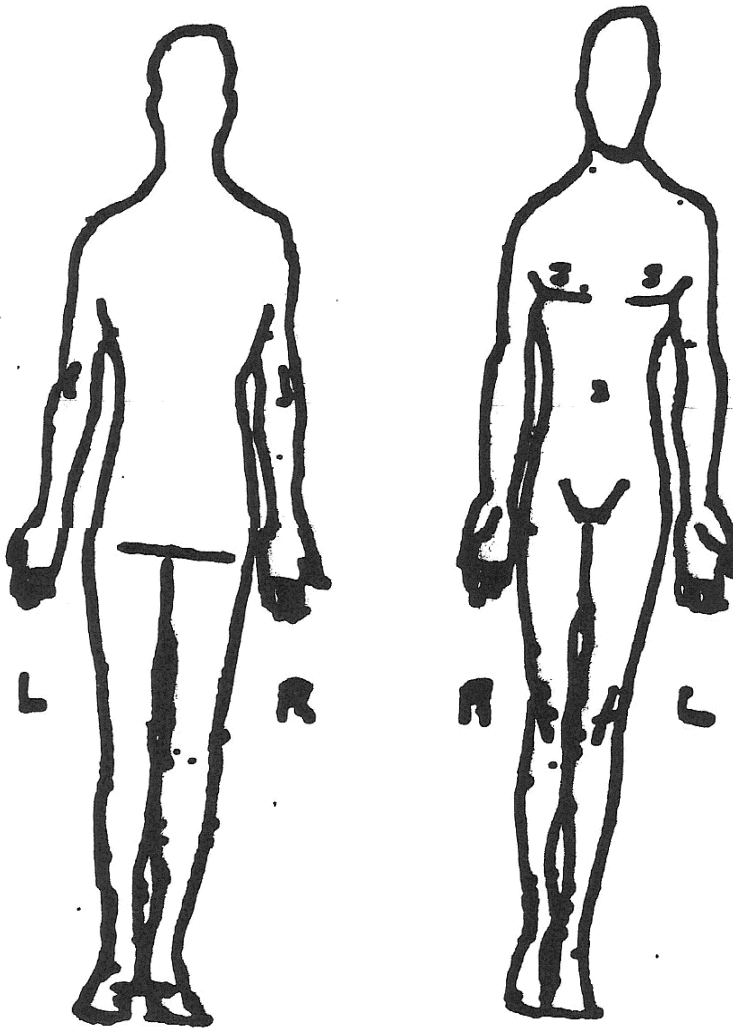
Stabbing //////////////// Burning \\\ Cramping :::::::::::::::::::::::

Pain in arm(s) compared to neck

Worse than:

Same as:

Less than:



Physicians signature Date

