WESTERN SPINE INSTITUTE
MARK A. WEIGHT, M.D.
2355 CORONADO STREET
IDAHO FALLS, ID 83404

Please complete this form as accurately as possible. This information is important in planning your care.
We will be happy to assist you as needed.

Date: _____ Name: _____
Age: _____ Occupation: _____
Employer or school: _____ Year in school: _____
Primary Care Physician: _____
Who referred you to us? _____
Right or left handed? _____

Please describe why you are here to see the doctor by filling the following blanks.

_____

_____

What Body Part is injured? L or R | Pain/Swollen/Weak/Unstable | Date this began? | Where injured? Work/School/Other

HPI
Describe in detail how this began:

_____
_____
_____

Describe treatments you or your doctor have tried. (medicines, ice, braces, therapy, which doctor)

_____
_____
_____

Sports/Activities you enjoy: _____
_____

Office Use: _____
_____

PMHx
List all medical problems you have had. (e.g. high blood pressure, diabetes, asthma, heart, etc.):

_____ _____
_____ _____
_____ _____

PSHx
List all surgeries and year. (e.g. appendix 1956, heart bypass 1995, knee scope 1980, etc.):

_____ _____
_____ _____
_____ _____

MEDs
List all medications you are taking. Include insulin and other injectables:

Medications	Dosage (mg strength)	How often you take this medication?
		PRN/once/twice/thrice daily
		PRN/once/twice/thrice daily
		PRN/once/twice/thrice daily
		PRN/once/twice/thrice daily
		PRN/once/twice/thrice daily

ALLERGIES

List all allergies to medications and identify your reaction:

Medication	Reaction (circle)
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious

Circle any other allergy: Iodine Shellfish IV dye Latex Tape Other:_____

Fam Hx

List any medical problems that run in your family (e.g. arthritis-mom, heart disease-grandpa, prostate cancer-uncle):

_____

_____

_____

Social Hx

Marital Status_____ Number of children at home:_____ out of home_____

How much do you smoke?_____ How much do you drink?_____

If you are ill or recovering from surgery, is there someone to assist you at home? YES NO

ROS

Circle any problems you have ever had:

Stomach Ulcers
Blood Clots
Unusual Bleeding
Cancer or Tumors
Diabetes
Heart Problems
High Blood Pressure
Chest Pain or Angina
Mitral Valve Prolapse
Recent Weight Gain > 20 lbs.
Recent Weight Loss > 20 lbs.

If yes, how was this treated?_____

Prednisone Use
Kidney Problems
Liver Problems
Hepatitis/Jaundice
Asthma
Other Lung Problems
Stroke
Seizures
Depression
Pacemaker

Other: _____

Height:_____ ft_____inches

Weight: _____lbs

This information is true to the best of my knowledge.

_____

Patient or guardian signature

Nurse:_____ Physician: _____

WESTERN SPINE INSTITUTE

MARK A. WEIGHT, M.D.

PATIENT REGISTRATION

Patient's Name: _____ Today's Date: _____
Last First Middle Initial

Address: _____
Number Street City State Zip

Home Phone: _____ Patient's S/S No. _____

Patient's Age: _____ Patient's Birthdate: _____

Patient's Employer: _____ Occupation: _____

Address: _____ Work Phone No: _____
Number Street City State Zip

SEX: ___ Male ___Female MARITAL STATUS: ___Single ___Married ___Divorced ___Widowed

Name of Spouse: _____ Spouse's S/S No.: _____

Spouse's place of employment: _____ Spouse's Occupation: _____

Spouse's Work No.: _____ Spouse's Birthdate: _____

Responsible Party: _____ Social Security No: _____
Last First Middle Initial

Address: _____ Birthdate: _____
Number Street City State Zip

Patient's Relationship to Policy Holder: _____ Phone No.: _____

Place of Employment: _____ Work No.: _____

Name of friend or relative (not living with you) _____ Phone No.: _____

_____ _____
Patient Referred By Signature of Patient or Responsible Person

INSURANCE INFORMATION

IS YOUR INJURY ___Work Related ___Auto Accident ___Farm Accident ___Other

What was the date of your onset of illness or injury? _____

PRIMARY Insurance Co.: _____ Policy No.: _____

Address _____ Group No.: _____

Name of Policy Holder: _____

SECONDARY Insurance Co. _____ Policy No.: _____

Address: _____ Group No.: _____

Name of Policy Holder: _____

WESTERN SPINE INSTITUTE

MARK A. WEIGHT, M.D.

INFORMATION RELEASE AND FINANCIAL AGREEMENT

I hereby, authorize Mark A. Weight, M.D. along with any contracted billing service of Mark A. Weight, M.D. to furnish the Centers of Medicare and Medicaid Services, formally the Health Care Finance Administration, or my insurance carriers and/or any agency working in their behalf, and any of my healthcare providers any and all medical information concerning my treatment and diagnosis pertaining to Mark A. Weight, M.D.

I request that payment of authorized Medicare/Insurance benefits be made either to me or on my behalf to Mark A. Weight, M.D. for services furnished me by that physician.

In the event that I have a legal claim against some third party that I believe to be liable to reimburse Mark A. Weight, M.D. for charges, other than my insurance carrier, I understand I remain personally responsible to pay my charges when due.

By signing I confirm that I have read, understand and agree to this Financial Policy. I understand my bill will be filed to my insurance as a courtesy. Any pending insurance balance after 90 days is the guarantors' responsibility regardless of insurance response.

Date:_____X _____

(Policy Holder or Responsible Party)

Relationship to Patient:_____Witness:X _____

Second Witness:X _____

(Policy Holder or Responsible Party)

Medicare Recipients

MEDIGAP ASSIGNMENT AUTHORIZATION

BENEFICIARY: _____

MEDICARE #: _____

MEDIGAP POLICY #: _____

I request that payment of authorized Medigap benefits be made on my behalf to Mark A. Weight, M.D. for any services furnished by that physician.

I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits.

Date:_____X _____

(Policy Holder or Responsible Party)

RELEASE OF HEALTH INFORMATION/ AUTHORIZATION TO DISCLOSE INFORMATION

PATIENT NAME:_____ DOB:_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" (PHI) under a federal health privacy law, as indicated or described below:

☐ All health information relating to me

☐ Only the following specific information (Describe specific information including dates)

_____

_____

ORGANIZATION TO WHOM DISCLOSURE MAY BE MADE:

WESTERN SPINE INSTITUTE
MARK A. WEIGHT, M.D.
2355 CORONADO STREET
IDAHO FALLS, ID 83404
TELEPHONE: (208) 523-0303
FACSIMILE: (208) 523-9815

☐ You have my permission to speak with my spouse about my medical care

☐ You have my permission to leave all information on my answering machine regarding my medical care and test results

☐ You have my permission to speak with my children or other family members involved with my medical care:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand in making this request that:

*If the individual(s) or organization(s) that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

*I may revoke this authorization at any time by notifying you in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by you before receiving my revocation.

PATIENT SIGNATURE:_____ DATE:_____