Spinal Institute of southern Utah

415 West Tabernacle, St. George, Utah 84770
Dr. Michael K. Hobson – 435-656-1777

Patient Information

Welcome to my office! I am pleased that you have selected this office to assist you in treatment and management of your condition. I specialize in structural and nerve related conditions, also nutritional medicines and healthy lifestyles to prevent future disease. Examinations are done routinely to determine the nature and extent of problems. These exams may consist of chiropractic, orthopedic, neurological, x-ray and laboratory tests, etc., depending on what is necessary. The minimum fee for preliminary examinations with treatment is $60.00. More detailed or specific examinations may be needed in complex or chronic cases to make an accurate diagnosis, which may add to the fee.

This office recognizes the responsibility of filing insurance claim forms for the patient, however, patients are held due and responsible for their bills to this office. In selected cases, Workman's Compensation and automobile accident insurance will suffice. Arrangements can be made with the insurance secretary.

The following information is necessary and confidential. **Please answer all questions**. If you do not understand or need assistance, please ask the receptionist.

PATIENT INFORMATION **DATE:_______________**

Last Name:____ SS # ________-______-__________ (for insurance identification)
First name:____ Birth Date:________/_________/_________Age:_________
Household Address:__________________________________ Height:________________Weight:______________________
Mailing Address:_____________________________________ Marital Status: (circle) S M W D Spouse:____________
City: ________________State:________Zip:_____________ Emergency Contact::__________________________________
Cell. Ph#__________________Cell Carrier:_____________ Their Ph# _____-_____-________
Hm. Ph#__________________WK. Ph#________________ Whom may we thank for referring you? ________________
Email:____ Your Occupation:_____________________________________
Preferred Contact__Hm__Wk___Cell___Email__Post Mail Your Employer:_______________________________________

1. Race: ___ White___American Indian or Alaska Native ___ Asian ___Native Hawaiian/Other Pacific Islander___ Black or African American___ Hispanic or Latino ___ Decline to answer ___Other_________________
2. Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

Assignment & Release

INSURANCE INFORMATION (Please provide card to front desk)

Name of Ins.:__________________Policyholder Name:__________________________ Policyholder DOB:_______________

I understand and agree that the health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the Spinal Institute/staff will prepare any necessary reports and forms to assist me in making collection from insurance company and that any amount authorized to be paid directly to Dr. Michael K. Hobson will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable and further, agree to pay the actual expenditures incurred in any attempt to collect the amount due. Including reasonable attorney's fees and costs. I certify that all the above information given is true and correct. A finance charge of 1.5% per month (annual Percentage rate of 18%) will be applied to any amount not paid after 60 days.

Patient's/Parent's/Guardian's Signature: ____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: ____

PLEASE COMPLETE INFORMATION ON BACK OF PAGE

Please check only the conditions you now suffer from:

__Headaches (describe) _______________
__Depression
__Tremors or seizures
__Abdominal pain
__Chest pain
__Blurred vision
__Bladder dysfunction (burning)
__Colon dysfunction (evacuation pain)
__Loss of sexual feeling
__Hands drop objects involuntarily
__Weight gain of ____ lbs
__Weight loss of ____lbs
__Buzzing/ ringing in the ears
__Difficulty in breathing
__Vomiting
__Digestive disorders
__Constipation
__Memory loss
__Insomnia
__Feet cold/ hands cold
__Loss of balance
__Legs buckle involuntarily
__Swelling of _____________
__Loss of eye movement
__Nervous tension
__Visual problems
__Dizziness
__Hot flashes
__Sinus trouble
__Diarrhea
__Fatigue
__Anxiety
__Fainting
__Obesity
__Menstrual problems
__Hearing difficulty
__Loss of smell
__Loss of taste
__Loss of voice
__Nausea
__Fever
__Rib pain
__Bedwetting
__Coughing
__Tooth pain
__Jaw pain
__Ear pain
__Scarring
__Palpitations
__Hoarseness
__Hearing loss
__Sore throat

Medical Information and History- please check all that apply

___Have you ever had cancer?
___Are you now losing weight without trying?
___Are you seeing another doctor now for any reason?
___Are you coughing up blood?
___Do your pains ever wake you from a sound sleep?
___Have you had any loss of bladder control?
___Have you noticed any blood in your stools or urine?
___Have you lost consciousness or had double vision recently?

Information and history- please check all that apply – Present complaint is due to:

___On the Job ___ Home Injury ___ Auto Accident ___ Illness ___ Old Injury ___ Disease ___Athletic Injury ___ Poor Condition

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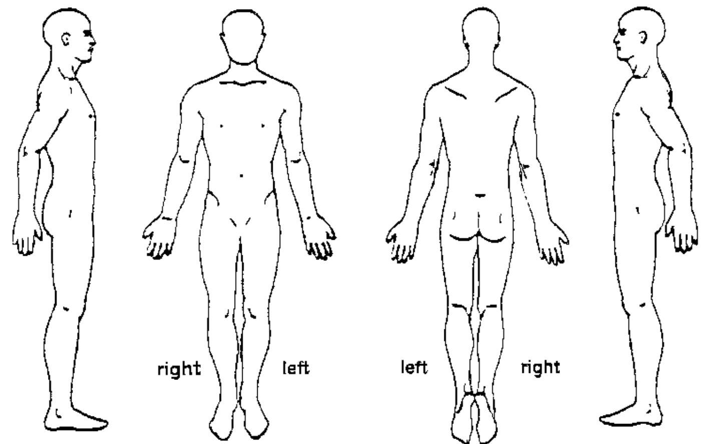
How often do you experience your symptoms?

___Constantly (76-100% of the day)
___Frequently (51-75% of the day)
___Occasionally (26-50% of the day)
___Intermittently (0-25%of the day)

How are your symptoms changing?

___Getting better
___Staying the same
___Getting worse

Dull Ache	XXX
Pins and Needles	OOO
Numbness	----
Burning	+++
Stabbing	***
Other_______	###



Please fill in the pain diagrams to the right.

No Pain Intolerable Pain

How bad are your symptoms at their:

Worst [--]
Best [--]
Now [--]

Have you been treated for this condition? ___YES ____NO

If yes name and address of treating physician: ____

Please select the type of care desired so we can provide you with the best treatment and management of your condition.

___Relief care- Temporary or short-term care. ___ Corrective care- Basic Stabilization/medium care.
___Comprehensive care – long-term/ultimate improvement. ___ I would like to know what the doctor thinks is best for me.

List all pharmaceutical medication you are currently taking and the condition requiring their use. **Include vitamins, herbs, minerals…**

1.____ Condition:__________________________________
2.____ Condition:__________________________________
3.____ Condition:__________________________________
4.____ Condition:__________________________________