NEUROSURGERY
& SPINE CENTER

Regional West Medical Plaza North
Two West 42nd Street │ Suite 2100
Scottsbluff, NE 69361

308.630.1947 │ 308.630.1439 fax │ PhysiciansClinic.net

Welcome!

Thank you for choosing Regional West Physicians Clinic - Neurosurgery. Please feel free to ask any questions you have about your care. We will be happy to explain anything you don't understand.

Please complete the patient information form, health history form, and any other forms that are included with this letter or can be downloaded from our website and bring them with you on your first visit. You need to bring your current insurance cards. If we are seeing you for an injury that is being paid by a third party payer such as workman's comp or auto, please bring that billing information with you. Plan to arrive 30 minutes before your scheduled appointment to complete registration and other paperwork.

Office Hours/Appointments
Our clinic hours are **8 a.m. to 5 p.m.**, Monday through Friday. Our medical staff sees patients by appointment during normal office hours. To schedule an appointment, call 308-630-1947. If you are more than 10 minutes late for your appointment you may be asked to reschedule.

Cancellation/No Show Policy
We require 24-hours notice of appointment cancellation so we may offer these appointments to other patients in need of treatment. Patients who do not give 24 hours notice will be considered a "no-show." A patient who has three "no-shows" in six months may be dismissed by the provider and/or the clinic.

Billing & Insurance Information
Regional West Physicians Clinic accepts most major insurance carriers and will assist you in filing claims for health care services. Should you have any questions about any insurance or billing issues please call our office during normal business hours. We bill insurance companies as a courtesy to you. Please check with your insurance company for specific coverage benefits. Co-payments, deductibles, and co-insurance amounts are due at the time of service. We accept personal checks, Visa, MasterCard, Discover, and debit cards. If you should need to make special arrangements concerning your bill, please call the office prior to your appointment.

If you have any special needs please let us know in advance so that we may adequately prepare for your visit. Please keep this letter for future reference and call us if you have any questions.

________________________________ ________________________________
Date of Appointment *Time of Appointment*

Check in time ____________________
Appointment with ___Omar Jimenez, MD
___Raqeeb Haque, MD
___Mary Schweitzer, APRN
___Robert Gantz, APRN

In order for us to obtain a complete medical history, it is important for you to fill out these forms as completely as possible. This information will be entered into our computer. You are welcome to a copy of these reports if you wish.

Patient Name _______________________________________ Preferred Name ___________________
Address ________________________________ City __________________ State ______ Zip _________

Home Phone Number ______________________ Work Phone Number _____________________
Other Phone Number ______________________ E-mail Address __________________________

Date of Birth _________________ Sex ___M____F Social Security Number ___________________
Marital Status ___ Single ___Married ___Divorced ___Widowed ___Legally Separated

Work Status ___Employed ___Unemployed ___Retired ___Self-Employed ___ Other _____________
Employer ____________________________________ Occupation _______________________________
Employer Address ____

Guarantor if different from Patient
Name ____________________________________ Relationship to Patient ______________________

Home Phone Number ______________________ Work Phone Number _____________________
Other Phone Number ______________________ E-mail Address __________________________
Date of Birth _________________ Sex ___M____F Social Security Number ___________________

Emergency Contact Information
Name ______________________________________ Relationship to Patient _____________________
Home Phone Number ______________________ Work Phone Number ___________________
Other Phone Number ______________________

Is this visit accident-related? ___Yes____ No If yes, is it? ____Auto ____Work Comp ___ Other
Date of injury: ________________ Briefly describe injury _____________________________________
____
Claim number of Auto or Work Comp ____
Employer at time of Work Comp Injury ____

Name of Primary Insurance Company ____
Address: ____
Subscriber ID # ____________________________ Group ID# ______________________________
Insured name ______________________________ Insured Date of Birth ____________________

Name of Secondary Insurance Company ____
Address: ____
Subscriber ID # ____________________________ Group ID# ______________________________
Insured name ______________________________ Insured Date of Birth ____________________

Primary Care Physician ____

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New Patient Information

Name______________________________ Date of Birth______________________

General Information

Reason for appointment ____

Do you have pain? Yes ______ No______

Location ____

Severity (0-10) ______________________

Describe Pain (*circle all that apply*)

Stabbing Throbbing Dull Sharp

Aching Tingling Numbness

Have you had any recent studies to evaluate the pain?

MRI ______ CT ______ CT Myelogram _____ X-rays _____

Recent Treatment

What non-surgical therapies have you undergone? (*circle all that apply*)

Physical Therapy Chiropractor Spinal Injection

Acupuncture Oral Steroids NSAIDS

Past Medical History (*circle known diagnoses*)

Allergies
Anemia
Arthritis
Bleeding Disorder
Breathing Problems (Asthma, COPD, Emphysema)
Cancer (*specify*) ____________________________
Dementia (memory loss)
Epilepsy
GI Problems (*Bleed, Reflux, Ulcers*)
Heart Disease
Hepatitis (A, B, C)

High Cholesterol
Hypertension
Kidney Disease
Neuropathy
Pain (*specify*)______________________________
Parkinsons
Siezures
Stroke
Spine Problems (*Disk disease, Fractures, Stenosis*)

Other ____________________________________

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Name____ Date of Birth______________________________

Past Surgical History

(Please circle any surgical procedures you have had and list the date when you had them in the blank.)

Appendix ____________________

Breast Biopsy/Mastectomy ________________

Colon ________________________

Gallbladder ___________________

Heart, Angio/Stent ____________________

Heart, Bypass ___________________

Heart, Valve ___________________

Hernia ____________________

Hip Replacement __________________

Knee Surgery/Replacement _________________

Spine Surgery _____________(specify)________

Thyroid Surgery ___________________

Vascular Surgery __________________

Other ___________________________

Medications *(Please List, by name, all current prescription medications, over-the-counter medication, and all vitamins and/or supplements and herbs, including dose that you take regularly at this time.)*

Name	*Dose*	*Frequency*	*When did you start?*

Prescribing Physician ____

Allergies (Do you have any drug, food or chemical allergies? If so, please list them below)

Allergy	*Reaction*

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Name____ Date of Birth________________________________

Family History (circle all that apply)

NONE
Aneurysm
Diabetes
Epilepsy
Heart Disease
Hypertension
Stroke
Tumor/Cancer (*list types*) _________________________
____
Other ____

Social History

Right Handed_________ Left Handed___________
Alcohol Drinks/Week ________________________
Tobacco Packs/Day _________________________
With whom do you reside? ____________________
Working Occupation _________________________
Retired when? ______________________________
Unemployed since when? ____________________
Circle one: Married Single Divorced Widowed
Work-related injury? When did it occur?__________

(To be filled out by Medical Assistant)

Temp_________________ BP__________________ HT_______________ WT_________________

We welcome the opportunity to share patient testimonials for the benefit of others who may need comprehensive spine care. May we contact you to share your story about the care you received at Regional West Physicians Clinic Neurosurgery & Spine Center? Yes______ No_____

THIS INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

Patient or Guardian Signature ____ Date_____________

Information on form is reviewed by ___________________________________Date______________

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Pain Disability Index

Name ______________________________ Date ____________________

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. **A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.**

Family/home responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (eg, yard work) and errands or favors for other family members (eg, driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Name ____ Date ___________________________

Sexual behavior: This category refers to the frequency and quality of one's sex life.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-support activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

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Patient Health Questionnaire-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some	0	1	2	3
FOR OFFICE CODING	0 +	_______ +	_______ +	_______ +
			Total Score:	________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very diffcult	Extremely difficult
	☐	☐	☐	☐

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EQ-5D Health Questionnaire

Client ID ____________________________ New User ___________ Existing User __________

Date ________________________________

By placing a mark in one box in each group below, please indicate which statements best describe your own health state today.

Mobility
I have no problems in walking about ❑
I have some problems in walking about ❑
I am confined to bed ❑

Self-Care
I have no problems with self-care ❑
I have some problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

Usual Activities (*e.g. work, study, housework, family or leisure activities)*
I have no problems with performing my usual activities ❑
I have some problems with performing my usual activities ❑
I am unable to perform my usual activities ❑

Pain/Discomfort
I have no pain or discomfort ❑
I have moderate pain or discomfort ❑
I have extreme pain or discomfort ❑

Anxiety/Depression
I am not anxious or depressed ❑
I am moderately anxious or depressed ❑
I am extremely anxious or depressed ❑

Visual Analogue Scale

Please indicate on this scale how good or bad your own health state is today.

The best health state you can imagine is marketed 100 and the worst health state you can imagine is marked o.

Please draw a line from the box to the point on the scale that indicates how good or bad your health state is today.

Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =