COASTAL SPINE
INSTITUTE

Welcome to the Coastal Spine Institute. Patient satisfaction is our highest priority. Enclosed is a packet of information to help acquaint you with our office as well as prepare you for your initial appointment. Please arrive **15 MINUTES** prior to your scheduled appointment time so we have time to acquire any additional records prior to the provider seeing you.

We ask that the following items be brought to your initial appointment

1. Completed enclosed packet
2. Insurance Cards
3. Valid Photo ID
4. Medical records pertaining to what we are seeing you for (including x-ray images and reports, CT scan images and reports, MRI images and reports, etc.). PLEASE BRING THE CD WITH IMAGES.
5. A list of your current medications
6. Insurance referral (only if your insurance carrier requires one)
7. Co-pay (only if your insurance requires one)

if you arrive to the appointment without all the necessary information you may need to be rescheduled

Directions to the office are available on Google Maps

610 Ocean Hwy W
Supply, NC 28462
Phone 910-356-6100
Fax 949-404-6806
Questions about your appointment can be sent to info@coastalspineinstitute.com

COASTAL SPINE
INSTITUTE

Dear Patient,

Welcome and thank you for choosing us for your spine care needs! The Coastal Spine Institute is here to assist you with your spine care. Our medical and office staff strives to provide you with outstanding care and address your needs. We hope your visit with us exceeds your expectations.

We appreciate your careful consideration of the following guidelines, in accordance with the American Medical Association. Please do not ask the staff to make exceptions to this policy, as it can be disruptive to patient care.

FINANCIAL GUIDELINES

If you are unable to provide the office with complete healthcare insurance or Workers Compensation information, or if your insurance carrier does not cover visits and/or procedures, you will be asked to make full payments at the time of service. We may accept Letters of protection as arranged in advance with local attorneys in personal injury cases on a case by case basis. Please let us know in advance whom is representing you and the contact information for their office along with case information and date of injury.

Co-payments and/or deductible, depending on insurance status: are required prior to you seeing a Medical Provider. Our records with insurance carriers dictate co-payments and/or deductibles must be collected on the day of service. All outstanding balances are expected to be paid prior to the time of your next visit. Failure to do so will result in rescheduling your appointment.

Surgical deposits. Depending on your private insurance plan, a fully refundable pre-payment of $600 may be requested prior to scheduling your surgical procedure. This deposit will be fully refunded if you do not undergo the surgery. The deposit will be credited towards any co-payments due and refunded if not used.

Patients who lose/cancel/end their Healthcare insurance under the care of the Coastal Spine Institute will be given a 90 day time period to obtain insurance or risk being terminated from the practice under the guidelines of the American Medical Association Council on Ethical and Judicial Affairs.

Should you have any questions regarding billing issues or billing statements you receive please contact our practice manager at **(910) 356-6100**, Monday through Friday during regular business hours, excluding holidays.

Thank you

Kevin S. Cahill, MD, PhD, MPH

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE AND OR BALANCE NOT PAID BY MY INSURANCE.

Patient Signature Date

Signature of parent/guardian if minor Date

COASTAL SPINE INSTITUTE, PC
610 Ocean Hwy W, Supply, NC 28462

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from **Coastal Spine Institute, PC**. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

NEW PATIENT INTAKE FORM

COASTAL SPINE INSTITUTE

Name: _____

DOB: _____ Date: _____

REASON FOR VISIT

Please describe the major problem that brings you in today to see a spine surgeon:

_____

_____

Is this visit related to worker's compensation? ☐ No ☐ Yes

Is this visit related to any legal actions? ☐ No ☐ Yes

If this problem is the result of an accident, when did the accident occur? _____

Was it a motor vehicle accident? ☐ No ☐ Yes

When did the problem start? _____

What symptoms are you currently experiencing:

_____

_____

What test(s) have you had for your current problem?

❑ X-Rays When:	❑ CAT scan When:	❑ MRI Scan When:
❑ Bone Scan When:	❑ Electrical Tests When:	❑ Injections When:
❑ Blood Tests When:	❑ Discogram When:	❑ Other: When:

Which of the following treatments have you tried in the past for the condition? (Check all that apply)

❑ Anti-Inflammatory Medications
❑ Muscle Relaxants
❑ Antidepressants
❑ Anti-seizure Medications
❑ Trigger Point Injections
❑ Surgery
❑ Other:

❑ Chiropractic
❑ Narcotic Pain Medications
❑ Acupuncture
❑ TENS Unit
❑ Spinal Injections
❑ Pain Program

❑ Massage
❑ Yoga
❑ Meditation/Relaxation
❑ Pain Pump
❑ Spinal Stimulator
❑ Physical Therapy

Name: _____ DOB:_____

COASTAL SPINE
INSTITUTE

MEDICAL HISTORY

Height_____feet_____inches Weight_____pounds

Please list all **OPERATIONS** you have had. Date:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all **ACTIVE MEDICAL PROBLEMS**. Duration:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you **ALLERGIC** to any medicines, latex, x-ray dye, or iodine?

If yes, please explain: _____

Have you had any **PROBLEMS WITH ANESTHESIA**?

If yes, please explain: _____

Are you taking any **BLOOD THINNING MEDICATIONS**? ☐ Yes – indicate below ☐ No

☐ Aspirin or aspirin-containing medication
☐ Anti-inflammatory medication (for example, Advil, Motrin, Celebrex)
☐ Plavix
☐ Coumadin
☐ Fish oil
☐ Other:_____

Name: _____ DOB:_____

COASTAL SPINE INSTITUTE

REVIEW OF SYSTEMS

CARDIOVASCULAR

Chest pain/pressure	☐Y	☐N
Fainting	☐Y	☐N
Heart attack	☐Y	☐N
Heart defect	☐Y	☐N
Heart murmur	☐Y	☐N
High blood pressure	☐Y	☐N
Low blood pressure	☐Y	☐N
Leg swelling	☐Y	☐N

CONSTITUTIONAL

Altered taste/smell	☐Y	☐N
Change in appetite	☐Y	☐N
Excessive sleepiness	☐Y	☐N
Fatigue	☐Y	☐N
Fever	☐Y	☐N
Depression	☐Y	☐N
Anxiety	☐Y	☐N
Recent sore throat	☐Y	☐N
Sleep apnea	☐Y	☐N
Weight loss or gain	☐Y	☐N

EAR, NOSE, & THROAT

Hearing loss	☐Y	☐N
Mouth sores	☐Y	☐N
Ringing in ears	☐Y	☐N
Sinus disease	☐Y	☐N
Trouble swallowing	☐Y	☐N

EYES

Blurred vision	☐Y	☐N
Cataracts	☐Y	☐N
Double vision	☐Y	☐N
Glaucoma	☐Y	☐N
Macular degeneration	☐Y	☐N
Peripheral vision issue	☐Y	☐N
Visual impairment	☐Y	☐N

GASTROINTESTINAL

Black stool	☐Y	☐N
Constipation	☐Y	☐N
Diarrhea	☐Y	☐N
Gall bladder problems	☐Y	☐N
Ulcer	☐Y	☐N
Vomiting	☐Y	☐N

SKIN

Birth marks	☐Y	☐N
Psoriasis	☐Y	☐N
Skin rashes	☐Y	☐N
Melanoma	☐Y	☐N

RESPIRATORY

Asthma	☐Y	☐N
Bronchitis	☐Y	☐N
Chronic cough	☐Y	☐N
COPD	☐Y	☐N
Emphysema	☐Y	☐N
Pneumonia	☐Y	☐N
Shortness of breath	☐Y	☐N
Trouble breathing	☐Y	☐N
Tuberculosis	☐Y	☐N
Wheezing	☐Y	☐N

MUSCULOSKELETAL

Connective tissue disorder	☐Y	☐N
Low back pain	☐Y	☐N
Neck pain	☐Y	☐N
Joint pain	☐Y	☐N
Joint replacement	☐Y	☐N
Joint swelling	☐Y	☐N

GENITOURINARY

Blood in urine	☐Y	☐N
Change in habits	☐Y	☐N
Urinary infections	☐Y	☐N
Kidney disease	☐Y	☐N
Kidney stones	☐Y	☐N
Loss of control	☐Y	☐N
Painful urination	☐Y	☐N
Urinary urgency	☐Y	☐N
Vaginal bleeding	☐Y	☐N

HEMOLYMPHATIC/ ENDOCRINE

Anemia	☐Y	☐N
Blood disorder	☐Y	☐N
Circulatory problems	☐Y	☐N
Diabetes	☐Y	☐N
Dry eyes/mouth	☐Y	☐N
Endocrine disorder	☐Y	☐N
Low blood sugar	☐Y	☐N
Lymph node swelling	☐Y	☐N
Hepatitis	☐Y	☐N
HIV/AIDS	☐Y	☐N
Pituitary disorder	☐Y	☐N
Sickle cell disease	☐Y	☐N
Thyroid disease	☐Y	☐N

NEUROLOGICAL

Balance difficulty	☐Y	☐N
Choking	☐Y	☐N
Clumsiness	☐Y	☐N
Concussion	☐Y	☐N
Confusion	☐Y	☐N
Concentration difficulty	☐Y	☐N
Dizziness	☐Y	☐N
Drooling	☐Y	☐N
Falls	☐Y	☐N
Hallucinations	☐Y	☐N
Headache	☐Y	☐N
Loss of consciousness	☐Y	☐N
Memory problems	☐Y	☐N
Muscle twitching	☐Y	☐N
Nausea	☐Y	☐N
Numbness	☐Y	☐N
Personality change	☐Y	☐N
Seizure	☐Y	☐N
Shooting pains	☐Y	☐N
Smelling difficulty	☐Y	☐N
Stroke	☐Y	☐N
Tasting difficulty	☐Y	☐N
Tingling sensation	☐Y	☐N
Vertigo	☐Y	☐N
Walking difficulty	☐Y	☐N

Name: _____ DOB:_____

COASTAL SPINE INSTITUTE

SOCIAL HISTORY

Are you married? ☐ No ☐Yes ☐ Separated/divorced ☐Widow(er)

What is your **SMOKING** HISTORY?

☐ Currently smoke **every day** How much daily? _____
☐ Currently smoke **some days** How much weekly? _____
☐ Formerly smoked
☐ Never smoked

Do you drink alcohol? ☐ No ☐ Yes Drinks per day: _____
Use any recreational drugs? ☐ No ☐ Yes Please specify: _____
Prior alcohol or drug abuse? ☐ No ☐ Yes Please explain: _____

Do you participate in activities inside the home (i.e. vacuuming, cooking, general housework)?

☐ No ☐Yes
If yes, describe your level of activity: ☐Sendentary or light ☐Moderate ☐Strenuous

Do you participate in activities outside the home (i.e. gardening, golf, walking, cycling, volunteering)?

☐ No ☐Yes
If yes, describe your level of activity: ☐Sendentary or light ☐Moderate ☐Strenuous

What is the highest level of **EDUCATION** you have achieved? (Check one)

☐ Less than high school
☐ High school diploma or GED
☐ Two-year college degree
☐ Four-year college degree
☐ Post-college

Are you currently **EMPLOYED** (paid employee or self-employed)? (Check all that apply)

☐ Employed and currently working
  ☐ Full time
  ☐ Part time
☐ Employed but not working
  ☐ On short-term disability
☐ On leave
☐ Unemployed
  ☐ On disability
  ☐ Retired
  ☐ Homemaker
  ☐ None of the above
☐ Attending school

If disabled or unemployed, is this due to your **spinal condition**? ☐ No ☐Yes

Was your spinal condition work related? ☐Yes ☐No ☐Unknown

Which description best characterizes your occupation?

☐ Sedentary: requires the ability to sit up to 6 hours in an 8-hour work day, lift light objects such as files and paperwork frequently during the day, and objects weighing up to 10 pounds occasionally during the day
☐ Light: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 10 pounds frequently and up to 20 pounds occasionally
☐ Medium: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 25 pounds frequently and 50 pounds occasionally
☐ Heavy: requires the ability to stand up to 6 hours in an 8-hour work day, lift up to 50 pounds frequently and lift more than 50 pounds occasionally

Name: _____ DOB:_____

COASTAL SPINE
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FAMILY HISTORY

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancer, etc.) please list below.

Relationship_____Age_____Condition_____
Relationship_____Age_____Condition_____
Relationship_____Age_____Condition_____
Relationship_____Age_____Condition_____
Relationship_____Age_____Condition_____
Relationship_____Age_____Condition _____

Do you have children? ☐ No ☐Yes If yes, age(s) and condition

_____

_____

HEALTHCARE PROVIDERS

Please provide names and contact information for your current healthcare providers.

Primary care doctor: _____ Phone: _____
Pain management doctor: _____ Phone: _____
Orthopedic doctor: _____ Phone: _____
Neurology doctor: _____ Phone: _____
Cardiology doctor: _____ Phone: _____
Other doctor: _____ Phone: _____

SIGNATURES

This form is confidential and is part of your medical record.

Completed by: _____ _____ _____
Printed Signature Date

Reviewed by:_____ _____ _____
Printed Signature Date