WORKER COMPENSATION FORM

PATIENT INFORMATION

Name __________________________ D.O.B _________________ Soc. Sec. Num. _______-_______-_______

Address____
____

Telephone (____) ________________ Mobile Phone: (_____)______-________________

Emergency Contact: ________________ ________ Phone: (_____) ____________________

EMPLOYER INFORMATION (at time of incident)

Employer Name ____

Employer Address ____

Employer Telephone (____) ____- ______________ Injury Verified By (For Office Use)________________

Contact Person ____

COMPENSATION CARRIER (For Office Use)

Worker Compensation Carrier ____
Carrier Address____

Carrier Phone Number (_____) ______-________ Coverage Verified By _______________________________

Adjuster's Name ___________________________ Claim Number _____________________________________

INJURY INFORMATION

Date of Injury _______________________ Time _________________ _____ A.M. _____ P.M.
Place of Injury ___________________________________ Accident reported to employer? Yes or No (circle)

Give full description of how accident happened. ____
____
____
____

Have you lost time from work? Yes or No (Circle) How much time? ______________

Other doctors seen for this condition : Doctor's Name ___________________________ Diagnosis ________________

Were X-Rays taken ? Yes Or No (Circle) Other Tests? Yes or No (Circle)

If yes, by whom? Please list test(s) and result(s)____
____

Any previous Worker Compensation injuries? Yes or No (Circle) Dates____
Describe previous Worker Compensation Injuries____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient Signature ____Date ___________________________________

HEALTH HISTORY (Confidential)

Name: ______________________________ Date: ______________

Age: ______________ Date of Birth: ______________ Date of last physical examination: ______________

What is your reason for today's visit? ______________________________
Have you suffered any previous injury(i.e.:car accident/work related injury) to your neck/mid/lowback prior to this visit?
When?______________________________

____

SYMPTOMS (mark symptoms you currently have or have had in the past year)

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness or numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Eye, Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

Skin
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump n testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ______________.

Date of last Pap Smear ______________

Have you had a mammogram?

Are you pregnant? ______________.

Number of children ______________.

CONDITIONS (mark each condition you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS (list medications you are currently taking)	**ALLERGIES** (to medications or substances)
Pharmacy Name Phone	

(All information is strictly confidential)

FAMILY HISTORY (Fill in health information about your family)

Relation	Age	State of Health	Age at Death	Cause of Death	Check (X) if your blood relatives had any of the following: Disease		Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates

HEALTH HABITS-Check (X) which substances you use and describe how much you use.

	Caffeine
	Tobacco
	Drugs
	Other

SERIOUS ILLNESS / INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS-Check (X) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

PATIENT SIGNATURE　　DATE　　PHYSICIAN'S SIGNATURE　　DATE

WELLSPINE, P.A.

FRANCISCO J. BATLLE, M.D.
Neurological Surgery

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

____Accepted ______ Denied

Signature______________________________

Date: ________________________________

WELLSPINE, P.A.

FRANCISCO J. BATLLE, M.D.
Neurological Surgery

MEDICATION GUIDELINES

At some point in your treatment, Dr. Batlle may prescribe medication to help control your pain. This will likely be a controlled substance or narcotic. These medications have a high potential for abuse and misuse and are closely controlled by the local state and federal governments. If used excessively, the medications can cause serious adverse effects such as lethargy, respiratory depression, liver failure and even death. Certain guidelines must be followed in order for patients to receive these medications. Please read carefully and sign below to indicate that you will comply with guidelines. A copy of this agreement will be placed in your chart.

- Read the instructions on your medication bottle. Take the medication only as directed.
- No prescription will be filled before it is due.
- If your medication is due please call your pharmacy and give them the request. The pharmacy will call us for the approval.
- If your refill is due on a weekend, please call your pharmacy a couple of days early so that our office may authorize the refill for Saturday or Sunday as appropriate.
- Most calls to pharmacies are returned before the end of the business day.
- If your medication is lost or stolen, the office will be unable to refill it early. It is the patients' responsibility to keep narcotics and other medications in a safe place.
- No prescriptions will be refilled after 3:00 p.m. on Fridays. No prescription will be refilled on Nights, Weekends, and Holidays or on an "Emergency" basis.
- All patients are expected to abide by the dosing directions that are on your prescription bottle. It is not our intent that you should be in pain. If you feel that your medication is not controlling your discomfort please call our office.

I have read the guidelines and agree to abide by the recommendations.

____________________________ ____________________________

Patient Signature Date **Witness Signature Date**

8215 Westchester Dr * Dallas, Texas 75225 * Phone: (214) 819-9600 * Fax: (214) 819-9601