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:**	

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)*: ____

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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

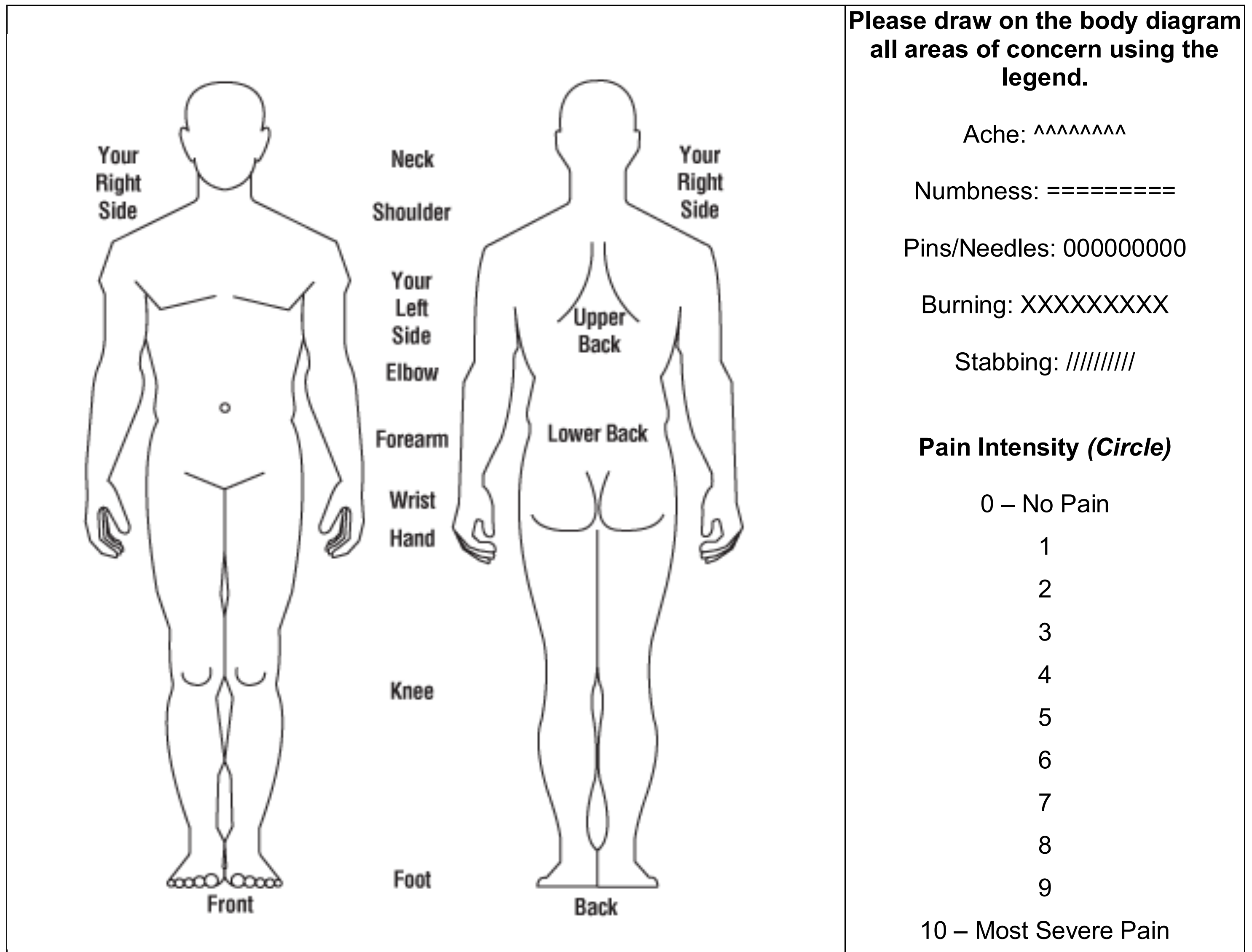
By signing below, I acknowledge that I have read and agree to the above policies or information, including Financial Policy, Paperwork and No Show Fees, Prescription Policy, the Disclosure of Physician Financial Interest. I have been given an opportunity to ask questions, if any.

Patient Name: ______________________________ DOB: ____________________

Patient Signature: ____

MEDICAL HISTORY

PATIENT NAME: DOB: Height _______ Weight _______



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

Main Problem	
How long have you had the pain?	
What improves your pain?	
Previous imaging or treatments for THIS problem.	CT Scan MRI Discogram EMG Physical Therapy Steroid Injections
Is the pain related to a car or work accident?	Yes No Date of Injury? _____________

Craig C. Callewart, MD, PA

MEDICAL HISTORY (Continued)

PLEASE CHECK ALL OF THE PROBLEMS YOU ARE CURRENTLY HAVING	
❑ Hurts when coughing or sneezing	❑ Hurts sitting in a straight chair
❑ Hurts when sitting in soft chair	❑ Hurts bending forward to brush teeth
❑ Hurts in the middle of the morning	❑ Hurts in the middle of the afternoon
❑ Hurts lying on my back	❑ Hurts lying on my stomach
❑ Hurts lying with my knees bent	❑ Hurts riding in my car
❑ Hurts when looking upwards	❑ Hurts when I am tense
❑ Back "gets stuck" when I bend forward	❑ After walking, bending forward relieves pain
❑ Headache	❑ Pain stops me from walking distances
❑ I have shoulder tip tenderness	❑ Pain wakens me from sleep at night
❑ Pain is worse at night	❑ Pain keeps me from sleeping at night
❑ Trouble swallowing	❑ I have an attorney helping me

Allergies/Intolerances:				
Social History:	Have you ever smoked?	Yes	No	Packs/Day
		If quit, when?		
	Drink alcohol?	Yes	No	Drinks/Week
	Use recreational drugs?	Yes	No	Drugs Used

YOUR MEDICAL CONDITIONS

❑ Anemia	❑ Heart problems	❑ Kidney disease
❑ Asthma		
❑ Cancer: Type:____________________	❑ High blood pressure	❑ Psoriasis
❑ Colitis	❑ High cholesterol	❑ Stomach or peptic ulcer
❑ Diabetes	❑ HIV/AIDS	❑ Stroke
❑ Heart murmur	❑ Hypothyroidism	❑ Tuberculosis

MEDICATION LIST

❑ Antibiotics or Sulfa Drugs	❑ Nitroglycerin	❑ Insulin, Tolbutamide or Similar Drug
❑ High Blood Pressure Meds		❑ Vicodin/Lortab
❑ Tranquilizers	❑ Cortisone (steroids)	Please list others:
❑ Hydrocodone	❑ Digitalis of drugs for heart trouble	______________________________
❑ Tylenol #3	❑ Aspirin	______________________________
❑ Anticoagulants (blood thinners)	❑ Flexeril	______________________________

ORTHOPEDIC SIGNIFICANT HISTORY (YOU OR YOUR FAMILY)

❑ Skeletal Dysplasia	❑ Spondyloepiphyseal dysphasia	❑ Duchenna's muscular dystrophy
❑ Achondroplasia	❑ Marfan's syndrome	❑ Charcot-Marie Tooth
❑ Morquio	❑ Ehlers-Danlos	❑ Arthogryposis Multiplex
❑ Psuedoachondroplasia	❑ Osteogenesis imperfecta	❑ Sickle cell disease
❑ Diastrophic dwarism	❑ Homocystinuria	❑ Thrombocytopenia
❑ Hemi-hypertrophy	❑ Pseudocolonesterase deficiency	❑ Malignant hyperthermia

Patient Name: DOB: Date:

MEDICAL HISTORY (Continued)

Circle all surgeries that apply

Tonsils & Adenoids	Appendix	Gallbladder	Hernia	Vasectomy
Hysterectomy	Prostate	Biopsies	Cancer	Fractures
Due to Car Accident	Neck	Back	Colon	Small Bowel

Other: ______________________________

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 sweats

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/JOINTS/BONES
- ❑ 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 conditions

ENDOCRINE
- ❑ Fatigue
- ❑ Unusual weight gain
- ❑ Other endocrine problems

HEMATOLOGIC
- ❑ Abnormal bruising
- ❑ Bleeding
- ❑ Other hematologic problems

ALLERGIC/IMMUNOLOGIC
- ❑ Allergic rash
- ❑ Sinus complaints
- ❑ Other allergy complaints

OTHER PROBLEMS:

DISEASES IN YOUR FAMILY

Please check all conditions that occur in your family:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer ________________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Patient Name: DOB: Date: