Heartland spine

Franklin Hayward II, DO NEUROSURGEON

WELCOME TO HEARTLAND SPINE!

Enclosed please find information forms that need to be completed prior to your appointment. Please bring these completed forms with you at your appointment time on:

You will need to have your insurance cards with you at the time of your appointment and a list of all medications you are currently taking. If you have had x-rays, CT scans or MRI's, you will need to bring the actual films with you along with a copy of the report. If you have had EMG/Nerve Conduction Studies, Dr. Hayward will also need a copy of that report. You will also need to come prepared to pay any co-pay you may have.

Note that if you do not bring the actual X-ray, MRI or CT Scan films with you to your appointment, your appointment may be rescheduled.

If you have any questions, please feel free to contact our office at 573-331-5761. Dr. Hayward and his staff look forward to serving you.

Please tell us how you heard about our office____

MEDICATION REFILLS

Any patient needing a medication refill will need to make their request at least 3 days prior to needing the medication. Narcotic prescriptions must be signed by the physician and last minute requests could result in the patient not having the medication they need immediately.

Name: ________________________ Date:______________-

HEARTLAND SPINE LLC
3450 GORDONVILLE RD. STE 450
CAPE GIRARDEAU, MO 63703

Please List Any Persons whom we may inform about your medical condition, diagnosis, and treatment:

____

____

____

Please List Family Members or Significant Other, if any, whom we may inform about your medical condition or treatment ONLY IN AN EMERGENCY:

____

____

____

Please indicate if you want correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

Please print the TELEPHONE NUMBER where you want to receive calls regarding your appointments, test results or other health care information OTHER THAN YOUR HOME PHONE __________________. NOTE THAT A CELL PHONE NUMBER IS **NOT** A SECURE AND PRIVATE LINE.

May we leave messages regarding your appointments or testing results on your voicemail or answering machine? YES____ NO____

PATIENT SIGNATURE____________________ (GUARDIAN IF UNDER 18)

DATE____________________-

PATIENT NAME ______________________________

APPOINTMENT POLICY

Due to a high rate of missed appointments or patient's cancelling appointments at the last minute, we have been forced to develop a written policy.

We always keep each patient's best interest and feelings in mind in our practice, so this policy is only meant to try to gently encourage responsible patient behavior. This notice is to inform our patients of our policy and to avoid any misunderstanding.

1) If you miss three appointments without calling to cancel, it may be necessary to release you from the care of this practice. This is a neurosurgical practice and most patients need to be seen as soon as possible. If we have cancellations we can work patients in at an earlier date.

2) If you are 15 minutes or more late for your appointment, you do not have the paperwork completed that was mailed to you or you do not have the requested MRI or CT Scan films with you at the time of your appointment, your appointment will be rescheduled.

We want all of our patients to receive the best of care on the earliest possible date. All of the above is necessary for this to be accomplished.

Please initial below that you understand the above stated policy. If you have any questions, please feel free to ask any member of our staff.

PATIENT INITIALS____________________ DATE___________________________

PATIENT INFORMATION

DATE___________________

PATIENT NAME___________________

ADDRESS___________________

CITY___________________STATE___________ZIP___________________

HOME PHONE___________________CELL/OTHER___________________

SOCIAL SECURITY #___________________DATE OF BIRTH___________________

SEX: M/F MARITAL STATUS___________________M/S/D/W/OTHER

REFERRING PHYSICIAN_______________ PHYSICIAN PHONE NUMBER_______________

FAMILY PHYSICIAN_______________ PHYSICIAN PHONE NUMBER_______________

EMPLOYER___________________PHONE___________________

SPOUSE/RESPONSIBLE PARTY___________________

ADDRESS___________________

CITY___________________STATE___________ZIP___________________

PHONE___________________CELL/OTHER___________________

SOCIAL SECURITY #___________________DATE OF BIRTH___________________

EMERGENCY
CONTACT___________________RELATIONSHIP___________________

HOME PHONE___________________CELL/OTHER___________________

HEALTH
INSURANCE___________________ID#___________________GROUP_______________

IF VISIT DUE TO WORKER'S COMP INJURY OR MOTOR VEHICLE ACCIDENT (CIRCLE ONE)

WORKER'S COMP EMPLOYER/INSURANCE COMPANY Date of Injury _______________

____

ADDRESS___________________CITY_______________ZIP_________

CLAIM/INJURY #___________________CONTACT PERSON_______________

PHONE___________________EXT___________FAX_______________

ATTORNEY___________________ADDRESS___________________

CITY/STATE/ZIP___________________PHONE___________________

FAX___________________

Thank you for selecting us. To help us meet all of your healthcare needs, please fill this form out completely. If you have any questions, PLEASE ask and we will be happy to help.

PATIENT MEDICAL HISTORY:

Name: ______________________________ Today's Date: _____/_____/_____

Age: _____ Family Physician: ______________ Phone: __________________

1. Why are you here today? ____

2. When did your problems start? ____________________________________

3. What occurred at that time? ______________________________________

4. What problems did you experience at that time?_________________________

5. Have you ever had any similar problems in the past? YES NO If so,
When? ______________ What type of problems did you have? ________________
Who did you treat with? ____

6. Have you had any work-related or any other significant disabling injuries or illnesses?

7. Please list the names of any other doctors you have seen for this condition:
____

8. What is your greatest concern? ____________________________________

9. Where is your pain located? ______________________________________

10. What does it feel like? ____

11. What makes it worse? ____

12. What makes it better? ____

13. Is your pain: Constant? Intermittent? Occasional?

14. Please rate your pain on a scale of 0 (no pain) to 10 (worst): ________________

15. Are you having any other problems? YES NO ____________________________

16. What do you believe is causing your problem? __________________________

17. What tasks are most difficult for you? _______________________________

18. Do you believe this injury was work related? YES NO

19. If "yes" who were you working for at the time of the injury? __________________
20. What was your job? ____

21. What is your work status now? ____

22. Do you have any work restrictions imposed by a physician? YES NO

23. Please circle if you have any of these symptoms: fever, weight loss, shortness of breath, chest pain, bowel or bladder incontinence, blurry vision, swallowing difficulties, diarrhea, rashes, bleeding problems, hallucinations.

24. Do you smoke? YES NO If yes, how many packs during an average day? ___________
Did you smoke? YES NO If yes, when did you quit? __________
How many years did you smoke? __________

25. Do you drink alcohol? YES NO If yes, how many drinks during an average day? __________

26. List any disease that run in your family: ____

27. List any previous surgeries: ____

28. List any other medical problems for which you were hospitalized: ______________________
____

29. List any other medical problems: ____
(DIABETES, HIGH BLOOD PRESSURE, BLOOD DISORDERS, etc.)

30. Since our office may need to order an updated MRI for you, please answer the following:

A) Is there any metal, other than titanium, in your body? YES NO
B) Are you claustrophobic? YES NO
C) What is your weight? __________lbs What is your height? ________ft________in

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such healthcare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or medical group insurance benefits otherwise payable to me. I understand that my health insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Your Signature: ___________________________________Date: _____/_____/_____

Late Charge:

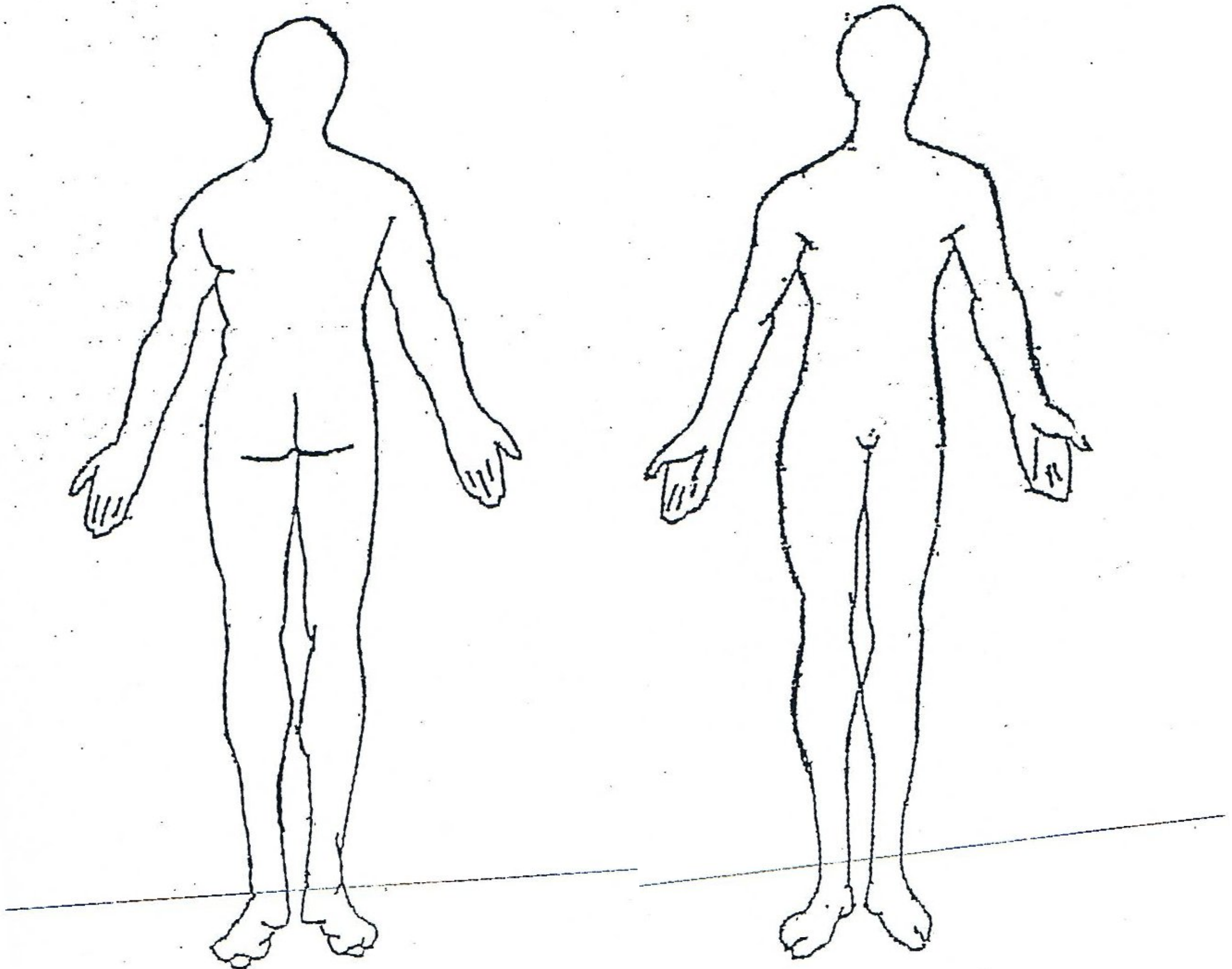
If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

PAIN DRAWING

Name: ______________________________________ Today's Date: ______/______/______

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
△△△	=====	000	XXX	////	000



MEDICATION LIST

Patient Name:______________________________ DOB: __________________________

Please List Any Drug Allergies:

____

____

Medication Name:	Dosage:	Prescribed by: (Dr.)	Reason Taking:

Pharmacy(s) used in the last year (Name and phone number):

1.____

2.____

3.____

Board Eligible in Neurological Surgery

Date: ______________________________

Patient: ____
Employer: ______________________________________
Insurance Co:____________________________________
SSN/ID#:____

I hereby instruct and direct ____________________________________Insurance Company to pay by check made out and mailed to: Heartland Spine LLC, 3250 Gordonville Rd., Suite 450, Cape Girardeau, MO 63703.

Or, if my current policy prohibits direct payment to the doctor, I hereby instruct and direct you to make the check out to me and mail it to my home, address as follows: ___________________________
____,
for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, and said balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustors, physicians, assignees, and/or beneficiaries or any attorneys involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Date:____

____
Signature of Policy Holder

____
Witness

____
Signature of Claimant, if other than policy holder.

All physicians at Heartland Spine participate in the training of Senior Neurosurgical residents. These residents may or may not participate in your care and treatment.

If for any reason you prefer a resident not to participate in all or any portion of your care, please inform the office of such.

I understand the above and give permission to my treating physician at Heartland Spine to implement the services of a Senior Neurosurgical resident in the course of my care and treatment.

____

Patient signature

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back and leg pain is affecting your ability to manage in everyday life. Please answer by checking one box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1: Pain Intensity

- ❑ I have no pain at the moment
- ❑ The pain is very mild at the moment
- ❑ The pain is moderate at the moment
- ❑ The pain is fairly severe at the moment
- ❑ The pain is very severe at the moment
- ❑ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, dressing)

- ❑ I can look after myself normally without causing extra pain
- ❑ I can look after myself normally but it causes extra pain
- ❑ It is painful to look after myself. I am slow and careful
- ❑ I need some help. I can manage most of my personal care
- ❑ I need help every day in most aspects of self-care
- ❑ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ❑ I can lift heavy weights without extra pain
- ❑ I can lift heavy weights but it gives me extra pain
- ❑ Pain prevents me lifting heavy weights off the floor but I can manage if conveniently placed, e.g., on a table
- ❑ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned

Section 4: Walking

- ❑ Pain does not prevent me walking any distance
- ❑ Pain prevents me from walking more than 1 mile
- ❑ Pain prevents me from walking more than half a mile
- ❑ Pain prevents me from walking more than 100 yards
- ❑ I can only walk using a stick or crutches
- ❑ I am in bed most of the time

Section 5: Sitting

- ❑ I can sit in any chair as long as I like
- ❑ I can only sit in my favorite chair as long as I like
- ❑ Pain prevents from me sitting more than one hour
- ❑ Pain prevents me from sitting more than 30 minutes
- ❑ Pain prevents me from sitting more than 10 minutes
- ❑ Pain prevents me from sitting at all

Section 6: Standing

- ❑ I can stand as long as I want without extra pain
- ❑ I can stand as long as I want but it gives me extra pain
- ❑ Pain prevents me from standing for more than 1 hour
- ❑ Pain prevents me from standing more than 10 minutes
- ❑ Pain prevents me from standing more than 10 minutes
- ❑ Pain prevents me from standing at all

Section 7: Sleeping

- ❑ My sleep is never disturbed by pain
- ❑ My sleep is occasionally disturbed by pain
- ❑ Because of pain I have less than 6 hours sleep
- ❑ Because of pain I have less than 4 hours sleep
- ❑ Because of pain I have less than 2 hours sleep
- ❑ Pain prevents me from sleeping at all

Section 8: Sex Life (is applicable)

- ❑ My sex life is normal and causes no extra pain
- ❑ My sex life is normal but causes some extra pain
- ❑ My sex life is nearly normal but is very painful
- ❑ My sex life is severely restricted by pain
- ❑ My sex life is nearly absent because of pain
- ❑ Pain prevents any sex life at all

Section 9: Social Life

- ❑ My social life is normal and gives me no extra pain
- ❑ My social life is normal but degree of pain increases
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ❑ Pain has restricted my social life. I do not go out often
- ❑ Pain has restricted my social life to my home
- ❑ I have no social life because of pain

Section 10: Travelling

- ❑ I can travel anywhere without pain
- ❑ I can travel anywhere but it gives me extra pain
- ❑ Pain is bad but I manage journeys over two hours
- ❑ Pain restricts me to journeys of less than one hour
- ❑ Pain restricts me to short necessary journeys under 30 minutes
- ❑ Pain prevents me from travelling except to receive treatment

NECK DISABILITY INDEX

Please read carefully: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please circle the LETTER that most closely describes your situation.

1 Pain Intensity
A. I have no pain at the moment
B. The pain is very mild at the moment
C. The pain is moderate at the moment
D. The pain is fairly severe at the moment
E. The pain is very severe at the moment
F. The pain is the worst imaginable at the moment

2. Personal Care (washing, dressing, etc)
A. I can look after myself normally without causing extra pain
B. I can look after myself normally but it causes extra pain
C. It is painful to look after myself and I am slow and careful
D. I need some help but manage most of my personal care
E. I need help every day in most aspects of self care
F. I do not get dressed, wash with difficulty and stay in bed

3. Lifting
A. I can lift heavy weights without extra pain
B. I can lift heavy weights but it gives me extra pain
C. Pain prevents me from lifting heavy weights off the floor,
but I can manage if they are conveniently positioned, e.g.
on a table
D. Pain prevents me from lifting heavy weights, but I can
manage light to medium weights if they are conveniently
positioned
E. I can lift only very light weights
F. I cannot lift or carry anything at all

4. Reading
A. I can read as much as I want with no pain in my neck
B. I can read as much as I want with slight pain in my neck
C. I can read as much as I want with moderate pain in my
neck
D. I cannot read as much as I want because of moderate pain
in my neck
E. I can hardly read at all because of severe pain in my neck
F. I cannot read at all

5 Headaches
A. I have no headaches at all
B. I have slight headaches which are infrequent
C. I have moderate headaches which are infrequent
D. I have moderate headaches which are frequent
E. I have severe headaches which are frequent
F. I have headaches almost all the time

6. Concentration
A. I can concentrate fully when I want to with no difficulty
B. I can concentrate fully when I want to with slight difficulty
C. It is fairly difficult to concentrate when I want to
D. I have a lot of difficulty concentrating when I want to
E. I have a great deal of difficulty concentrating when I want
to
F. I cannot concentrate at all

7. Work
A. I can do as much work as I want to
B. I can only do my usual work, but no more
C. I can do most of my usual work, but no more
D. I cannot do my usual work
E. I can hardly do any work at all
F. I cannot do any work at all

8. Driving
A. I can drive without any neck pain
B. I can drive as long as I want with slight pain in my neck
C. I can drive as long as I want with moderate pain in my neck
D. I cannot drive as long as I want because of moderate pain
in my neck
E. I can hardly drive at all because of severe pain in my neck
F. I cannot drive my car at all

9. Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hr. sleepless)
C. My sleep is mildly disturbed (1-2 hrs. sleepless)
D. My sleep is moderately disturbed (2-3 hrs. sleepless)
E. My sleep is greatly disturbed (3-5 hrs. sleepless)
F. My sleep is completely disturbed (5-7 hrs. sleepless)

10 Recreation
A. I am able to engage in all my recreational activities with no neck pain at all
B. I am able to engage in all my recreational activities with some pain in my neck
C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck
D. I am able to engage in a few of my usual recreational activities because of pain in my neck
E. I can hardly do any recreational activities because of pain in my neck
F. I cannot do any recreational activities at all