J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

PLEASE PRINT	☐ Mr. ☐ Ms. ☐ Mrs. ☐ M.D.	PATIENT INFORMATION	SEX ☐ MALE ☐ FEMALE

NAME – Last, First, Middle Initial:

Age: Date of Birth: Phone: Email:

Address: City: State: Zip:

Employer: Occupation: DL# SS#

Employer Address: City: State: Zip:

Relationship to Responsible Party: ☐ Self ☐ Husband ☐ Wife ☐ Other

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

Ethnicity: ☐ African American ☐ American Indian/Eskimo ☐ Asian or Pacific Islander Caucasian Hispanic

NEAREST RELATIVE OR FRIEND (NOT LIVING WITH YOU)

Name: Relationship: ☐ Phone: ☐

Address: City: State: Zip:

MEDICAL INFORMATION

IMPORTANT – Please list all allergies to medications of any kind, or write none:

Have you ever been a patient of Dr. Kaufman's in the past? Yes No Year:

Have you ever been treated by Dr. Kaufman in the emergency room? ☐ Yes ☐ No

PRESENT COMPLAINT ☐ Neck ☐ Upper Back ☐ Lower Back Date of Injury/onset of symptoms:

Were X-Rays taken? Yes No Where? ☐ ☐

Primary Care Physician/PCP:

Referred By?

WORKER'S COMPENSATION

Injury on the job?: Yes No Are yo claiming worker's compensation ? ☐ Yes ☐ No

If on the job injury, please describe how accident occurred:

Treating Doctor: Have you notifieed youe employer? Yes No

AUTO INJURY

Auto Accident?? ☐ Yes ☐ No Accident Date: Lawyer Name/#:

INSURANCE INFORMATION

PRIMARY CARRIER

Insurance Company Name: Address:

Employer, If Group Coverage: Policy #: Group #:

Subscriber's Name: Date of Birth:

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY CARRIER

Insurance Company Name: Address:

Employer, If Group Coverage: Policy #: Group #:

Subscriber's Name: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SUBSCRIBER INFORMATION

NAME – Last, First, Middle Initial: Date of Birth: Phone #:

Address: City: State: Zip:

Responsible Party Social Security #: Driver's License #:

Responsible Party Employer: Employer Phone#:

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION:

1. I hereby have a right to privacy under HIPPA regulations. Therefore, any information that I provide on this demographics sheet, grants iSpine Renew to contact me via the information I have provided.
2. I hereby authorize iSpine Renew, to furnish any designated attorney or insurance company all information necessary to file a health insurance claim form, or to obtain reimbursement. I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, including healthcare and other government sponsored programs, private insurance, and any other health plans to iSpine Renew.
3. Also I hereby authorize disclosure of health information in any data format including x-ray, regarding my treatment, hospitalization and/or outpatient care ISPine Renew Consultants ,LLP. By my signature below you are fully authorized to disclose such information when requested by iSpine Renew Consultant, LLC.
4. I authorize iSpine Renew to be my personal representative, which allows iSpine Renew Consultants: (1) submit all appeals when my insurance denies my benefits, (2) initiate formal complaints to any state or federal agencies that have jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt. If my insurance company (including Workers Comp) has refused to pay 100% of my benefits, within 90 days of all appeals or request information. I also agree that any fines leveled agree against my insurance will be paid to iSpine Renew for acting as my personal representative.
5. The following information is true and correct to the best of my knowledge.

Date: _____ Patient or Guardian Signature: _____

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

MEDICATIONS: **Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.**

1.			NAME STRENGTH FREQUENCY
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

PharmacyName/Number: _____

Occupation: _____ **Highest Level of Education:** _____

RECREATIONAL ACTIVITIES/EXERCISE/HOBBIES:

Running Walking Cycling Golf Yoga Treadmill Elliptical Machine Weightlifting

Aerobics Class Other: _____

Please do not write below this space.

The physician has reviewed this form and acknowledges the findings.

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

Patient Name: _____

Please complete this form carefully. Your answers will help us better understand your presenting problem and design the best treatment for you.

MAIN CONCERN: _____

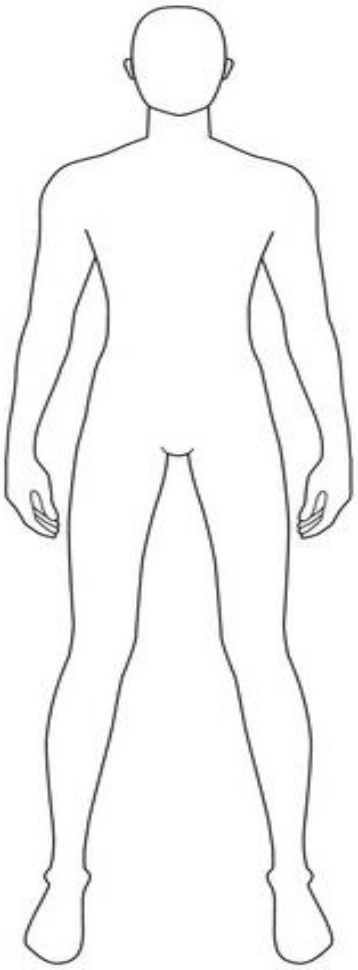
_____

How long has this been an issue? _____

Was there a specific event that stated this issue? ☐ Yes ☐ No **If yes, please explain:** _____

USE SYMBOLS BELOW, MARK DRAWING ACCORDSNG TO YOUR PAIN. INCLUDE ALL AFFECTED AREAS (Please draw in your face):

Ache/Sore: >>>>	Dull: DDD	Sharp: SSS	Throbbing: TTT	Numb: nnn
Cramping: ccc	Pressure: ppp	Tingling: xxx	Pins/Needles: ooo	Stabbing: ///
	Burning: BBB	Shooting: +++		



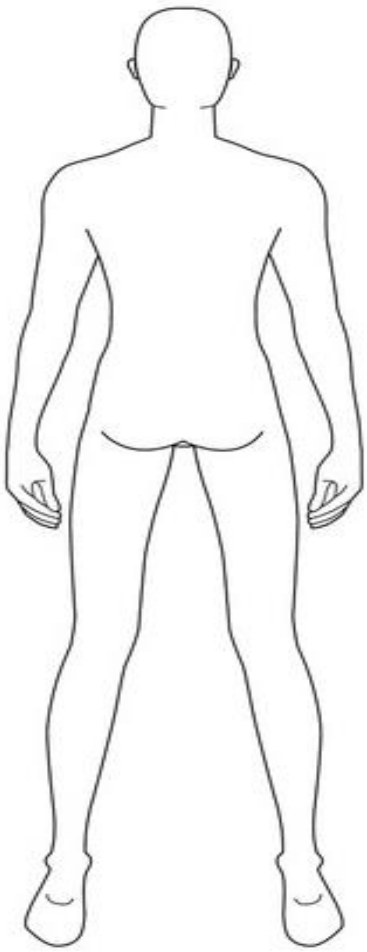
Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in arm(s) compared to neck
Worse than
Same as
Less than

Upper back: Circle Severity Pain Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Neck Pain: Circle Severity Level
0 1 2 3 4 5 6 7 8 9 10
minor moderate severe

Pain in arm(s) compared to neck
Worse than
Same as
Less than



Check/Circle/Highlight any that apply:

RATE YOUR USUAL PAIN: NO PAIN 1 2 3 4 5 THE WORSE PAIN IMAGINABLE **DOES**

PAIN COME ON:
☐ Suddenly
☐ Gradually

PAIN IS:
☐ Constant
☐ Good & Bad Days

PAIN IS WORST:
☐ When I wake up
☐ After I have been active
☐ Before I go to sleep

ARE YOU GETTING:
☐ Better
☐ Worse
☐ Unchanged

SpineRenew

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

Are you working? ☐ Yes ☐ No If not, when did you stop? _____

Is this problem the result of an on-the-job injury? ☐ Yes ☐ No

Is this problem the result of a motor vehicle accident (MVA)? ☐ Yes ☐ No If yes, please check one of the following:

MVA/ Driver MVA/Passenger
Motorcyclist Motorcycle Passenger
MVA vs. Bike MVA vs. Pedestrian Pedestrian Hit By Car

Is this problem a result of a fall? ☐ Yes ☐ No If yes, please circle one of the following:

At Home Stairs Chair Commode
Sidewalk/Curb Tree Ladder Scaffolding
Snow Skis Snowboard Inline Skates Skateboard
Water Skis

Which INCREASE your pain/discomfort? Please check or circle:

Standing Sitting Walking Bending forward Bending backward
Lying on back Lying on stomach Lying on side Rising from sitting
Coughing Sneezing Urination Bowel movement

What is the approximate amount of time you can perform the following activities?

Sit _____ minutes Stand _____ minutes Walk _____ minutes

PLEASE CHECK ALL OF THE FOLLOWING TREATMENTS YOU HAVE TRIED FOR YOUR PAIN & THEN CHECK APPROPRIATE

	TREATMENT	DATE (approx)	NO RELIEF	MODERATE REFILEF	EXCELLENT RELIEF
☐	Physical/Occupational Therapy		☐	☐	☐
☐	Heat/Ice		☐	☐	☐
☐	Traction		☐	☐	☐
☐	Injections (back/neck)		☐	☐	☐
☐	TENS		☐	☐	☐
☐	Ultrasound		☐	☐	☐
☐	Brace or collar		☐	☐	☐
☐	Massage		☐	☐	☐
☐	Psychtherapy		☐	☐	☐
☐	Chirpractic		☐	☐	☐
☐	Other		☐	☐	☐

Have you had surgery for this pain? Yes _____ or No _____

If yes, what procedure? _____ When? _____

Did it help? Yes _____ or No _____

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

DISCLOSURE AUTHORIZATION FORM

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Requested by: _____ **Relationship:** _____

Phone: _____ **Cell:** _____

I authorize iSpine Renew, LLC (Practice) to disclose my protected health information to those listed below, (specify name, relationship, and contact information):

_____

_____

_____

The protected health information to be disclosed is: Please check next to option:

Entire Medical Record

☐ **Only information relating to** _____

☐ **Only information occurring from** _____ **to** _____

☐ **Other (specify)** _____

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

NEW/EXISTING PATIENT DRUG TESTING POLICY

Our (pain) patients are required to undergo drug testing to receive drug prescriptions or refills. This is required by State Law.

Cost is $80.00 for Lab-Based Drug Tests (which stay in your chart/medical records). You will be tested at the most, every appointment and at least once every three months.

The law is set up to protect our patients and society in general. The testing shows the physician that the prescribed medications are being taken as directed.

The testing is NOT covered by your insurance BUT, it must be done to receive many of your insurance benefits (including prescription coverage in most cases).

If the physician determines that you are not taking your medication as prescribed, he/she is required by law to discontinue any prescriptions that are involved, So, it is very important & is taken seriously.

Thank you for your understanding in this matter as it is the law & is required for treatment (for patients being prescribed controlled medications).

Sincerely,

iSpine Renew Staff

Date: _____

Patient Signature: _____

Patient (please print): _____

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

CONTROLLED SUBSTANCE AGREEMENT

Between: Dr. J. Kevin Kaufman, M.D., and patient _____

The purpose of this agreement is to prevent possible misunderstanding about certain medicines doctors at iSpine Renew prescribe to you. The terms and thew explanations in this agreement are non-negotiable and meant to help the patient and the doctor to comply with all laws.

Narcotics are recognized as useful medications. They are only effective when used properly. However, narcotics have a high abuse/misuse potential and can have sever side effects such as drowsiness, vomiting, constipation and even death. Because of this, you are now entering into a binding agreement that will remain in effect while you are receiving narcotics.

I hereby agree to the following terms and conditions:

1. **I understand that managing and controlling the prescription is my sole responsibility. Lost or stolen prescriptions will NOT be replaced without a police report and an appointment with the doctor. NO after-hours prescriptions will be issued.**
2. **I agree to use the prescribed medications only as directed by the prescribing physician. I will NOT attempt to self-medicate myself. Controlled substances are only ordered for three months.**
3. **I will use only one pharmacy. I will provide the name of the pharmacy to the doctor upon request and/or present the prescription bottle for examination.**
4. **I agree to undergo urine drug testing when requested by the physician. I understand the purpose of the urine drug test is to monitor all substances that I am using. I understand that failure to undergo such testing can result in immediate termination of all prescription medications discharge from the doctor's care. I also understand that non-compliance may give my insurance carrier the right to disallow further medical treatment.**
5. **Under no circumstances will I use additional drugs, whether legal or illegal, while using the medications prescribed by my doctor. I will not accept or request any controlled substances from any other physicians or individuals while I am receiving medications from the physician indicated below. I understand that it is illegal to do so and may endanger my health.**

I acknowledge that I discussed or had the opportunity to discuss this agreement with the doctor. I have read this agreement and fully understand its terms and have signed it freely and voluntarily without inducement or pressure. I intend my signature to be a complete and conditional acceptance of the terms and conditions of this agreement.

Patient: _____ Date: _____

J. Kevin Kaufman, MD
501 w. Harwood Road, Suite 100
Hurst, TX 76054
PHONE: 817-377-0143; FAX: 817-377-0173

OPIOID TREATMENT INFORMED CONSENT AGREEMENT

I understand that Dr. Kaufman ("my physician") is recommending opioid medicine, sometimes called narcotic analgesics, to treat my _____. I understand that this medication is being recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effects. Therefore, I have told my physician about all other medicines and treatments completely that I am receiving- and that I will promptly advise my physician if I start to take any new medications or have new treatments. Likewise, I have told my physician about my complete personal drug history and that of my family. I have been informed by my physician that the initiation of a narcotic/opioid medication is a trial. Continuation of this medication is based on evidence to me from, associated side effects of, and compliance with dosage of this medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions. Lack of significant improvement, the development of adverse side effects, or other considerations may lead my physician to discontinue this treatment or to change dosage.

It has been explained to me that taking this narcotic/opioid medication has realistic benefits and certain known risks associated with opioid history. It has been added that serious risks include potentially fatal respiration, depression and development of a potentially serious lifelong opioid use disorder. Certain risks include, but not limited to, the following:

- Allergic reactions
- Overdose (which could result in harm or even death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgement and inability to operate machines or drive motor vehicles.
- Nausea, vomiting and/or constipation.
- Itching
- Physical dependence or tolerance to pain-relieving properties of the medication (This means that if my medication is stopped, reduced is dose, or rendered less effective by other medications. I may be taking it. I may experience a runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and flu-like feeling. These can be very painful but are generally not life-threatening).
- Addiction
- Failure to provide pain relief.
- Changes in sexual function (This is generally caused by reduced testosterone levels. Reduced levels may affect mood, stamina, sexual desire, and physical and sexual preference).

In addition, use of these medications poses special risks to women who are pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether the mother is on medicine and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequences on a child's development who was exposed to opioids is not understood.

It has been explained to me that there are other medications that do not involve the use of narcotic/opioid medications. Having been informed of these potential risks and potential benefits both of such medication and possible alternative treatment. I have freely consented to taking the narcotic/opioid medication.

Patient: _____ Date: _____