Atlanta Spine Specialists
New Workers Comp Paperwork

Patient Name: _____ Patient Date of Birth: _____

Chief complaint: Please briefly describe why you are coming to see Dr. Skaliy

Where is your pain located? Select all that apply. Choose side Left (L), Right (R), or Both (B)

Low back:	□R, □L, □B	Knee:	□R, □L, □B	Neck:	□R, □L, □B	Hand:	□R, □L, □B
Mid back:	□R, □L, □B	Hip:	□R, □L, □B	Head:	□R, □L, □B	Chest:	□R, □L, □B
Upper back	□R, □L, □B	Calf:	□R, □L, □B	Face:	□R, □L, □B	Abdomen:	□R, □L, □B
Buttock	□R, □L, □B	Ankle:	□R, □L, □B	Shoulder:	□R, □L, □B	Other:	
Thigh	□R, □L, □B	Foot:	□R, □L, □B	Arm:	□R, □L, □B		

Have you ever had back surgery? If yes, please list:

Medication List: Please list all current medications, including any over the counter medications or supplements:

Medication Name:	Dosage:	How Many Times a Day:

Please list any medication allergies you have? Do you have an allergy to shellfish?

Please rate your pain for the following. 0 is no pain and 10 is the worst pain you have ever felt.

Worst pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Least pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Average pain during the last month:	0	1	2	3	4	5	6	7	8	9	10
Current pain, as of this office visit:	0	1	2	3	4	5	6	7	8	9	10

Please check the words that best describe your pain:

- ☐ Aching
- ☐ Sharp
- ☐ Penetrating
- ☐ Throbbing
- ☐ Tender
- ☐ Nagging
- ☐ Shooting
- ☐ Burning
- ☐ Numb
- ☐ Stabbing
- ☐ Exhausting
- ☐ Miserable
- ☐ Gnawing
- ☐ Tiring
- ☐ Unbearable

Does your pain travel anywhere, for example your leg or arm?

☐ Yes ☐ No If yes, where?

Which statement best describes your pain frequency?

- ☐ Always present, always same intensity
- ☐ Always present, intensity varies
- ☐ Usually present, but have short periods without pain
- ☐ Often present, but have pain free periods lasting for one to several hours
- ☐ Often present, but am pain free for most of the day
- ☐ Occasionally present, have pain once to several times per day, lasting minutes to an hour
- ☐ Occasionally present for brief periods, a few seconds to a few minutes
- ☐ Rarely present, have pain every few days or weeks

What time of day is your pain the worst?

- ☐ Early morning
- ☐ Late morning
- ☐ Afternoon
- ☐ Evening
- ☐ Bedtime
- ☐ Night
- ☐ Pain is always the same
- ☐ Pain varies, but is not worse at any particular time.

Do you have any of the following associated with your pain. Check all that apply

- ☐ Numbness
- ☐ Tingling
- ☐ Increased sweating
- ☐ Coldness
- ☐ Bowel problems
- ☐ Muscle spasms, tightness
- ☐ Skin discoloration
- ☐ Weakness
- ☐ Bladder problems

What makes your pain feel worse? Check all that apply

- ☐ Sitting
- ☐ Coughing, sneezing
- ☐ Lying down
- ☐ Standing
- ☐ Physical activity
- ☐ Sexual activity
- ☐ Walking
- ☐ Other:

What makes your pain feel better? Check all that apply

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lying down
- ☐ Heat
- ☐ Relaxation
- ☐ Sexual activity
- ☐ Alcohol
- ☐ Nothing
- ☐ Other:

Medications for pain relief:

Before your pain began, did you consider yourself to be:

Extremely ill 0 1 2 3 4 5 6 7 8 9 10 Perfect health

Very tired 0 1 2 3 4 5 6 7 8 9 10 Very energetic

Do you feel you are helpless to change your present pain condition?

Always helpless 0 1 2 3 4 5 6 7 8 9 10 Never helpless

Very hopeless 0 1 2 3 4 5 6 7 8 9 10 Never hopeless

Since your pain began, overall has it: ☐ Increased, ☐ Decreased, ☐ Stayed the same

	Year
When did you first notice your pain?	
Date of injury or accident if different?	
When did you first see a doctor for this pain?	

Under what circumstances did your pain begin?

☐ Accident at work ☐ At work, not accident ☐ Following surgery ☐ Accident at home
☐ Pain just began, no reason ☐ Following illness ☐ Motor vehicle accident ☐ Other:

Describe the accident or circumstances:

If pain began at work, please list:

Place of employment when pain began?	
How long had you been employed there?	

If injured in motor vehicle accident, please answer the following.

☐ Driver ☐ Passenger ☐ Pedestrian ☐ Rider ☐ Automobile ☐ Truck ☐ Motorcycle

Details:

Have you seen other physicians for your pain? If yes, please list

Date	Physician	Specialty	Diagnosis/Treatment

What tests have you had done to diagnose your pain? Check all that apply

☐ X-ray ☐ CT scan ☐ MRI scan ☐ Bone scan ☐ Myelogram ☐ EMG/NCS
☐ Other:

Have you had injections for pain relief? ☐ Yes ☐ No

If yes, please list what type of injection:

How long did pain relief last? ☐ None, ☐ Few hours, ☐ Few days, ☐ Few Weeks, ☐ Month or more

Have you had any of the following for pain relief? Check all that apply

☐ Hypnosis ☐ Biofeedback ☐ Osteopathic ☐ Psychotherapy ☐ TENS
☐ Acupuncture ☐ Chiropractic ☐ Heat therapy ☐ Bed rest ☐ Physical therapy

How much does your pain interfere with you daily activities?

	Does not interfere										Completely interferes
General Activity:	0	1	2	3	4	5	6	7	8	9	10
Mood:	0	1	2	3	4	5	6	7	8	9	10
Walking Ability:	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine:	0	1	2	3	4	5	6	7	8	9	10
Social Activity:	0	1	2	3	4	5	6	7	8	9	10
Sleep:	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life:	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate:	0	1	2	3	4	5	6	7	8	9	10
Appetite:	0	1	2	3	4	5	6	7	8	9	10

Review of systems:

Has you appetite: ☐ Increased, ☐ Decreased, ☐ No change

Has your weight: ☐ Increased, ☐ Decreased, ☐ No change – How much gained/lost? _____

Please check any of the following conditions that you are currently experiencing:

General System:

☐ Weight loss/gain ☐ Fever ☐ Loss of appetite ☐ Fatigue

Skin:

☐ Rash ☐ Itching ☐ Pigmentation ☐ Dry Skin

Allergic/Immunologic

☐ Cancer ☐ Season Allergies ☐ Immune Deficiency

Ear/Nose/Throat:

☐ Nose Bleeding ☐ Hoarse Voice ☐ Gingival Bleeding ☐ Sinusitis

☐ Trouble Hearing ☐ Thyroid Mass ☐ Neck Stiffness, pain or tenderness

Head/Eyes

☐ Headaches ☐ Vertigo ☐ Lightheadedness ☐ Tearing

☐ Head Injury ☐ Vision Change ☐ Double Vision ☐ Eye Pain

Respiratory:

☐ Pain with Breathing ☐ Shortness of Breath ☐ Wheezing ☐ Cough

☐ Coughing up Blood ☐ Recurring Infections ☐ Tuberculosis ☐ Night Sweats

Cardiovascular:

☐ Chest Pain ☐ Palpitations ☐ Fainting ☐ Discomfort Breathing While Laying Flat

☐ Difficulty Breathing on Exertion ☐ Edema ☐ Severe Shortness of Breath at Night, during sleep ☐ Heart Murmurs

☐ High Blood Pressure

Gastrointestinal:

☐ Loss of Appetite ☐ Trouble Swallowing ☐ Abdominal Pain After Eating ☐ Heartburn

☐ Nausea/Vomiting ☐ Vomiting Blood ☐ Jaundice (yellow skin) ☐ Constipation

☐ Diarrhea ☐ Abnormal Stools ☐ Hemorrhoids

Genitourinary (Females):

☐ Urgency ☐ Frequency ☐ Painful Urinating ☐ Blood in Urine

☐ Excessive Urinating ☐ Urinary Retention ☐ Recurring Infections ☐ Kidney Stones

☐ Vaginal Discharge ☐ Vaginal Bleeding

Endocrine:

☐ Excessive Thirst	☐ Cold Intolerance	☐ Goiter	☐ Excessive Urinating
☐ Heat Intolerance	☐ Excessive Hunger		

Musculoskeletal:

☐ Pain	☐ Swelling	☐ Limited Range of Motion	☐ Joint Pain
☐ Weakness	☐ Muscle Atrophy	☐ Night Cramps	

Neurologic:

☐ Seizures	☐ Paralysis	☐ Incoordination	☐ Tremor
☐ Tingling	☐ Loss of Memory	☐ Sensory of Motor Disturbances	☐ Impaired Coordination

Psychiatric:

☐ Depression	☐ Hallucinations	☐ Suicidal Thoughts	☐ Anxiety

Blood/Lymphatic:

☐ Easy Bruising	☐ History of Blood Clots	☐ Lymphedema	☐ Bleeding History
☐ History of Swollen Glands	☐ Blood Transfusions		

Past Surgical History:

☐ No previous surgeries or hospitalizations

☐ Gallbladder Removal	☐ Hernia Repair	☐ Spinal Fusion
☐ Appendectomy	☐ Cesarean Section	☐ Microdiscectomy
☐ Hysterectomy	☐ Joint Replacement	☐ Other Spine Surgery
☐ Other:		

Past Medical History:

☐ No significant past medical history

☐ Diabetes:	
☐ High Blood Pressure:	
☐ Neurological Disease:	
☐ Heart Disease:	
☐ Respiratory Disease:	
☐ Gastrointestinal Disease:	
☐ Liver Disease, Hepatitis:	
☐ Cancer:	
☐ Kidney Disease:	
☐ HIV, Infection Disease:	
☐ Other:	

Family History:

☐ No known significant family history of heart disease, cancer or other serious illness

Family Member					Health Status or Cause of Death
☐ Father	☐ Obesity	☐ Cancer	☐ HTN	☐ Diabetes	
☐ Mother	☐ Obesity	☐ Cancer	☐ HTN	☐ Diabetes	
☐ Sibling	☐ Obesity	☐ Cancer	☐ HTN	☐ Diabetes	

Do you have any family members with chronic pain?

☐ No ☐ Yes If yes, who? _____

Do you have any family members taking pain medicines on a regular basis?

□ No □ Yes If yes, who? _____

Do you have any family members with psychiatric illness?

□ No □ Yes If yes, what type of illness? _____

Social History:

		How often and how much?
Alcohol Consumption:	□ Yes, □ No	
Tobacco Consumption:	□ Yes, □ No	
Recreational Drugs:	□ Yes, □ No	

Marital Status: □ Married, □ Single, □ Divorced, □ Widowed, □ Separated

Living Situation: □ Alone, □ With Spouse, □ With Relatives, □ With Friends, □ With Roommate

Job History:

Current Work Status: □ Full time □ Part time □ Don't Work

Occupation: _____

Specific Duties: _____

Highest Grade in School: _____

Is the job satisfying? □ Yes □ No

Is the job financially satisfying? □ Yes □ No

Did you stop working because of pain? □ Yes □ No

Can you return to work?

□ Yes □ No	Explain:

Have you received financial compensation for pain? □ Yes, □ No, □ Lump sum

Have you received financial support related to pain? If yes, please explain

□ Yes □ No	Explain:

Is the compensation adequate? □ Yes, □ No

Are you bringing a lawsuit due to pain? □ Yes, □ No

Are you planning to file a lawsuit due to pain? □ Yes, □ No

Attorney Name:	Address:

Mental Health History:

Have you ever had psychological or psychiatric treatment? If yes, please explain

□ Yes □ No Explain: _____

Do you or have you taken antidepressants or antianxiety medication? If yes, please list

□ Yes □ No Explain: _____

Do you or have you had substance or alcohol abuse problems? If yes, please explain

□ Yes □ No Explain: _____

Have you lived with someone with alcohol or substance abuse problems? Explain relationship and substance

□ Yes □ No Explain: _____

Do you have any history of being abused? (physical, sexual, emotional)

□ Yes □ No Explain: _____

Atlanta Spine Specialist/Windward Surgery Center

Name: _____ Date: _____

1. Have you traveled outside of Georgia in the past 3 weeks? If so where?
   a. _____ Yes _____ No
2. Have you had contact with someone with confirmed diagnosis of COVID-19?
   a. _____ Yes _____ No
3. Have you or anyone in your family experienced a fever **AND** any of the following symptoms: sore throat, cough, shortness of breath, muscle aches in the last week?
   a. _____ Yes _____ No

COVID-19 Vaccination:

1. Are you planning of receiving the COVID-19 vaccine?
   a. _____ Yes _____ No
2. Have you received the COVID-19 vaccine already? If yes, how many doses?
   a. _____ Yes: 1st: _____ 2nd: _____ Pfizer ___ Moderna ___
   b. _____ No

Patient Signature: _____

Atlanta Spine Specialists
Michael Skaily M.D.
12425 Morris Road, Suite A
Alpharetta, GA 30005

Patient Registration Form

Tell us how you heard of us: (please circle)

Our website *Facebook* *Internet Search* *Google*

By you Physician, please share their name: _____

By one of our patients, please share their name: _____

Other: _____

Patient Information:

Name: _____ Nickname: _____
Last First Middle

Date of Birth: _____ Sex (please circle): *Female Male Unknown*

Marital Status (please circle): *Single Married Separated Divorced Widowed Partner*

Social Security Number: _____

Address: _____ Suite/Apt. Number: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext: _____

Preferred Method of Communication: (Please circle)

Email *Voice Message (cell)* *Voice Message (home)* *Voice Message (work)*

Preferred Pharmacy Information:

Pharmacy Name: _____

Address: _____ Phone Number: _____

Primary Care Physician:

Name: _____ Phone Number: _____

Atlanta Spine Specialists
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12425 Morris Road, Suite A
Alpharetta, GA 30005

Employment: (please circle)

Full-time Student *Part-time Student* *Employed* *Not Employed*

Self-Employed *Retired* *Active Military*

Name of Employer: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Information:

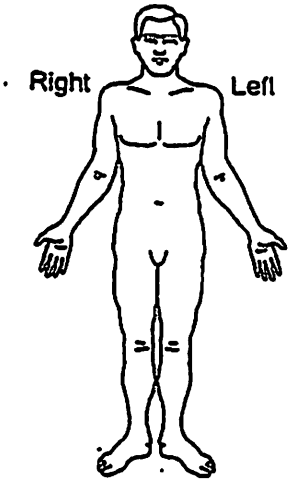
1. Name: _____ Relationship: _____
   Phone: _____ *cell, home or work (please circle)*
2. Name: _____ Relationship: _____
   Phone: _____ *cell, home or work (please circle)*

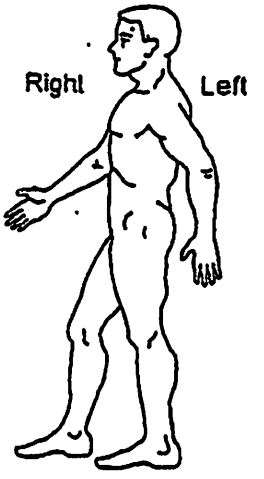
PAIN COLOR CHART

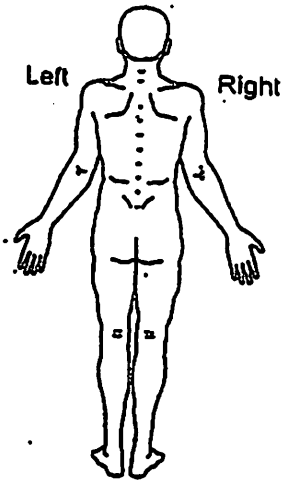
Red: Most Severe Pain

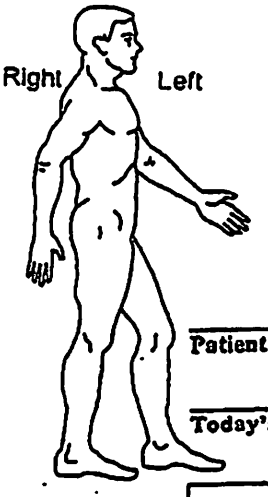
Blue: Less Severe Pain

Green: Numbness









Patient Name (Print Clearly) _____

Today's Date _____

For Office Use Only
Procedure:

Atlanta Spine Specialists
Michael Skaily M.D.
12425 Morris Road, Suite A
Alpharetta, GA 30005

Appointment Cancellations:

We understand that circumstances occasionally arise changing your plans. Therefore, if you need to cancel or reschedule your appointment, you are requested to notify us as soon as possible, but no later than 48 hours in advance. If you do not cancel within 48 hours or fail to show for you appointment, you will be responsible for a $50.00 cancellation charge. Cancellation charges are not covered by insurance and are due and payable prior to any further appointments.

If you need to reschedule your appointment, please call the office. If you call after hours, please leave a message.

I have read and understand these guidelines and agree to the terms therein.

Signature of patient Date

Revised 3/16/2021

Atlanta Spine Specialists

Michael Skaily M.D.
12425 Morris Road, Suite A
Alpharetta, GA 30005

Please read and initial each of the following statements. By initialing you indicate that you have read, understand and agree to each one.

HIPPA

Initials:

_____ My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers for my health care services.

Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my surgeon's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my surgeon has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Assignment of Benefits

Initials:

_____ I acknowledge that payment for services and supplies are due in full at the time services are rendered. In consideration for Atlanta Spine Specialists (Provider) not requiring me to pay all charges for care and services rendered during my visit at the time of delivery. I hereby assign to Provider any and all rights to receive insurance benefits otherwise payables to me for products or services provided by the Provider to the extent payable. I understand that my signature requests that payment by my insurance carrier be made directly to the Provider. I authorize Provider to appeal denied insurance authorization and/or benefits on my behalf. I agree to cooperate with the requests of the Provider for assistance in efforts made by the Provider with its efforts to assist me in filling and collecting claims for coverage. If my insurance carrier does not accept assignment of benefits, I understand that all correspondence and payments to Provider may be sent directly to me. I agree that when and if such payments are received, I will hold them in trust for Provider and promptly and immediately transmit them to the Provider for payment of my bill. I acknowledge that this assignment of benefits in no way absolve me from financial responsibility for ensuring that the Provider is promptly pain in full for all charges for care, services and supplies regardless of availability or lack of insurance coverage for such charges. I am responsible for the deductible, co-insurance and non-covered service as well as any other charges not promptly pain by my insurance carrier. I agree that I will be financially responsible for and promptly pay the Provider for any claim or portion of claim thereof, due to Provider for supplies and/or services no covered by my insurance policy as of the date that care, service or supply was rendered. If my insurance company denies coverage or within 60 days of bulling by the Provider has failed to pay for all or any billed charge, I will promptly pay the Provider for the full amount of any such charge. If my insurance company changes I will promptly notify the Provider within 30 days of such change. In Medicare assigned cases, Provider agrees to accept the charge determination of the Medicare carrier as the full charge for services and supplies that are covered by Medicare to the extent required by Medicare.
I acknowledge that Provider has supplied me with it Notice of Privacy Acts.
I acknowledge that Provider has the right to collect co-pay/co-insurance amounts.
I acknowledge that I am the patient or the patient's duly authorized representative and that the information given by me to the Provider for payment under insurance plans, Medicare is correct and complete. Any modifications, deletions or changes to this form are void and will not be honored. I understand and acknowledge and agree to the terms set forth above.

Atlanta Spine Specialists
Michael Skaliy M.D.
12425 Morris Road, Suite A
Alpharetta, GA 30005

Authorization to Release Claims Information

Initials:

_____ I hereby authorize Atlanta Spine Specialists (Provider), its employees and agents, to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits payable by or on the behalf of any such person. I hereby authorize Provider, its employees and agents to act on my behalf in completing claims.

Precertification

Initials:

_____ I understand that my insurer may require compliance with a utilization review (UR) program to ensure that plan benefits are justified. I understand that if the UR program determines that the admission or treatment is necessary and appropriate and issues certification, the benefits of my health plan will be made available to me in accordance with the terms of my policy. However, if certification is denied, healthcare benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party. I understand that Provider is willing to provide medical services and help in any precertification process.

Permission To Perform Pain Management Care

Initials:

_____ I understand that I am seeking medical care for pain management at Atlanta Spine Specialists. This may include care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry and coping strategies), alternative therapies, physical therapy, and weight management. I understand that Atlanta Spine Specialists may provide interventional pain management treatments, such as injections, to treat my pain condition after diagnosis. I understand that Atlanta Spine Specialists do not provide long-term pain medication to treat my pain condition.

I understand the type of medical care I receive may vary from visit to visit. I understand that is it impossible to predict the results of any pain management medical care. I understand that the doctors giving the medical care feel it may benefit or diagnose my condition; however they cannot guarantee that the medical care will help. I understand that if any problems occur or I believe a complication may have occurred and I cannot immediately speak with the office staff I should seek immediate emergency medical care at the closest hospital emergency room or other emergency medical facility. I understand that I may refuse any type of pain management medical care at any time by telling my physician and the medical staff.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. I understand that this form will be applicable to medical care today and that upon voluntarily returning for medical care this form will continue to be permission for all subsequent pain management medical care performed or directed by Dr. Skaliy. I understand that prior to any medical care I can and I am encouraged to ask questions including but not limited to diagnosis, the risks and nature of a medical care and also practice alternative to a medical care, and the prognosis with and without a type of medical care; and receive satisfactory answers to my questions from the physician and/or medical staff.

I hereby voluntarily request and consent for Dr. Michael Skaliy, as my physician, and such associate(s), assistant(s), or other medical personnel involved performing such Pain Management medical care.

Signature of person giving consent Date	Signature of witness Date
Print name of person giving consent	Print name of witness

Revised 03/16/2021