

CENTER FOR DISEASES AND SURGERY OF THE SPINE

INTERNATIONALLY RECOGNIZED SPINE CARE

John S. Thalgott, M.D.

Specializing in Orthopedic Spine Surgery

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WELCOME TO THE CENTER FOR DISEASES AND SURGERY OF THE SPINE

The Center for Diseases and Surgery of the Spine was organized to provide a specialized facility for comprehensive diagnosis and treatment of all spinal disorders. Our surgeon is fellowship trained in spine surgery and board certified.

The Center for Diseases and Surgery of the Spine staff is a multidisciplinary team. Our staff includes a physician (surgeon), physician assistant, clinical assistants, operating room assistant, x-ray technicians and front office staff. Each member plays an important role in assisting in your understanding of your medical condition, evaluation and treatment.

We are committed to quality patient care, education, and research.

Before your scheduled appointment with Dr. Thalgott you are required to come to a pre-workup appointment scheduled on _____ to discuss information regarding your injury/pain, so the doctor can review your concerns before your appointment. **If you do not come to the pre-work up appointment the doctor's appointment will be rescheduled or canceled.** Upon arrival to the office you must have your paper completely filled out, your insurance card, and picture ID. Your appointment is scheduled with Dr. Thalgott on _____.

Please bring all x-rays, MRI, CT scans, and any other tests (not just reports, but the actual films or CD) with you to your appointment. Failure to bring these to your appointment may result in cancellation of your appointment.

CENTER FOR DISEASES AND SURGERY OF THE SPINE

PATIENT INFORMATION (Please Print Clearly)

Patient Name: _____ Date: _____

Email Address: _____

Married: __ Single: __ Divorced: __ Widow (er): __ Female: __ Male: __ Smoker: __ Nonsmoker: __

Height: _____ Weight: _____ Birth Date: _____ Age: _____

Guardian/if minor: _____ Social Security #: _____

Address: _____ Spouse Name: _____

City: _____ State: _____ Zip: _____ Spouse Employer: _____

Home Phone #: _____ Referring Physician: _____

Referring Physician Address: _____

Emergency contact: (nearest relative not living with you)

Name: _____ Relation: _____

Address: _____ Phone#: _____

[] Legal Case: I authorize release of information to the named attorney:

Attorney Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____

EMPLOYER/INSURANCE INFORMATION

EMPLOYER:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Ext: _____

Are you on Welfare? Yes: ___ No: ___

INSURED PARTY IF OTHER THAN PATIENT

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birth Date: _____ SS# _____

Relation to Patient: Self: ___ Spouse: ___ Parent: ___ Other: ___

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____

Group #: _____ Adjuster: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____

Group #: _____

I will be paying today by: [] Cash [] Check # _____ [] Master/Visa Card

AUTHORIZATION

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information. I hear by authorize my insurance benefits be paid directly to the physician and I understand that I am financially responsible for non-coverage services. In the event of collection proceedings due to lack of payment on my part, I agree to pay and all collection fees that may be added to my account in order to recover monies due to your clinic. I also authorize the physician and / or insurance companies to release any information required to process this claim.

**All information was explained to this patient in Spanish or _____ and this patient indicates that he/she understands.

INTERPRETERS SIGNATURE: _____

Patient/Guardian Signature: _____ Date: _____

1. Where does it hurt? _____

2. What date did your pain start? _____
3. Previous problems related to this visit (same body part) _____ Date: _____

4. MEDICINES-List them, please: _____

5. Have you ever been denied insurance for medical reasons? Yes ___ No ___
6. Are you pregnant or do you think you might be? Yes ___ No ___
7. Have you been treated for your present problems? Yes ___ No ___
If yes when _____
By whom _____
8. Have x-rays been made? Yes ___ No ___
If yes when _____
Where _____
9. Have laboratory tests been made? Yes ___ No ___
If yes when _____
Where _____
10. Has this problem disabled you from working? Yes ___ No ___
11. **Allergies**-list them, please _____

12. **Previous Surgeries**-list them, please _____

13. **Previous Illnesses**-list them, please _____

14. **Previous Serious Injuries**-list them, please _____

Signature of Patient or Guardian

Date

NAME: _____

DATE: _____

PLEASE READ:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box which applies to you. We realize you may consider that 2 of the statements in any one section relate to you but please just mark the box which most closely describes your problems.

Section 1 – Pain Intensity

- I can tolerate the pain I have without having to use pain killers.
- The pain is bad but I manage without taking pain killers.
- Pain killers give me complete relief from pain.
- Pain killers give me moderate relief from pain.
- Pain killers give very little relief from pain.
- Pain killers have no effect on pain. I do not use them.

Section 2 – Personal Care (Washing, Dressing, etc.)

- 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 and I am slow and careful.
- I need some help but 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 from lifting heavy objects off the floor but I can lift heavy objects if they are on a table
- Pain prevents me from lifting heavy weights off the floor but I can manage if light and medium weights are conveniently positioned (for example on a table).
- I can lift only very light weights.
- I cannot lift or carry anything at all.

Section 4 – Walking one Block

- Pain does not prevent me from walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ½ mile.
- Pain prevents me walking more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

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 me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- 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 pain.
- Pain prevents me from standing more than 1 hour.
- Pain prevents me from standing more than 30 minutes.
- Pain prevents me from standing more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 – Sleeping

- Pain does not affect my sleep.
- Pain occasionally interrupts my sleep.
- Pain interrupts my sleep half the time.
- Pain often interrupts my sleep.

- Pain always interrupts my sleep.
- I never sleep well.

Section 8 – Sex Life

- 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 increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of pain.

Section 10 – Traveling

- I can travel anywhere without extra 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 traveling except to the doctor or hospital

NAME: _____

DATE: _____

Please answer the following questions about your pain in as much detail as possible

1. What is the approximate start date of the pain you are currently experiencing?

Answer

2. What percent of your waking hours do you have pain?

Answer

Please respond to the following questions with a value of 0-10.

1. With respect to your physical condition, rate your present disability level (0 means no disability, 10 means total disability)

2. What is your present pain level? (0 is no pain, 10 is unbearable pain)

3. What is your least pain level? (0 is no pain, 10 is unbearable pain)

4. What is your worst pain level? (0 is no pain, 10 is unbearable pain)

Pain Location

Put an **X** mark next to the statements that best describe your present pain location. Put two **XX** marks next to the statements that describe your worst pain.

	Right	Left	Front	Back	Top
Neck	_____	_____	_____	_____	_____
Upper Back	_____	_____	_____	_____	_____
Shoulder	_____	_____	_____	_____	_____
Arm	_____	_____	_____	_____	_____
Mid-back	_____	_____	_____	_____	_____
Low back	_____	_____	_____	_____	_____
Thigh	_____	_____	_____	_____	_____
Buttocks	_____	_____	_____	_____	_____
Calf	_____	_____	_____	_____	_____
Knee	_____	_____	_____	_____	_____
Ankle	_____	_____	_____	_____	_____

John S. Thalgott, M.D.

**PLEASE READ THE FOLLOWING CAREFULLY:
PLEASE BE AWARE OF OUR OFFICE POLICIES REGARDING TELEPHONE
COMMUNICATION WITH OUR OFFICE AND PLEASE SIGN THE BOTTOM OF
THIS FORM INDICATING THAT YOU UNDERSTAND. IF YOU HAVE QUESTIONS,
PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM ANY
MEMBER OF OUR STAFF.**

Office hours are 9:00 am. to 5:00 pm. Monday thru Thursday and 9:00 am. until 1:00 pm on Friday. All routine telephone calls to the office should be made during these hours.

I hereby authorize and request John S. Thalgott M.D. to release my complete medical records (including x-rays) when referring to other facilities concerning my treatment at our facility. Patient initials: _____

I hereby assign to John S. Thalgott, M.D., Physicians Assistants, surgical techs, and/or all benefits for surgical and medical care payable under the attached policy and/or policies. I also authorize release of information to secure payment. A photocopy of this assignment is to be considered valid as the original. Patient initials: _____

I understand that I am financially responsible for all services rendered whether or not paid by said insurance. Payment is expected at the time of service. We accept Visa and MasterCard for your convenience. If you are on a lien, it is your responsibility to notify this office in writing if there are any changes in your legal representation. Any services performed prior to this office receiving written notification to bill insurance will be the patient's sole responsibility due to insurances having to be billed in a timely manner or they will not pay. There will be a charge of \$25 for all returned checks. Patient initials: _____

I hereby consent to have myself photographed by CDSS or a designated assistant. I understand that the photographs are to be used for purposes of documentation and evaluation of my treatment and will be treated as part of my medical record. I give my permission for these materials to be used by CDSS to assist in my treatment. Patient initials: _____

ORTHOPAEDIC OR SPINAL EMERGENCIES USUALLY REQUIRE HOSPITAL ADMISSIONS. IF YOU SHOULD FIND YOURSELF IN THAT EMERGENCY SITUATION, PLEASE GO TO THE NEAREST HOSPITAL EMERGENCY ROOM AND SOMEONE WILL REACH YOUR PHYSICIAN THROUGH THE ANSWERING SERVICE. PLEASE KEEP IN MIND THAT ON SOME WEEKENDS THERE WILL BE OTHER SURGEONS COVERING YOUR DOCTOR'S PRACTICE AND THEREFORE, YOU MAY BE SEEN BY SOMEONE OTHER THAN YOUR DOCTOR.

PATIENT/GUARDIAN SIGNATURE

DATE

John S. Thalgott, M.D.

MEDICATION POLICY

If you are prescribed medication during your treatment, there are several guidelines you must follow.

1. The medications given to you should be taken as prescribed by your doctor. The medications may not be used for any other purposes than that which they were given to you. These medications may not be given or sold to any other individual.
2. You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specific time. It is your responsibility to have follow-up appointments scheduled far enough in advance so that you do not run out of your medication.
3. Requests for medication refills will only be considered during regular office hours Monday-Thursday 9:00am-5:00pm and Friday 9:00am to 1:00pm. No refills will be given after hours, weekends or holidays.
4. Requests for medication refills should be called to your pharmacy who will, in turn, call our office. **Please allow 48 hours for this procedure.** No refills of medications will be given if you have not been seen **for 3 months**. Your refill will need to be reviewed by your physician and may not be refilled until you have been seen again. It is your responsibility to make a follow-up appointment with your doctor. **This will be strictly enforced.**
5. If you call for medications or refills outside of regular office hours, you will be instructed to go to the emergency room. There, you will be evaluated by an emergency room physician who will decide whether or not to refill your medication. Emergency Department Policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the Emergency Department is busy, you may be required to wait a long period of time to be seen.
6. While under the doctor's care, all pain medications will be given at the doctor's discretion. **Do not seek pain medication from any other physicians. Breaking these rules will be grounds for termination of your treatment.**
7. Telephone requests for prescriptions renewals are accepted only during regular business hours. In some instances there is a 24-hour waiting period before prescriptions will be refilled, so call for your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

Patient's Signature (or parent if patient is a minor)

Date

Authorization for the Use/Disclosure of Protected Health Information

John S. Thalgott, M.D

Center for Diseases and Surgery of the Spine
600 South Rancho Drive Ste. 107
Las Vegas, NV 89106

I, _____ hereby authorize the use and disclosure of *ALL* personal health information contained in my medical office chart at this facility, as well as all radiological films and tests performed at this facility or other health care facilities.

I understand that though personally identifiable information about me including but not limited to: my name, address, phone number, employer, and social security number, may be viewed by other healthcare professionals both inside and outside this facility.

I authorize all agents of the following corporate entities to view or receive copies of my health information including radiological films, test results, and written reports from other facilities where I have received treatment:

**Center for Diseases and Surgery of the Spine
600 South Rancho Drive Ste. 107
Las Vegas, NV 89106**

I understand that I may revoke this authorization at any time in writing and return it to: Center for Diseases and Surgery of the Spine, 600 South Rancho drive Ste. 107, Las Vegas, NV 89106. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I further understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that this authorization meets all Nevada Laws (NRS. 629.061) and any laws under the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

My signature on this authorization form supercedes any and all other authorizations regarding use and disclosure of my private medical information (PHI) at other facilities.

Signature

Date

Social Security Number

Date of Birth

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Specializing in Orthopedic and Spine Surgery

JOHN S. THALGOTT, M.D.

Authorization of Use and Disclosure of Protected Health Information

Date: _____

_____ hereby authorize the use and
(PRINT YOUR NAME)
disclosure of my medical records to:

(PERSON OR INSTITUTION RECEIVING RECORDS)

The medical records I wish to release are as follows:

- ALL my medical records.
- Only the following item(s): _____

I would like to:

- Pick up my medical records. Phone number: _____
- Have my records faxed to: _____
Phone number: _____ Fax number: _____
- Have my medical records mailed to: _____

Patient's Signature*: _____

*The use of the information disclosed under this authorization will no longer be protected by the Center and may be disclosed again by the person or institution to which this is sent. This authorization is also valid until I revoke or terminate this authorization by submitting a *written* revocation. I also understand that there may be a fee of sixty cents per page as provided by Nevada law.

Office Use Only

Patient Account Number: _____

ACCIDENT INJURY QUESTIONNAIRE

PATIENT NAME: _____

SSN/ID#: _____

1. When did the illness or injury occur? Date: _____ Time of Day: _____ ()am ()pm

2. Where did the illness or injury occur?

3. How did the illness or injury occur?

4. Do you believe your illness/injury was work related? ()YES () NO

5. Did you report the condition to anyone? ()YES () NO

If yes, to whom? _____ Date: _____

6. Do you expect to receive, or have you been provided with, Workers' Compensation benefits? ()YES () NO

(Note: Workers' Compensation is not the same as State Disability.)

7. Is treatment for an auto accident? () YES () NO

If yes, what was the date of accident? _____

How did the accident happen?

Where did the accident occur?

What time of day did accident occur? _____ ()am ()pm

PATIENT SIGNATURE

DATE: _____