Craig C. Callewart, MD, PA

DATE: _____

PATIENT INFORMATION

Name		DOB		
Address				
	Street	City	State	Zip
Contact Numbers				
	Cell	Home	Other	
OK to Leave Msg?	Circle to indicate **yes** for:	Cell	Home	Other
E-Mail				
Work Status *(Circle)*	Employed	Unemployed	Retired	Other
Marital Status (circle)	Single	Married	Divorced	Widowed
Emergency Name & Phone				

RESPONSIBLE PARTY INFORMATION *(if different than patient)*

Name		DOB	
Relationship to Patient *(Circle)*	Spouse	Parent	Other
Contact Numbers			
	Cell	Home	Other

INSURANCE INFORMATION

Is your complaint related to a work injury?	***Yes***	***No***

Primary Medical Insurance

Please Circle	Group (Employer)	Individual	Worker's Compensation*	Other
Insurance Company				
Policy Holder Name				
Policy Number			Group Number	
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other

Secondary Medical Insurance *(if any)*

Insurance Company				
Policy Holder Name				
Policy Number			Group Number	
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other

Primary Care Physician	

How did you hear about us?	**If referred by a physician, please provide name:**	

Craig C. Callewart, MD, PA

CONSENT FOR CARE AND TREATMENT

I,_____(patient name) hereby agree and give my consent for Craig C. Callewart, MD, PA to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby have a right to privacy under Health Insurance Portability and Accountability Act (HIPAA) regulations. I understand that Craig C. Callewart, MD, PA is committed to protect this information. A copy of our Privacy Notice will be provided to you upon request. By signing, you acknowledge that you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date.

RELEASE OF INFORMATION AUTHORIZATION

I give Craig C. Callewart, MD, PA authorization for the release of medical records and privacy information, which includes my personal health information, any medical conditions, and/or billing and financial information to the following:

Name: _____ Relationship: Phone: _____

Name: _____ Relationship: Phone: _____

FINANCIAL POLICY

I hereby authorize Craig Callewart, MD, PA to furnish to any designated insurance company or attorney 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 medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Craig C. Callewart, MD, PA. I understand that I am financially responsible for all charges whether paid or not paid by my insurance company.

PAPERWORK AND NO-SHOW FEES

In today's medical world and given the type of illnesses our practice works with, the amount of paperwork and forms that need attending to is often overwhelming. Due to the time-consuming nature of filling out and managing insurance claims, disability forms, as well as other length forms, we (as with most medical offices) find it necessary to charge a nominal fee for this service.

If Dr. Callewart is required to fill out a form or dictate a note regarding a matter, our office will charge the following fees:

1. Disability or FMLA forms: $10.00 for 1st page and $5.00 each additional page.
2. Disability letter: $25.00-$40.00 depending on the length of letter and amount of time required to review chart.
3. Insurance forms: $5.00 per page.
4. Letter of medical necessity: $25.00
5. ONLY within your global period, there will be no charge for disability or FMLA paperwork

CHARGES FOR INSURANCE, DISABILITY, AND OTHER OFFICIAL FORMS (cont.)

We will do our best to expedite taking care of your requests, however the speed with which we will be able to do so is dependent on many factors, including how many forms we have pending at any given time. For this reason, please allow two weeks to process your request. If you require immediate service, which may require overtime work by our staff, a fee of $30.00 will be assessed. For any appointment that you either no-show or cancel within 24 hours. There will be a $20.00 fee assigned to your account.

If you need special assistance in any way, please let us know. We do our best to give individualized service so that every one of our patients feels special. If we are not meeting your expectations, please let us know how we can serve you better.

PRESCRIPTION POLICY

Dr. Callewart diagnoses and treats conditions of the spine. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harp to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. Craig C. Callewart, MD, PA, follows those laws, and those laws became more restrictive in 2015. Additionally, Medicare has further restrictions.

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced, unless a police report is filed.
2. Prescriptions are to be taken as directed. Do not take more pills than the prescription states, or the insurance/pharmacy/DEA may not allow a refill.
3. Certain controlled substances such as Oxycontin, MS Contin, Percocet, and Hydrocodone are written for a maximum of 30 day supply. It is necessary to make monthly follow up appointments in order to receive a refill. Patients are subject to urine screening as outlined by State Boards. By law, these controlled substance medications cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions cannot be refilled.
    a. Anti-inflammatories such as Celebrex
    b. Narcotics such as Tylenol #3 & Tylenol #4
    c. Muscle relaxers such as Soma, Robaxin, or Flexeril
5. Craig C. Callewart, MD, PA will monitor your pain medication intake for your health and safety. Patients placed on opioid therapy and/or narcotics will be subject to drug screening at Craig C. Callewart MD, PA's discretion.
6. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly If there are no refills left, you will need to contact our office and schedule an appointment for a re-evaluation.
7. Refills cannot be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Address *(minimum cross street)*: _____

_____

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

Pursuant to Federal and Texas Law, I have been informed that either Craig C. Callewart, MD, PA or one or more of its affiliates, physicians, or owners have a financial interest in one or more of the following organizations: Baylor Medical Center at Uptown and Methodist Hospital for Surgery. We want you to know that you do have the option to use an alternative health care provider, should you choose.

ACKNOWLEDGEMENT AND AGREEMENT

By signing below, I acknowledge that I have read and agree to the above policies or information, including Financial Policy, Paperwork and No Show Fees, Prescription Policy, the Disclosure of Physician Financial Interest. I have been given an opportunity to ask questions, if any.

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

I hereby authorize the disclosure of health information in any data format (including any images) regarding my treatment, hospitalization, and outpatient care to Callewart, Craig C , MD, PA. I understand that this facility will maintain medical records in accordance with state requirements and are hereby released from all legal respinsibility or liability that may arise from this authorization. By my signature below, you are fully authorized to disclose such information when requested by Callewart, Craig C , MD, PA

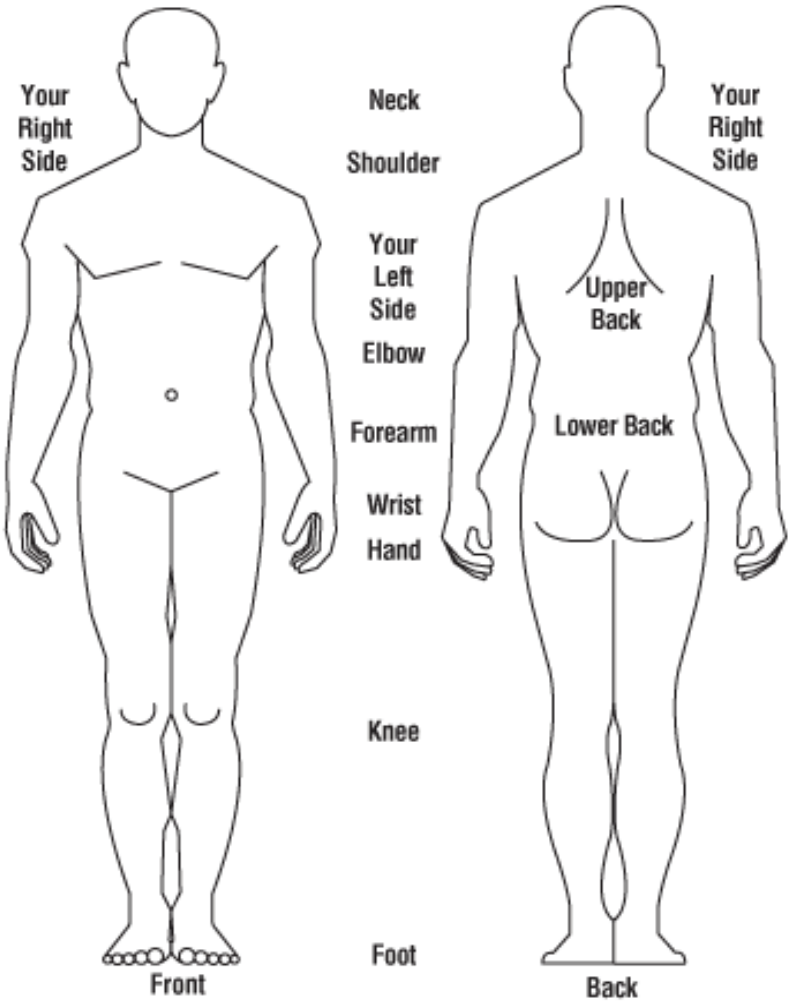
Patient Name: _____ DOB: _____

Patient Signature: _____

NEW PATIENT PAPERWORK

Craig C. Callewart, MD, PA

DESCRIBE THE PROBLEM



Please draw on the body diagram all areas of concern using the legend.

Ache: ^^^^^^^^

Numbness: ==========

Pins/Needles: 000000000

Burning: XXXXXXXXX

Stabbing: //////////

Pain Intensity (Circle)

0 – No Pain

1

2

3

4

5

6

7

8

9

10 – Most Severe Pain

Height _____ **Weight** _____

What do you want to happen as a result of this visit?

_____

_____

_____

How and when did your problem begin? (Please mark each answer that applies to your neck/back pain.)

☐ I don't know how it began.
☐ It comes and goes.
☐ I've had it along time.(_____ years)
☐ Injury (date of injury_____) On the job? ☐ yes ☐ no
Please explain how the injury happened.

_____

Are you currently in litigation with regards to your back pain?
☐ yes ☐ no

Have you been laid off from your job? ☐ yes ☐ no ☐ N/A

Patient Name: **DOB:** **Date:**

MEDICAL HISTORY

Do you have any of the following problems? (Please check your answer.)

Is your pain worse at night? ☐ yes ☐ no
Does your pain awaken you from sleep? ☐ yes ☐ no
Does coughing affect your pain? ☐ yes ☐ no
Do your legs tire/hurt if you walk too far? ☐ yes ☐ no
If YES, how far can you walk?
☐ less than 1 block ☐ 1-3 blocks ☐ more than 3 blocks
Is this relieved by resting your legs? ☐ yes ☐ no
Is this relieved by bending forward? ☐ yes ☐ no

Bladder Control (urine):
☐ No problem
☐ Can't empty bladder
☐ Loss of urine (accidents)

Bowel Control:
☐ No problem
☐ Constipation
☐ Loss of control (accidents)

How does each of the following affect your pain? (check your answer)

Sitting	☐ Better	☐ Worse	☐ No Change	
Standing	☐ Better	☐ Worse	☐ No Change	
Walking	☐ Better	☐ Worse	☐ No Change	
Lying down	☐ Better	☐ Worse	☐ No Change	
Rising from chair	☐ Better	☐ Worse	☐ No Change	
Physical activity	☐ Better	☐ Worse	☐ No Change	
Heat	☐ Better	☐ Worse	☐ No Change	☐ Don't know
Cold	☐ Better	☐ Worse	☐ No Change	☐ Don't know

We need to know about the treatments you have already received for your current back/neck pain. If YES, did it make your condition better or worse?

Have you had:

Chiropractic care	☐ Better	☐ Worse
Physical therapy	☐ Better	☐ Worse
Injections	☐ Better	☐ Worse
Psychological consultation	☐ Better	☐ Worse
Other:_____	☐ Better	☐ Worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6mo	<12mo
X-rays	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV(nerve test)	☐	☐

Have you ever had surgery on your back or neck? ☐ yes ☐ no

If YES, complete the following:

1) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐ better or ☐ worse?

2) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐ better or ☐ worse?

3) Type of surgery_____
Date_____
Surgeon_____
Did it make your pain ☐ better or ☐ worse?

GENERAL MEDICAL HISTORY

Check all the conditions below that you have currently or have had in the past. If NONE check ☐

- ☐ Heart Attack
- ☐ ADD/ADHD
- ☐ Heart Murmur
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Stomach Ulcer
- ☐ Duodenal Problems
- ☐ Anemia (low blood count)
- ☐ Colon Problems

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Kidney Stones
- ☐ Kidney Infection
- ☐ Degenerative Arthritis
- ☐ Osteoarthritis
- ☐ Migranes
- ☐ Rheumatoid Arthritis
- ☐ Bleeding Tendency

- ☐ Gout
- ☐ Anxiety
- ☐ Depression
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic Bronchitis
- ☐ Frequent Pneumonia
- ☐ Asthma
- ☐ Sexual Difficulty
- ☐ Enlarged Prostate

- ☐ AIDS/HIV
- ☐ Menstrual Problems
- ☐ Cancer: Type_____
  _____
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Medication/Alcohol Dependency Drug
- ☐ Other_____
  _____
  _____

MEDICATION LIST

- ☐ Antibiotics or Sulfa Drugs
- ☐ Anticoagulants (Blood thinners)
- ☐ Ambien
- ☐ Anxiety
- ☐ Aspirin
- ☐ Anti-inflamatory (NSAIDS)
- ☐ Cortisone (Steroids)
- ☐ Cymbalta
- ☐ Elavil/Amitripryline
- ☐ Eliquis

- ☐ Flexeril/Cyclobenzaprine
- ☐ High Blood Pressure Meds
- ☐ Insulin/Similar Medication
- ☐ Lyrica
- ☐ Metformin
- ☐ Neurontin/Gabapentin
- ☐ Nitroglycerin
- ☐ Oxycodone/Percocet
- ☐ Plavix
- ☐ Tylenol #3

- ☐ Vicodine/Lortab / Hydrocodone
- ☐ Xanax
- ☐ Immunosuppression
- ☐ Allergies / Intolerances:
  _____
  _____
- ☐ Other Medications
  _____
  _____
  _____

Check All Surgeries That Apply

- ☐ Appendix
- ☐ Bariatric
- ☐ Biopsies
- ☐ Cancer
- ☐ Cardiac Stent
- ☐ Colon/Small Bowel

- ☐ Fractures
- ☐ Gallbladder
- ☐ Heart
- ☐ Hernia
- ☐ Hip Replacement
- ☐ Hysterectomy

- ☐ Knee Replacement
- ☐ Lung
- ☐ Prostate
- ☐ Tonsils & Adenoids
- ☐ Vascular Surgery
- ☐ Vasectomy

- ☐ Other_____
  _____
  _____
  _____
  _____

SOCIAL HISTORY

Marital Status
☐ Married
☐ Separated
☐ Divorced
☐ Single
☐ Widow/widower

Education
Check the highest level completed:
☐ Grammar school
☐ High school
☐ College
☐ Post-graduate

Smoking
☐ Current Every Day Smoker
☐ Current Some Day Smoker
☐ Former Smoker
☐ Never Smoker

Year Smoked _____

☐ Smokeless / Chewing Amt: _____ per day

Alcohol
Do you drink:

Frequency of drinking:
☐ never
☐ rarely Amt: _____ drinks / day
☐ socially
☐ daily

Do you have a history of heavy drinking?
☐ yes ☐ no

Effect of your back/neck pain on your lifestyle.

My home setting is supportive of me during this time.	☐ Yes	☐ No
My work setting is supportive of me during this time.	☐ Yes	☐ No
My pain has affected my interaction with my family and friends.	☐ Yes	☐ No
The changes in my lifestyle due to my problem have been difficult for me.	☐ Yes	☐ No

What is your ability to enjoy life?
☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

Household Situation - Who Lives There (Circle all that apply)
Live Alone With Spouse/Adults With Childrem less than 12 y.o. Disable Person

Diet: (Circle all that apply)
Regular High Protein Vegetarian Other:_____

Supplements: (Circle all that apply)
Calcium Vitamin CVitamin DVitamin E Fish Oil Tumeric Ginger

Other:_____

Current Employment: (Circle all that apply)
Desk JobComputer Standing Walking Stairs Lifting Pushing Pulling

Overhead Walking

Exercise: (Circle all that apply)
Jog Bicycle Tennis Golf Walk Treadmill Exercise Ball Horses

Weight Training Water Aerobics Swim Yoga Eliptical Squats Kettleball

REVIEW OF SYSTEMS

In the past month, have you had any of the following problems?

GENERAL
☐ Chills
☐ Fatigue/Weakness
☐ Malaise
☐ Poor Weight Gain
☐ Weight Loss
☐ Night Sweat

EYES
☐ Vision Loss
☐ Visual Disturbance

EAR/NOSE/THROAT
☐ Difficulty Swallowing
☐ Sinus Pressure/Pain
☐ Tinnitus

CARDIOVASCULAR
☐ Chest Pains
☐ Palpitations
☐ Other Cardiac Problems

RESPIRATORY
☐ Asthma
☐ Shortness of Breath
☐ Other Respiratory Problems

GASTROINTESTINAL
☐ Change in Bowel Habits
☐ Reflux
☐ Other Gastrointestinal Problems
☐ Vomiting

GENITOURINARY
☐ Incontinence
☐ Other Genitourinary Problems

MUSCLE/BONE/JOINT
☐ Numbness
☐ Joint Pain
☐ Muscle Weakness
☐ Joint Swelling

SKIN
☐ Itching
☐ Lesions
☐ Rash/Redness
☐ Other Skin Problems

NERVOUS SYSTEM
☐ Headaches
☐ Dizziness
☐ Numbness or Tingling

PSYCHIATRIC
☐ Anxiety
☐ Depression
☐ Suicidal ideation
☐ Other Psychiatric Problems

ENDOCRINE
☐ Fatigue
☐ Unusual Weight Gain
☐ Other Endocrine Problems

HEMATOLOGIC
☐ Abnormal Bruising
☐ Bleeding
☐ Other Hematologic Problems

ALLERGIC/INMUNOLOGIC
☐ Allergic Rash
☐ Sinus Complaints
☐ Other Allergy Complaints

OTHER PROBLEMS:

FAMILY MEDICAL HISTORY

☐ **I do not know the medical history of my biological parents or other family members.**
(Go on to next section.)

MOTHER
☐ Alive Age:_____
☐ Deceased at age:_____
due to:_____

FATHER
☐ Alive Age:_____
☐ Deceased at age:_____
due to:_____

Number of living brothers/sisters:_____

Number of deceased brothers/sisters:_____
cause(s):_____

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply:
☐ Stroke
☐ Diabetes
☐ Lung disease
☐ High blood pressure
☐ Heart trouble
☐ Back problems
☐ Cancer
☐ Osteoporosis
☐ Scoliosis
☐ Kyphosis
☐ Arthritis
☐ None of these
☐ Don't know
☐ Other:_____
☐ Neck problem

ORTHOPEDIC SIGNIFICANT HISTORY (YOU OR YOUR FAMILY)

☐ Skeletal Dysplacia
☐ Achondroplasia
☐ Morquio
☐ Psuedoachondroplasia
☐ Diastrophic Dwarism
☐ Hemi-Hypertrophy
☐ Spondyloepiphyseal Dysphasia
☐ Marfan's Syndrome
☐ Ehlers-Danlos
☐ Osteogenesis Imperfecta
☐ Homocystinuria
☐ Pseudocholinesterase Deficiency
☐ Duchenna's Muscular Dystrophy
☐ Charcot-Marie Tooth
☐ Arthogryposis Multiplex
☐ Sickle Cell Disease
☐ Thrombocytopenia
☐ Malignant Hyperthermia