PATIENT MEDICAL HISTORY

ALLERGIES: (Please circle all that apply)

Adhesive tape, Anesthesia, Aspirin, Codeine, Dairy Products, Iodine/Shellfish/Contrast, Latex, Morphine, Penicillin

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you drink alcohol?☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you smoke? (___ packs per day)
☐**Yes** ☐ **No -** Do you drink caffeine? ☐ Daily ☐ Weekly
☐**Yes** ☐**No –** Are you sexually active?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following? (Please circle all that apply)

Anemia, Bleeding problems, Asthma, Allergies, Arthritis, Celiac disease, Cardiac arrest, Cancer, BPHCAD, coronary artery disease, Congestive heart failure, Depression, GERD, Drug/alcohol abuse, Chronic fatigue syndrome, Diabetes, Chest pain, Fibromyalgia, Erectile dysfunction, Heart disease, Hyperinsulinemia, Hyperlipidemia, Onychomycosis, Hypertension, Hypogonadism, Hypothyroidism, Infection problems, Neuropathy, Insomnia, Organ injury, Migraines/headaches, Irritable Bowel Syndrome, Kidney problems, Menopause, Pulmonary embolism, Shortness of breath, Seizure disorders, Osteoporosis, Wheat allergy, Sinus conditions, Syndrome X, Tremors, Stroke

Medications: List any medications you are currently taking (please include over the counter medications):

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Valor Spine Solutions assisting my care.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Valor Spine Solutions for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Valor Spine Solutions to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Valor Spine Solutions charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Valor Spine Solutions to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Valor Spine Solutions any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Valor Spine Solutions to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Valor Spine Solutions to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "HIPAA Agreement" of Valor Spine Solutions. Our "HIPAA Agreement" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "HIPAA Agreement " is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Valor Spine Solutions at 262-98VALOR.

In House Pharmacy: I understand that for my convenience, Valor Spine Solutions can dispense some prescription medications necessary to treat my medical condition(s). I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

Personal Valuables: Valor Spine Solutions shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property. Valor Spine Solutions, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: _____ Date: _____