

Spinal Institute of southern Utah

415 West Tabernacle, St. George, Utah 84770

Dr. M. Curtis Hobson – 435-656-1787

Patient Information

Welcome to my office! I am pleased that you have selected this office to assist you in treatment and management of your condition. I specialize in structural and nerve related conditions, also nutritional medicines and healthy lifestyles to prevent future disease. Examinations are done routinely to determine the nature and extent of problems. These exams may consist of chiropractic, orthopedic, neurological, x-ray and laboratory tests, ect., depending on what is necessary. The minimum fee for preliminary examinations with treatment is \$50.00. More detailed or specific examinations may be needed in complex or chronic cases to make an accurate diagnosis, which may add to the fee.

This office recognizes the responsibility of filing insurance claim forms for the patient, however, patients are held due and responsible for their bills to this office. In selected cases, Workman's Compensation and automobile accident insurance will suffice. Arrangements can be made with the insurance secretary.

The following information is necessary and confidential. **Please answer all questions.** If you do not understand or need assistance, please ask the receptionist.

PATIENT INFORMATION

DATE: _____

Last Name: _____ Birth Date: _____/_____/____ Age: _____
First name: _____ Marital Status: (circle) S M W Sep
Household Address: _____ Spouse: _____
Mailing Address: _____ Nearest Relative/Friend: _____
City: _____ State: _____ Zip: _____ (NOT in your household): Their Ph# ____/____/____
Hm. Ph# _____ WK. Ph# _____ Whom may we thank for referring you? _____
Cell. Ph# _____ Ht. _____ (in.) Wt. _____ (lbs)
Employer: _____ Occupation: _____

New HIPPA laws allow us to release your medical information to "only" those individuals or companies whom you deem appropriate. Please include a list of their names for this purpose (family, ect.) No other individuals or Co. will be allowed access to your medical information without an additional request from you. _____

RESPONSIBLE PARTY

Last Name: _____ Home Phone #: _____
First name: _____ Work Phone #: _____
Address: _____ Relationship to patient: _____
City: _____ State: _____ Zip: _____
Guardian's signature authorizing care (if patient is a minor): _____

INSURANCE INFORMATION (Provide insurance card to receptionist **OR fill in below)**

Insurance Company: _____ Policy ID# _____
Policy holders Name: _____ Policy holders birthday: _____/_____/____
Address: _____ Group#: _____
City: _____ State: _____ Zip: _____ Insured's Employer: _____

Please read carefully and sign:

I understand and agree that the health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Spinal Institute/staff will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to Dr. M. Curtis Hobson will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable and further, agree to pay the actual expenditures incurred in any attempt to collect the amount due. Including reasonable attorney's fees and costs. I certify that all the above information given is true and correct. A finance charge of 1.5% per month (annual Percentage rate of 18%) will be applied to any amount not paid after 60 days.

Patient or responsibility party's signature _____ Date _____

PLEASE COMPLETE INFORMATION ON BACK OF PAGE

Please check only the conditions you now suffer from

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Headaches (describe) _____ | <input type="checkbox"/> Difficulty in breathing | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tremors or seizures | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Rib pain |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tooth pain |
| <input type="checkbox"/> Bladder dysfunction (burning) | <input type="checkbox"/> Feet cold/ hands cold | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Colon dysfunction (evacuation pain) | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Obesity | <input type="checkbox"/> Ear pain |
| <input type="checkbox"/> Loss of sexual feeling | <input type="checkbox"/> Legs buckle involuntarily | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Hands drop objects involuntarily | <input type="checkbox"/> Swelling of _____ | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Weight gain of ___ lbs | <input type="checkbox"/> Loss of eye movement | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Weight loss of ___ lbs | <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Buzzing/ ringing in the ears | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Loss of voice | <input type="checkbox"/> Sore throat |

Medical Information and History- please check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Have you ever had cancer? | <input type="checkbox"/> Do your pains ever wake you from a sound sleep? |
| <input type="checkbox"/> Are you now losing weight without trying? | <input type="checkbox"/> Have you had any loss of bladder control? |
| <input type="checkbox"/> Are you seeing another doctor now for any reason? | <input type="checkbox"/> Have you noticed any blood in your stools or urine? |
| <input type="checkbox"/> Are you coughing up blood? | <input type="checkbox"/> Have you lost consciousness or had double vision recently? |

Information and history- please check all that apply – Present complaint is due to:

- On the Job Home Injury Auto Accident Illness Old Injury Disease Athletic Injury Poor Condition

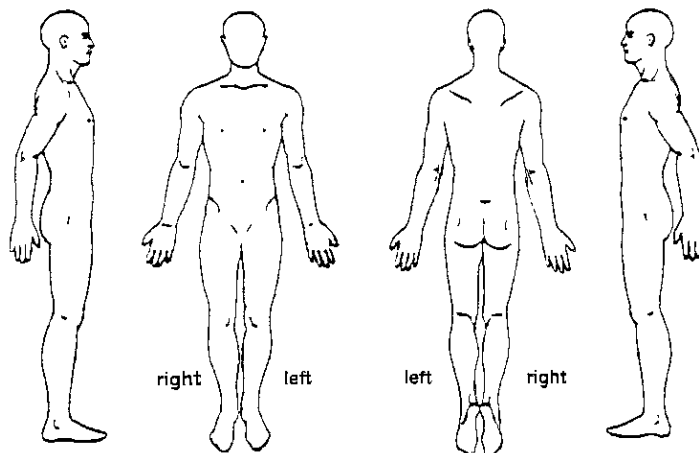
How often do you experience your symptoms?

- Constantly (76-100% of the day)
 Frequently (51-75% of the day)
 Occasionally (26-50% of the day)
 Intermittently (0-25% of the day)

How are your symptoms changing?

- Getting better
 Staying the same
 Getting worse

- | | |
|------------------|-----|
| Dull Ache | XXX |
| Pins and Needles | OOO |
| Numbness | --- |
| Burning | +++ |
| Stabbing | *** |
| Other _____ | ### |



Please fill in the pain diagrams to the right.

No Pain

Intolerable Pain

Worst [-----]

Best [-----]

Now [-----]

How bad are your symptoms at their:

Have you been treated for this condition? YES NO

If yes name and address of treating physician: _____

Please select the type of care desired so we can provide you with the best treatment and management of your condition.

- Relief care- Temporary or short-term care. Corrective care- Basic Stabilization/medium care.
 Comprehensive care – long-term/ultimate improvement. I would like to know what the doctor thinks is best for me.

List all pharmaceutical medication you are currently taking and the condition requiring their use. Don't forget non-prescription drugs.

- | | |
|----------|------------------|
| 1. _____ | Condition: _____ |
| 2. _____ | Condition: _____ |
| 3. _____ | Condition: _____ |
| 4. _____ | Condition: _____ |