CHRISTOPHER O. NEUBUERGER, MD INC.
ORTHOPEDIC SPINE SURGERY

Dear

You have been referred to Christopher O. Neubuerger, MD, for an evaluation. We welcome you to the practice and look forward to assisting you with your health care needs. Please call the office right away if this date and/or time does not work for you, or if you are experiencing flu-like symptoms one week prior to your appointment.

PROVIDER: CHRISTOPHER O. NEUBUERGER, MD

APPOINTMENT:

CHECK-IN TIME:

LOCATION: 3941 J STREET, SUITE 370, SACRAMENTO, CA 95819
PLEASE NOTE: THE OFFICE IS LOCATED IN THE NORTH TOWER.

Paid Parking is available in the Mercy Medical Plaza surface lot or in the Mercy General Hospital Parking structure. The cost for parking is $2 per 30 minutes or $12.00 max/day.

BEFORE YOUR APPOINTMENT:

1. Notify the office in advance if an interpreter is needed.
2. Complete the enclosed paperwork and bring it with you to the appointment.
3. Contact the office at (916) 229-8890 if you have any questions.

BRING THE FOLLOWING ITEMS:

1. Current insurance card(s) required.
2. Hand carry all diagnostic studies (MRI, CT, X-Ray). Failure to do so may result in rescheduling.

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ABOUT OUR OFFICE

MISSION STATEMENT: Our mission is to provide our patients with the highest level of comprehensive spine care in an atmosphere of compassion and respect. Dr. Neubuerger endeavors to be an advocate for his patients while providing a spectrum of treatments that include evaluation, education, conservative rehabilitation, and surgical intervention from minimally invasive procedures to the most complex spine surgeries.

HIPAA: Christopher O. Neubuerger, MD Inc. is HIPAA compliant. You may review a copy of the Privacy Policy to read upon check in, if you choose, a copy will be provided for you. If you have any questions, we would be happy to answer them when you arrive.

MEDICATION REFILL POLICY: Please contact your pharmacy for refill requests or request a refill during your scheduled visit. We do not refill on Fridays, weekends, or by telephone.

CANCELLATION POLICY: 24-hour notice is required for all cancellations.

Failure to provide required notification will result in the following fee:

Follow Up: $25.00 Consultation/Evaluation: $50.00.
The fee is due prior to rescheduling.

FORMS: (Disability, Insurance etc.):
Fees for completion of forms vary depending on the form. (Most range from $10-$50).

PAYMENT FOR SERVICES: It is your responsibility to know and understand your benefits prior to your appointment. Co-Pays, PPO deductibles, and HSA deductibles are due at the time of service. Accepted forms of payment are listed below and we will bill your insurance plan whenever possible. *Please remember that the primary responsibility for payment is yours, not your insurance company's.* Please check with your carrier to see if Dr. Neubuerger is a member of your insurance plan or medical group, if not you may be required to pay in full for the services. If you have any questions about insurances accepted, please contact us at 916-229-8890, as we are in the process of adding insurance plans to our practice at this time.

ACCEPTED FORMS OF PAYMENT: Check, debit cards, Visa, MasterCard or Discover.
We are a cashless office.

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ORTHOPEDIC SPINE SURGERY

RETURNED CHECK FEE: A $35.00 fee is due by debit card, money order, or credit card for returned checks.

OPEN PAYMENT DATABASE: The Open Payment Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpayments.cms.gov.

CHRISTOPHER O. NEUBUERGER, MD INC ***REVIEW CAREFULLY***

PATIENT:		
Marital Status:	[ ]Single [ ]Married [ ]Widow [ ]Divorced [ ]Domestic Partner	
Primary Language:	[ ]English [ ]Spanish [ ]Other, please list:	[ ]Interpreter needed? Y N
Race:	**Ethnicity:**	
Home Phone:		Okay to leave a message? [ ]Yes [ ]No
Cell Phone:		
Email Address:		
Appointment Reminder:	[ ]Phone call [ ]Text message [ ]Email message	
Emergency Contact:		Phone #:
Primary Care MD:	P: F:	
Referring MD:	P: F:	

HIPAA: Health Insurance Portability and Accountability Act: List any person that may act on your behalf and/or request information.	
List full name only or [ ]None:	
Smoking Status:	[ ]Never [ ]Ex-smoker [ ]Light smoker [ ]Occasional smoker [ ]Daily smoker [ ]Heavy smoker
Flu Shot:	Did you get your flu shot this season? [ ]Yes [ ]Not yet [ ]Declined shot

INSURANCE COVERAGE
You must present your insurance card at the time of service

	COMPANY	ID#	SUBSCRIBER/DOB & RELATIONSHIP
Primary:			[ ]Self [ ]Spouse:
Secondary:			[ ]Self [ ]Spouse:
Other:			[ ]Self [ ]Spouse:

WORKER'S COMPENSATION COVERAGE	
Insurance Carrier:	**Adjuster:**
Employer:	**Claim Number:**
Body Part(s):	**Date of Injury:**
Length of employment:	**Social Security Number:**

Notice of Privacy Practices: I hereby acknowledge that I received a copy or have access to a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Gabriella Neubuerger, 916-229-8890, Privacy Officer

Assignment of Benefits, Release of information: I hereby assign all necessary medical and/or surgical benefits to which I am entitled, including private insurance and any other plan to Christopher O. Neubuerger, MD Inc. for all services rendered by its medical providers and representatives. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid for by said insurance according to contract or regulations. I hereby authorize Christopher O. Neubuerger MD Inc. or its representatives to release or obtain necessary medical records for treatment purposes and/or to secure payment.

Open Payment Database Notice: "The Open Payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpayments.cms.gov." "For information purposes only, a link to the Federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The Federal Physicians Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

Patient or Parent/Guardian Signature:_____	**DATE:**
Printed Name:_____	_____

CHRISTOPHER O. NEUBUERGER, MD

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Physicians Name: Doctor (name): _____

Part of the body seen for today:

○ Neck	○ Right Shoulder	○ Left Shoulder	○ Right Arm	○ Left Arm	○ Ribs
○ Right Mid Back	○ Left Mid Back	○ Lower Back	○ Buttocks	○ Right Thigh	○ Left Thigh
○ Right Leg	○ Left Leg	○ Right Foot	○ Left Foot		

Percent of pain:

__% of pain in Neck	__% of pain in Back	__% of pain in Arm	__% of pain in Leg

Duration of Problem: ○ 0-1 month ○ 1-3 months ○ 3-6 months ○ 6-12 months ○ More than a year

Is the problem the result of an injury?

○ No Injury ○ Work injury Work injury date:_____ ○ Motor vehicle accident MVA date:_____

Describe Injury/Accident: **Litigation pending?** ○ Yes ○ No Date last worked:_____

_____

_____

_____

Patient taken to hospital for injury: ○ Yes ○ No **Hospitalized?** ○ Yes ○ No

Treating physician or health care provider:_____

Prior tests for this problem:

○ None ○ X-rays ○ MRI ○ CT Scan ○ Myelogram ○ Bone Scan ○ Nerve Test (EMG / NCV)

Prior treatment:

○ Back Brace ○ Chiropractor ○ Injection/Nerve Block ○ Medication ○ PT ○ Median branch block/Rhizotomy

If injections, dates: _____

On a scale of 0-10, TODAY the pain is a severity of: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

The quality of pain is: ○ Aching ○ Burning ○ Cramping ○ Dull ○ Numbness ○ Pressure ○ Sharp/Stabbing ○ Shooting ○ Tingling ○ Other _____

The pain is: ○ Constant ○ Intermittent **Pain wakes patient from sleep:** ○ Yes ○ No

Since the problem started, it is: ○ Getting Better ○ Getting Worse ○ Unchanged

 Patient Name: _____

Symptoms worsen with:

○ Bending Forward	○ Driving	○ Lying in Bed	○ Rising from sitting	○ Standing
○ Bending Backward	○ E-Stim	○ Massage	○ Spinal Cord Stim	○ Sweeping
○ Blocks	○ Heat	○ Meds	○ Sitting	○ TENS
○ Brace	○ Ice	○ Previous surgery	○ Sneezing	○ Twisting
○ Chiropractor	○ Increased Activity	○ PT/OT	○ Squatting	○ Walking
○ Coughing	○ Lifting	○ Rest	○ Stairs	

○ Other _____

Symptoms improve with:

○ Bending Forward	○ Driving	○ Lying in Bed	○ Rising from sitting	○ Standing
○ Bending Backward	○ E-Stim	○ Massage	○ Spinal Cord Stim	○ Sweeping
○ Blocks	○ Heat	○ Meds	○ Sitting	○ TENS
○ Brace	○ Ice	○ Previous surgery	○ Sneezing	○ Twisting
○ Chiropractor	○ Increased Activity	○ PT/OT	○ Squatting	○ Walking
○ Coughing	○ Lifting	○ Rest	○ Stairs	

○ Other _____

List all previous surgeries: ○ None

Year	Procedure	Surgeon	Outcome (relief/no relief)

Medications taken on a regular basis (including hormonal replacement therapy and birth control):

○ **None**

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Allergies to medications: ○ None

Medication	Reaction

Other allergies: ○ Yes ○ No If yes, what are they? _____

Allergy to Latex? ○ Yes ○ No **Iodine allergy?** ○ Yes ○ No

 Patient Name: _____

Do you have a personal history of any of the following? ○ **None**

○ Abnormal Blood Pressure	○ DVT (blood clots)	○ Liver disease
○ Aneurysm Where:_____	○ Emphysema	○ Lung disease
○ Anxiety Disorder	○ Epilepsy	○ Malignant hyperthermia
○ Arthritis Type:_____	○ Excessive or prolonged bleeding	○ MRSA Infection
○ Asthma	○ Fibromyalgia	○ Pacemaker
○ Birth Defects	○ Fractures / Joint dislocations	○ Paralysis Type: _____
○ Blood transfusion	○ Glaucoma	○ Peptic ulcers
○ Bone or joint infections	○ Heart Attack	○ Problems with wounds healing
○ Cancer Type: _____	○ Heart Disease / Defect	○ Psychiatric Care
○ Chemical dependency	○ Hematologic disorder	○ Pulmonary embolism
○ Chemotherapy/radiation	○ Hepatitis	○ Reaction to anesthesia Type:_____
○ Chronic fatigue syndrome	○ High Cholesterol	○ Rheumatic Fever
○ Circulatory problems	○ HIV / AIDS	○ Sleep Apnea
○ Concussion	○ Hyperthyroidism	○ Stroke
○ Continuous seizures	○ Hypothyroidism	○ Thrombophilia
○ Depression	○ Inflammatory bowel disease	○ Tuberculosis
○ Diabetes Type:_____	○ Kidney disease	○ Varicose veins

Are you currently pregnant? ○ Yes ○ No

Are you claustrophobic? ○ Yes ○ No

Do you use a CPAP? ○ Yes ○ No

Review of Systems

Please indicate if you have had any of the following problems in the last 6 months?					**None**
CONST	○ fatigue	○ weight loss	○ weight gain		○
HEMA	○ bleeding tendency	○ clotting disorder	○ anemia		○
HEENT	○ hearing loss	○ vision loss	○ dental problems	○ hoarseness	○
MUSCUL	○ neck pain	○ back pain	○ shoulder pain	○ knee pain	○
	○ joint pain	○ joint stiffness	○ joint swelling	○ ankle swelling	
	○ leg swelling				
CARDIO	○ chest pain	○ arrhythmias			○
PULM	○ shortness of breath	○ chronic cough	○ wheezing	○ congestion	○
NEURO	○ seizures	○ extremity weakness	○ headaches	○ numbness	○
PSYCH	○ depression	○ anxiety	○ suicidal thoughts	○ insomnia	○
GI	○ diarrhea	○ constipation	○ heartburn	○ abdominal pain	○
ENDO	○ diabetes	○ hormone replacement			○
GU	○ loss of bladder control	○ loss of bowel control	○ recurrent urinary infections		○
SKIN	○ frequent rashes	○ lesions	○ sores		○

 Patient Name: _____

Family History

Direct relatives (parents/siblings) have a history of any of the following disorders?

Father	○ NONE	○ Blood transfusion	○ Glaucoma	○ Stroke
	○ Arthritis	○ Cancer	○ Hypertension	○ Tuberculosis
	○ Back pain	○ Diabetes	○ Neck pain	
	Other relevant:	_____		
Mother	○ NONE	○ Blood transfusion	○ Glaucoma	○ Stroke
	○ Arthritis	○ Cancer	○ Hypertension	○ Tuberculosis
	○ Back pain	○ Diabetes	○ Neck pain	
	Other relevant:	_____		
Sibling	○ NONE	○ Blood transfusion	○ Glaucoma	○ Stroke
	○ Arthritis	○ Cancer	○ Hypertension	○ Tuberculosis
	○ Back pain	○ Diabetes	○ Neck pain	
	Other relevant:	_____		

Social History

Do you use tobacco? ○ Yes ○ No ○ Quit If ever, packs per day _____ Number of years _____

Informed of smoking risk? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No ○ Quit If yes, how much _____

Recreational drug use? ○ Yes ○ No ○ Quit

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ SO

Current work status? ○ Employed ○ Unemployed ○ Retired ○ Disabled ○ Student ○ Homemaker

If not working, last worked _____

Lost time due to injury ○ Yes ○ No If yes, how much _____

Any current restrictions? ○ Yes ○ No **If yes, specify:** _____

Occupation: _____ **Employer:** _____

Job description: _____

_____

_____ _____

Patient Signature **Date**

Patient Name:		DOB:
Address:		
Home:	Cell:	Email:
Please enter: Height: Weight: lbs		

IN THE PAST 10 DAYS	1.Have you experienced: [ ]Fever(+100.4) [ ]Cough [ ]Body Aches [ ]Shortness of breath 2.Have you been diagnosed or exposed to coronavirus (COVID-19): YES or NO
FLU SHOT:	Did you get your flu shot this season? [ ]Yes [ ]Not yet [ ]Declined shot
SMOKING:	No: [ ]Ex-smoker [ ]Never smoked Yes: [ ]Heavy [ ]Light [ ]Occasional [ ]Daily
HIPAA:	List any person(s) whom may discuss/request medical information on your behalf: 9/16/2022 12:00:00 AM [ ]None [ ]List full name(s) only:
IN THE PAST 6 MONTHS:	I have failed to improve with: [ ]6wks of Physical therapy [ ]Chiropractic [ ]Acupuncture [ ]Activity modification [ ]Heat/Ice [ ]NSAID medication

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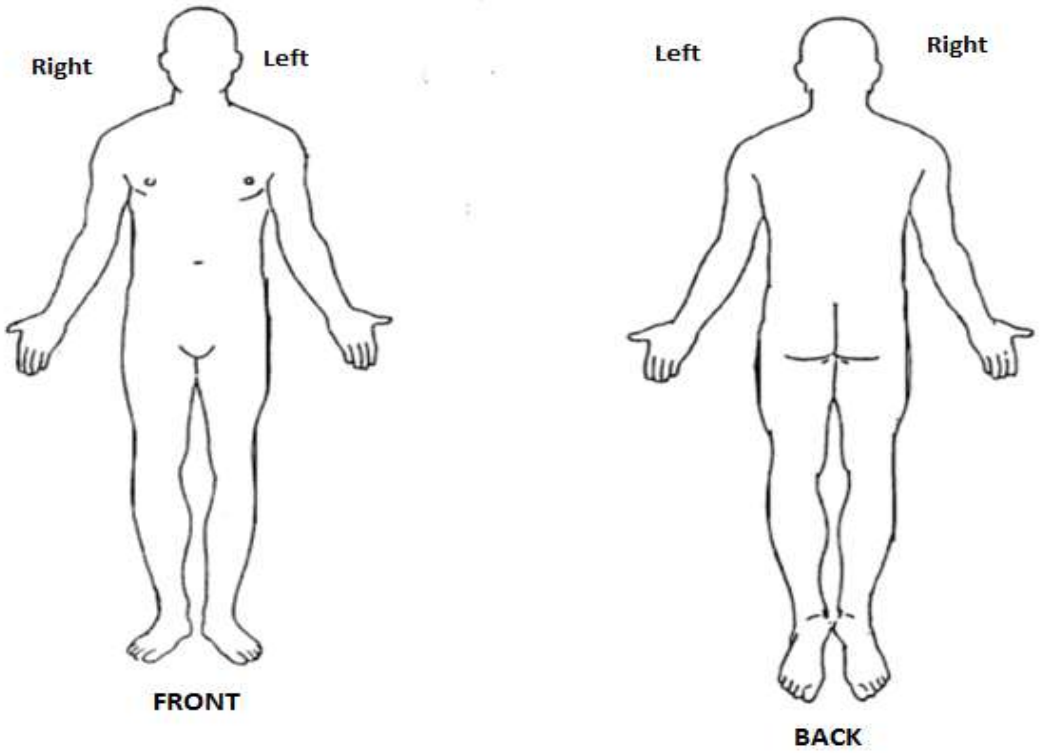
1) How bad is your pain/ discomfort today? Place a mark on the line below:

No pain 0 _____5_____10 Worst Possible

2) Where is your pain/discomfort today?

Use the symbols to mark all areas on your body where you feel the described sensations:

Aching: ^^^^ Numbness: 0000 Pins & Needles: ..... Burning: xxxx Stabbing: \\\\\



3) Just to complete the picture, please draw in your face.

Patient signature:_____

Christopher O. Neubuerger, MD Inc.:OSWESTRY **Patient Name:** Date:_____

This questionnaire has been designed to give us information regarding how your back and/or neck pain has affected your ability to manage everyday life. We realize you may consider that two or more statements in any one section relate to you. Please select only the one that most clearly describes your condition.

- ***Mark ONLY ONE answer for each section***
- ***Answer every section.***

Section 1: Pain Intensity

[ ]I have no pain at the moment.
[ ]The pain is very mild at the moment
[ ]The pain is moderate at the moment
[ ]The pain is fairly severe at the moment
[ ]The pain is very severe at the moment
[ ]The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. Washing, dressing)

[ ]I can look after myself normally without causing extra pain
[ ]I can look after myself normally but it causes extra pain
[ ]It is painful to look after myself and I am slow and careful
[ ]I need some help but can manage most of my personal care
[ ]I need help every day in most aspects of self care
[ ]I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

[ ]I can lift heavy weights without extra pain
[ ]I can lift heavy weights but it gives me extra pain
[ ]Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. On table
[ ]Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
[ ]I can lift very light weights
[ ]I cannot lift or carry anything

Section 4: Walking

[ ]Pain does not prevent me from walking any distance
[ ]Pain prevents me from walking more than 1 mile
[ ]Pain prevents me from walking more than 1/4 mile
[ ]Pain prevents me from walking more than 100 yards
[ ]I can only walk using a stick or crutches
[ ]I am in bed most of the time

Section 5: Sitting

[ ]I can sit in any chair as long as I like
[ ]I can only sit in my favorite chair as long as I like
[ ]Pain prevents me from sitting more than 1 hour
[ ]Pain prevents me from sitting more than 30 minutes
[ ]Pain prevents me from sitting more than 10 minutes
[ ]Pain prevents me from sitting at all

Section 6: Standing

[ ]I can stand as long as I want without extra pain.
[ ]I can stand as long as I want but it gives me extra pain
[ ]Pain prevents me from standing more than 1 hour
[ ]Pain prevents me from standing more than 30 minutes
[ ]Pain prevents me from standing more than 10 minutes
[ ]Pain prevents me from standing at all

Section 7: Sleeping

[ ]My sleep is never disturbed by pain.
[ ]My sleep is occasionally disturbed by pain.
[ ]Because of pain I have less than 6 hours of sleep
[ ]Because of pain I have less than 4 hours of sleep
[ ]Because of pain I have less than 2 hours of sleep
[ ]Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

[ ]My sex life is normal and causes no extra pain
[ ]My sex life is normal but causes some extra pain
[ ]My sex life is nearly normal but is very painful
[ ]My sex life is severely restricted by pain
[ ]My sex life is nearly absent because of pain
[ ]Pain prevents any sex life at all

Section 9: Social Life

[ ]My social life is normal and gives me no extra pain
[ ]My social life is normal but increases the degree of pain
[ ]Pain has no significant effect on my social life apart from limiting my more energetic interests eg. sports
[ ]Pain has restricted my social life and I do not go out as often
[ ]Pain has restricted my social life to home
[ ]I have no social life because of pain

Section 10: Travelling

[ ]I can travel anywhere without pain
[ ]I can travel anywhere but it gives me extra pain
[ ]Pain is bad but I manage journeys over two hours
[ ]Pain is bad but I manage journeys over one hour
[ ]Pain restricts me to short necessary journeys under 30 minutes
[ ]Pain prevents me from travelling except to receive treatment

By providing your email address below, you are giving Dignity Health, permission to contact you post spine surgery for follow-up assessment with an electronic version of the Revised Oswestry Disability Index. If you consent to receiving an email, please provide your email address:

Email address: _____Phone#_____

Patient Signature: _____