Fort Sanders Neurosurgery and Spine

Paul C. Peterson, M.D.
501 20th Street, Suite 503
Knoxville, TN 37916
Phone: 865-331-4321

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):	SSN#	Birthdate	Age	Sex

Mailing Address	City, State, Zip

Home Phone	Cell Phone	Email Address

Marital Status	Student Status	Smoker?	Veteran (Y/N)?	Ethnicity: Hispanic or	Primary Care Physician
	☐Full-Time ☐Part-Time	Yes or No		Non-Hispanic	

Referring Physician	Referring Physician Contact #	Other Medical Providers

Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White	Language

Emergency Contact Name	Emergency Contact Phone #s
	Hm: Cell:

Employer Name and Address	Work Phone #

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s
	Hm: Wk: Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle	SSN#	Birthdate	Sex

Address	City, State, Zip

Home Phone	Cell Phone	Work Phone	Relationship to patient

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES_____NO_____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____

Do you have a Power of Attorney? Yes_____ No_____

If yes to the above questions please make sure we have a copy for your medical record.

Covenant
Medical Group

Covenant Medical Group, Inc. ("CMG") Physician
Practice Patient Registration Agreement

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND RELATED SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees, including pharmacists and other professionals who are part of the healthcare team. The undersigned acknowledges and agrees treatment at the Practice also may be furnished by a resident physician (a medical school graduate supervised by a physician). The undersigned additionally consents to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds appropriate or medically necessary, as well as any supervising physician's remote video monitoring of resident physicians. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question or refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and associated professionals and staff shall be released from any and all liability for failure to provide treatment to thepatient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio, video, and other electronic communications), patient portal communications, and by telephone (collectively, "Virtual Services"). **RISKS AND BENEFITS:** Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision- making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. While a patient may expect the anticipated benefits from the use of telehealth, no results can be guaranteed. It is the patient's duty to inform his or her physician of electronic interactions that the patient may have with other health care providers. **CONSENT TO TREATMENT VIA VIRTUAL SERVICES:** By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due. The undersigned hereby authorizes CMG, the Practice, and all health care professionals providing care to patient at the Practice, together with any billing service, collection agency, attorney, or other individual or entity working on their behalf, to contact the patient and patient's representatives by cellular and home telephone using prerecorded or artificial voice messages, automatic telephone dialing systems or other computer-assisted technology, text messages, and other forms of electronic communication.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to CMG's/the

practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. The undersigned further assigns to CMG, Practice, and any of its parent entities, affiliates, subsidiaries, or assigns any and all rights and benefits the patient has or may become entitled to under any policy of insurance, any type of health plan under the Employee Retirement Income Security Act (ERISA), whether self-funded or otherwise, indemnity agreement, or from any other collateral source or third-party payor of any kind or nature, including all the rights to collect benefits directly from any insurance company, indemnity agreement, health plan covered by ERISA, or from any other collateral source or third-party payor of any kind or nature, and any and all right to proceed against the same in any action, including legal suit, if for any reason any of the same should fail to make payment of benefits due. It is patient's intent to assign to the fullest extent possible any and all rights patient has under ERISA to CMG and any of its parent entities, affiliates, subsidiaries or assigns without limitation. The patient further assigns to CMG and any of its parent entities, affiliates, subsidiaries or assigns, the right to the proceeds to pay the chargemaster rate for patient's bill from any claim and/or any action at law or equity for personal injuries which patient may have to the extent allowed by law. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. **The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services.** If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICES OF PRIVACY PRACTICES AND NONDISCRIMINATION; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices (NPP), which is provided at Https://www.covenanthealth.com/privacy-notice/ and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with the NPP, including without limitation, for purposes of the treatment, payment, and health care operations functions described in the NPP, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required. The undersigned additionally acknowledges receipt of the Practice's Notice of Nondiscrimination.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to the Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. ADVANCE CARE PLAN/HEALTH CARE DECISIONMAKER.

Is the patient providing a copy of an advance care plan to include in the patient's medical record today (e.g., living will)?

☐ **Yes*** ☐ **No**

**if yes, provide patient's health care provider with a copy of advance care plan so it can be included in the patient's medical record*

Does the patient want to name a surrogate health care decision maker?

☐ **Yes*** ☐ **No**

**If yes, name of surrogate health care decision maker:* _____ *and relationship to patient:* _____

X.* CONTACTING PATIENT.** Patient may be contacted at the following number: _____. In addition, ***please check one:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name: _____ Relation to patient: _____ Phone: _____

Name: _____ Relation to patient: _____ Phone: _____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than the patient.

Covenant
Medical Group

Covenant Medical Group, Inc. ("CMG") Physician
Practice Patient Registration Agreement

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF. A COPY OF THIS AGREEMENT WILL BE PROVIDED ON REQUEST.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ Printed Name _____

Patient Name _____ Relationship to Patient _____

Date and Time _____

Fort Sanders Neurosurgery and Spine

Paul Peterson, M.D.
501 20th Street, Suite 503
Knoxville, TN 37916
Phone: 865-331-4321

Patient Health History
CHIEF COMPLAINT

Referring MD: _____
PCP: _____
Chart #: _____

Patient Name: _____ Date of Birth: _____ Age: _____
Reason for visit? _____
Do you have leg pain? *(circle one)* Right Left Both Do you have arm pain? *(circle one)* Right Left Both
Do you have weakness? ____ Where? _____ Do you have numbness? _____ Where? _____
Is your problem due to accident? ____Car ____Work ____Other ____No If accident, date_____
Date of onset of symptoms: _____
Average Pain Level *(1to10)* _____ Constant _____ Intermittent _____
Able to work ____Yes ____No Last date worked: _____
Treatment for this problem to date: *(circle all that apply)*

PAIN MEDS	NSAID	STEROIDS	PT	CHIROPRACTOR	TESTS *(Indicate Date)*
Hydrocodone	Ibuprofen	Oral	#_____	#_____	MRI
Oxycodone	Aleve	Injection	Visits	Visits	CT
Tramadol	Advil	Epidural			Myleogram
Flexeril	Mobic				X-Ray
Robaxin	Other				EMG

Have Your Symptoms Improved With Treatment? ____Yes ____No

PAST ILLNESSES *(Circle All That Apply)*			
Hypertension	Diabetes	GERD	Sleep Apnea
Coronary Artery Disease	COPD	Anxiety	Other:
High Cholesterol	Asthma	Depression	

PAST SURGERIES:		
PROCEDURE	YEAR	SURGEON

Drug Allergies:

_____

_____

Latex Allergy ____ Yes ____ No Right-Handed _____ Left-Handed _____
Height _____ Weight _____
Do You Have Any Metal In Your Body? ____Yes ____ No Are You Claustrophobic? ____Yes ____ No

Family History	Family Member	Alive	Deceased	Age	Health Status Or Cause Of Death
Grandmother *(Mom's)*					
Grandfather *(Mom's)*					
Grandmother *(Dad's)*					
Grandfather *(Dad's)*					
Mother					
Father					
Sister/Brother					
Sister/Brother					
Sister/Brother					
Sister/Brother					

Social History

Occupation: _____ Do You Have Children? ❑ Yes ❑ No How many? ____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you live alone? ❑ Yes ❑ No

Do you smoke? ❑ No ❑ Yes, I've smoked _____ packs per day for _____ years.

❑ No, I quit ____ years ago. At that time I smoked _____ packs per day.

Do you drink alcohol? ❑ No ❑ Yes If yes, please estimate amount: _____

Fort Sanders Neurosurgery and Spine

Medication List

*please list medications you are currently taking on this sheet

Patient Name:______________________________ **Date of Birth:**________________

Pharmacy Name:____________________________ **Pharmacy Telephone:**_________

Name of Medication	Exact Dose(mg,mcg,tsp)	Frequency (How often?)	Who prescribed this medication?	How long have you been on this medication?

PATIENT NAME:_____ DOB:__/__/__

TO BE COMPLETED BY NURSE			
Weight	lbs kgs	Height	inches cm

PHQ-2 Depression Screening Questionnaire

How often have you been bothered by the below symptoms the last two weeks?

Feeling Down, Depressed, Hopeless	O Not at all O Several Days	O More than half the days O Nearly every day
Little Interest - Pleasure in Activities	O Not at all O Several Days	O More than half the days O Nearly every day

PHQ-9 Detailed Depression Screening Questionnaire

If you selected "Not at all" for both questions above, please ignore this section.

Trouble Falling or Staying Asleep	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Tired or Little Energy	O Not at all O Several Days	O More than half the days O Nearly every day
Poor Appetite or Overeating	O Not at all O Several Days	O More than half the days O Nearly every day
Feeling Bad About Yourself	O Not at all O Several Days	O More than half the days O Nearly every day
Trouble Concentrating	O Not at all O Several Days	O More than half the days O Nearly every day
Moving or Speaking Slowly	O Not at all O Several Days	O More than half the days O Nearly every day
Thoughts Better Off Dead or Hurting Self	O Not at all O Several Days	O More than half the days O Nearly every day

Medication Adherence

Does the patient have any barriers to medication adherence?
(Ie. Any reason that the patient cannot take medication as prescribed?)

O YES O NO

If YES, the reason is?
- O Financial
- O Transportation
- O Trouble Remembering
- O Health literacy
- O Lack of Confidence
- O Time Constraints
- O Cognitive deficit
- O Functional status impairment
- O Other

Is the patient taking over-the-counter medications?

O YES O NO

Fall Risk Assessment

1. Have you fallen in the last year? O YES O NO
2. Are you worried you might fall? O YES O NO
3. Do you use a cane or walker? O YES O NO
4. Do you need someone to help you get up in the morning? O YES O NO

Tobacco Use:

- ☐ Never (less than 100 in lifetime)
- ☐ 4 or less cigarettes (less than 1/4 pack)/day in the last 30 days
- ☐ 5-9 cigarettes (between 1/4 to 1/2 pack)/day in the last 30 days
- ☐ 10 or more cigarettes (1/2 pack or more)/day in the last 30 days
- ☐ Cigars or pipes daily within the last 30 days
- ☐ Cigars or pipes, but not daily within the last 30 days
- ☐ Smokeless tobacco user within last 30 days
- ☐ Smoker, current status unknown
- ☐ Former smokeless tobacco user, quit
- ☐ Former smoker quit more than 30 days
- ☐ Refused tobacco status screen
- ☐ Unable to assess due to cognitive impairment

Types:
- ☐ Cigarettes
- ☐ Cigars
- ☐ Oral
- ☐ Pipe
- ☐ Smokeless Cigarettes
- ☐ Spit Tobacco
- ☐ SNUS Products
- ☐ Other: _____

Packs Per Day ☐

Years Smoked ☐

Alcohol:

Use:
- ☐ Never used
- ☐ Deny use
- ☐ Past User
- ☐ Not used since pregnant
- ☐ Used early in pregnancy
- ☐ Unable to assess due to cognitive impairment
- ☐ Current user

Type:
- ☐ Beer
- ☐ Wine
- ☐ Liquor
- ☐ Other:_____

Frequency:
- ☐ 1-2 times per year
- ☐ 1-2 times per month
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ Daily
- ☐ Several times per day
- ☐ Binge
- ☐ Occasional use
- ☐ Regular use

Advanced Directive

- O Yes
- O No
- O No Advanced Directive, information given
- O Unable to answer at this time
- O Healthcare Proxy
- O Revocation

Patient Preferred Pharmacy

Pharmacy Name

Phone

REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE OF BIRTH:_____

General:

	Yes	No
Weight Change > 10lbs		
Fever		
Fatigue		
Difficulty Sleeping		

Male:

	Yes	No
Sexual dysfunction		
Infertility		
Painful Intercourse		

Head and Neck:

	Yes	No
Visual Changes (Not Glasses)		
Dizziness		
Sinus problems		
Frequent persistent nosebleeds		
Ear pain		
Trouble hearing		
Ringin in Ears		
Hoarseness		
Persistent sore throat		
Mouth sores		
Swollen glands (Frequent)		

Women:

	Yes	No
Breast pain/lumps		
Pelvic pain		
Vaginal discharge		
Vaginal dryness		
Frequent sweats/hot flashes		
Mentstrual problems		
Menopause		
Pregnancy Problems		

Respiratory/Lungs:

	Yes	No
Stop breathing during sleep		
Shortness of Breath		
Coughing up blood		
Wheezing		
Cough		
Sore Throat		
Snoring		

Skeletal:

	Yes	No
Gout		
Back Pain (Major)		
Neck Pain (Major)		
Weakness of arm or leg		
Joints Swelling/Stiffness		
Deformities of Back/Extremeties		

Heart/Vascular:

	Yes	No
Chest pain/tightness		
Smothering feeling at night		
Ankle swelling		
Palpitations		
Passing out		

Neuro:

	Yes	No
Numbness or tingling		
Severe frequent headaches		
Abnormal coordination		
Trouble with speech		
Forgetfulness/confusion		

Stomach/Bowel:

	Yes	No
Black/Bloody stools		
Nausea/Vomiting (Frequent)		
Frequent heart burn/acid (GERD)		
Abdominal pain		
Diarrhea (Frequent)		
Constipation		
Difficulty swallowing		

Skin and Hair Problems:

	Yes	No
Changes in hair/hair loss		
Major skin problems		
Wounds that will not heal		
Persistent rash		
Changes in moles		

Kidney/Bladder:

	Yes	No
UTI		
Urinary Incontinence		
Urinary Hesitancy		
Frequent Urination		
Urinary Urgency		
Urinating at night		
Pain with urination		
Blood in urine		
Urinary Retention		

Psych/Social:

	Yes	No
Anxiety		
Depression		
Insomnia		

_____

Signature (Patient or Legal Representative)

_____

Relationship to Patient *Date*

Patient Name _____ DOB _____

(1) I Live With

Alone, Independent _____
Alone, Need Assistance _____
Caregiver _____
Family _____
Father _____
Friend _____
Legal Guardian _____
Mother _____
Parent(s) _____
Sibling(s) _____
Signifcant Other _____
Spouse _____

My Primay Care Giver Is

_____

(2) My Living Situation

Assisted Living _____
Extended Care Facility _____
Group Home _____
Home _____
Homeless _____
Hospice _____
Law Enforcement Detention _____
Nursing Home _____
Psychatric Unit _____
Rehabilitation Unit _____
Skilled Nursing Facility _____

(3) I Live In

Apartment _____
Facility _____
Hotel/Motel _____
Multilevel home _____
RV Camper/Motor Home _____
Shelter _____
Single Level Home _____
Split Level Home _____
Street _____
Tent _____
Vehicle _____
Unknown _____

Dependent Minor

Are Parents Married Y N
Number of Siblings _____

(4) Issues at Home Affecting My Care

None _____
Absence of Family Member _____
Absent Family Member Due To Military _____
Bug Infestation _____
Food Insecurity _____
Inadequate Drinking Water Supply _____
Lack of Insurance _____
Lack of Transporation _____
Narrow Doorways _____
No Air Conditioning _____
No Eelectricity _____
No Elevator _____
No Heat _____
No Primary Care Physician _____
No Phone _____
No Running Water _____
No Shower/Bathtub on 1st Level _____
Stairs/Outside _____
Stairs/Inside _____
Unable Afford Medications _____
Unemployed _____
Upstairs Bedroom/Bathroom _____

Current Home/Outpatient Treatments

Apnea Monitoring _____
BiPaP/CPAP Dependent _____
Blood Glucose Monitoring _____
Cardiorespiratory Monitoring _____
Catheter/Indwelling _____
Catheter/Intermittent _____
Chemotherapy _____
Dialysis/Hemo _____
Dialysis /Peritoneal _____
IV Infusion Therapy _____
Mechanical Ventilation _____
Nebulizer Treatments _____
Oxygen Therapy _____
Radiation Therapy _____
TPN _____
Tube Feeding _____
Wound Care _____

Regular Means of Transportation

Ambulance _____
Bicycle/Scooter/Motorcycle _____
Family/Friends _____
Governemt Transporation/ETHRA,SETHRA _____
Motorized Wheechair _____
Public Transport/Bus/Taxi/Uber _____
Private Vehicle _____
Walking _____
Other _____

COVID-19 Screening

Does the patient have any of the following symptoms/risk factors for COVID-19?

- ☐ Respiratory Symptoms (cough, shortness of breath); Fever (of equal to or greater than 100.0 degrees F) or Loss of smell or taste
- ☐ Close contact with a person with confirmed COVID-19
- ☐ Other COVID-19 Symptoms: headache, muscle/body aches, sore throat, fatigue, nausea/vomiting or diarrhea
- ☐ None of the above
- ☐ Unable to obtain
- ☐ Unable due to cognitive impairment/mental health status

Please document the start date of the respiratory symptoms, fever or loss of smell/taste mm/dd/yyyy

Have you completed the COVID-19 Vaccination series greater than 14 days ago?

○ Yes ○ No ○ Unknown

Have you ever been tested for COVID-19?

○ Yes ○ No ○ Unknown

Have you been tested for COVID-19 within past 14 days?

○ Yes ○ No ○ Unknown

What were the results of the COVID-19 test?

- ○ Positive
- ○ Negative
- ○ Results pending
- ○ Unknown

Have you tested positive for COVID-19 within the past 90 days?

- ○ Yes
- ○ No
- ○ Unknown

Where was the COVID-19 testing performed?

Based on patient's responses is pre-procedural COVID-19 testing indicated?

○ Yes ○ No

Patients who have completed the COVID-19 Vaccine series >14 days ago are NOT required to have a pre-procedural COVID-19 test. For patients who have had a Positive COVID-19 test within the last 90 days please refer to facility direction.

Do you work in healthcare?

- ○ Yes
- ○ No
- ○ Unknown

Have you had prolonged, unprotected exposure to a person with confirmed COVID-19?

- ○ Yes
- ○ No
- ○ Unknown

Reference Text: Prolonged close contact is defined as contact within 6 feet for at least 15 minutes

Is the patient a resident in a congregate care setting?

- ○ Yes
- ○ No
- ○ Unknown

Congregate care settings include: nursing homes, residential care for people with intellectual & developmental disabilities, psychiatric treatment facilities, group homes, board & care homes, prisons/jails, homeless shelters, foster care or other setting

Have you or a family member traveled outside the U.S. within the last 30 days?

- ☐ Yes, patient
- ☐ Yes, family member
- ☐ Yes, patient and family member
- ☐ No
- ☐ Unable to obtain
- ☐ Unable due to cognitive impairment/mental health status

NAME_____

DOB_____TEMP_____

Fort Sanders
Neurosurgery
and Spine

Paul C. Peterson, M.D.

PAIN MEDICATION PRESCRIPTION POLICY

1. Refill request must be made thru your pharmacy. In turn, they will fax a request to our office. Please allow 48 hours for refills to be ready at the pharmacy.

2. Medications must be taken as prescribed by Dr.Paul Peterson. Prescriptions will not be refilled early.

3. All medications are to be protected from theft and loss. It is your responsibility to keep them safe. We will not refill lost or stolen medications.

4. Refill request are to be made Monday thru Thursday between 8:00 am to 3:00pm. No refills will be called in on Fridays, after hours, or weedends. **It is your responsibility to anticipate any shortage** of the pain medication and call the office during the stated hours.

5. **Controlled prescriptions can only be obtained from one physician.** It is your responsiblity to let Dr. Peterson know if ou have received these medications from any other physician such as primary care, pain management, Etc. According to the Controlled Substance Monitoring Database (CSMD) and the Prescription Safety Act, any physician, who has actual knowledge that a person has knowingly,willfully, and with intent to deceive obtained or attempted to obtain a controlled substance must report that information within five(5) business days to the local law enforcement agency.

6. Abuse in any way of controlled prescription medications or disregard of the above policies is grounds for discharge from this practice.

I have read and understand the above PAIN MEDICATION PRESCRIPTION POLICY AND AGREEMENT of Dr. Paul Peterson and agree to abide by it.

_____ _____

Patient Signature DATE