

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PAIN DIAGRAM

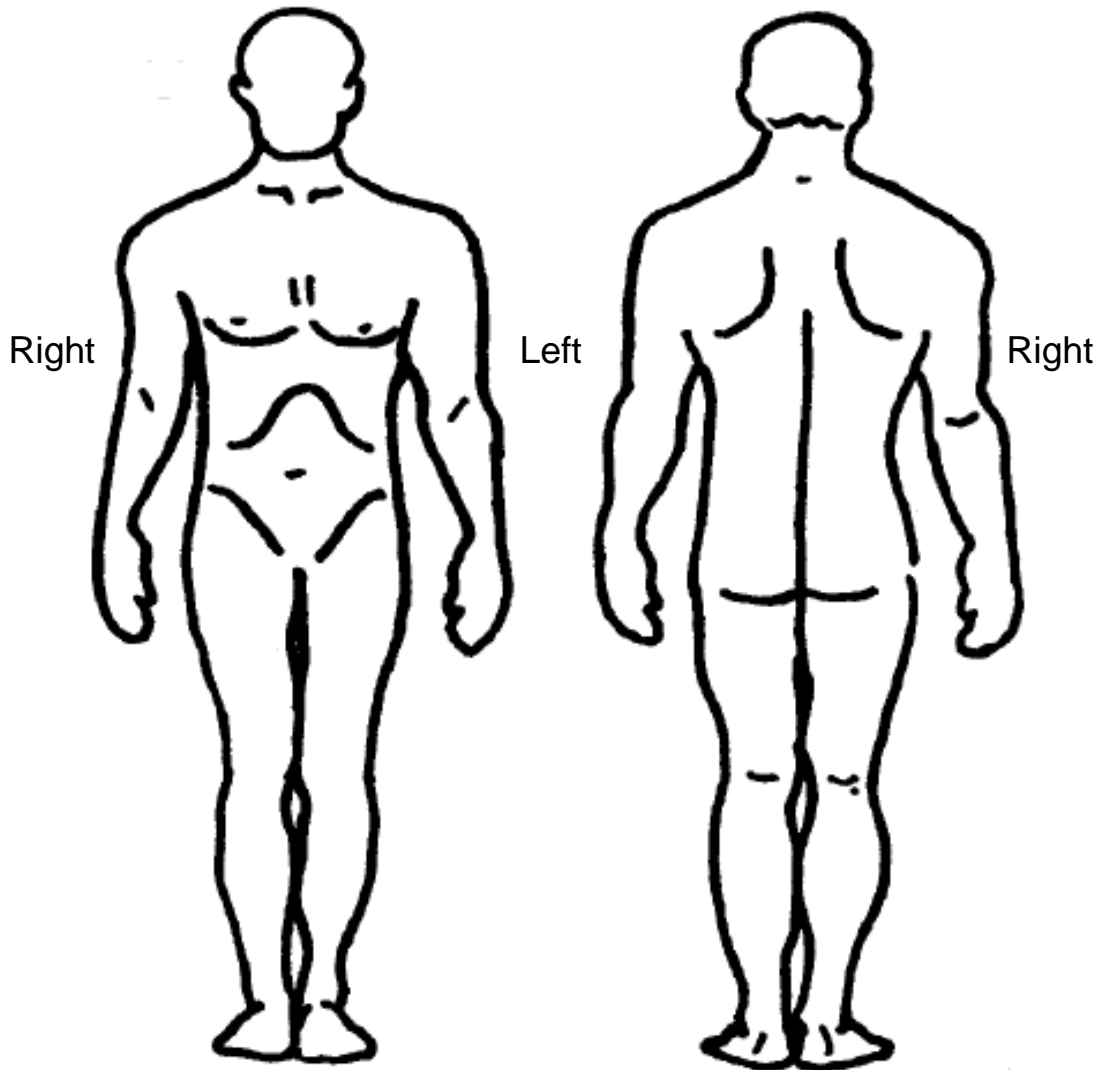
Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.

Major Pain – XXX  
Secondary Pain – ///  
Numbness – OOO

Tingling – YYY  
Burning – ZZZ  
Draw a line for radiating pain

Front

Back



Make any comments you feel are important:

## VISUAL ANALOG SCALE

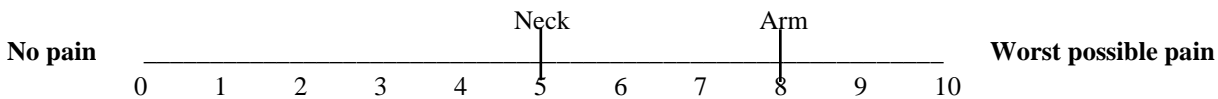
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please read carefully:**

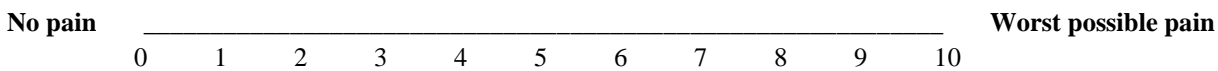
**Instructions:** Please place a mark on the line by the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

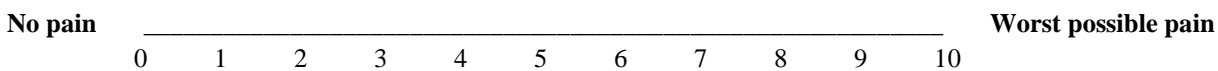
**EXAMPLE:**



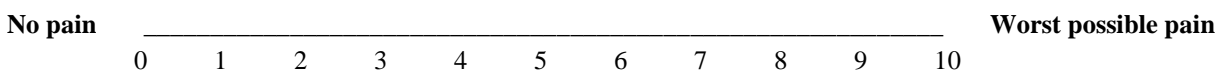
1- What is your pain level **AT ITS WORST** (How close to "10" does your pain get at its worst)?



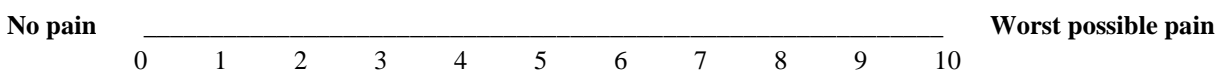
2- What is your **TYPICAL** or **AVERAGE** pain?



3- What is your pain level **AT ITS BEST** (How close to "0" does your pain get at its best)?



4- What is your pain **RIGHT NOW**?



**OTHER COMMENTS:**

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# HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Age:	Height:	Weight:	Right handed: <input type="checkbox"/>	Left-handed: <input type="checkbox"/>	Ambidextrous: <input type="checkbox"/>
------	---------	---------	---	--	---

**PAST MEDICAL HISTORY:** Have you ever had (circle No or Yes)

Diabetes.....	No	Yes	Myocardial Infarction(Heart Attack).....	No	Yes
Stroke.....	No	Yes	Rheumatic Fever.....	No	Yes
Cancer.....	No	Yes	Tuberculosis.....	No	Yes
High Blood Pressure.....	No	Yes	Hepatitis (A B C, please specify).....	No	Yes
Heart Problems.....	No	Yes	Anemia.....	No	Yes

Have you had, or do you have presently, any other serious illness or chronic medical condition that we should be aware of?.....No Yes

If yes, describe \_\_\_\_\_

Have you ever been hospitalized or been under medical care (other than surgery) for any period?

.....No Yes

If yes, for what reason? \_\_\_\_\_

**Injuries:**

Have you had any broken bones?.....No Yes If yes, briefly describe \_\_\_\_\_

Have you had any head concussions or injuries?.....No Yes If yes, briefly describe \_\_\_\_\_

Have you had any auto accidents?.....No Yes If yes, briefly describe \_\_\_\_\_

**PAST PSYCHOLOGICAL HISTORY:**

Have you ever had psychiatric care?.....No Yes describe \_\_\_\_\_

Have you ever been given a psychiatric diagnosis?.....No Yes describe \_\_\_\_\_

Have you ever been advised to undergo psychiatric care but not followed through? No Yes

If yes, briefly describe \_\_\_\_\_

**PAST SURGICAL HISTORY:** Have you had any surgery? No Yes

**If yes, list all procedures and dates of surgeries**

1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_
5. \_\_\_\_\_ Date: \_\_\_\_\_
6. \_\_\_\_\_ Date: \_\_\_\_\_
7. \_\_\_\_\_ Date: \_\_\_\_\_
8. \_\_\_\_\_ Date: \_\_\_\_\_
9. \_\_\_\_\_ Date: \_\_\_\_\_
10. \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Circle one:                      Single                      Married                      Divorced                      Widowed

Are you living with your husband/wife?.....No Yes

Do you have dependents at home?.....No Yes

Do you drink alcoholic beverages?.....No Yes

Amount and frequency: per day: \_\_\_\_\_ per week: \_\_\_\_\_ per month: \_\_\_\_\_

Do you smoke cigarettes?.....No Yes How many packs a day? \_\_\_\_\_ How long? \_\_\_\_\_

Have you ever smoked?\_\_\_\_\_ How many packs a day? \_\_\_\_\_ How long?\_\_\_\_\_ Last smoked \_\_\_\_\_

Is there any history of illegal drug abuse?.....No Yes

Is there any history of prescription drug abuse?.....No Yes

Are you currently working?.....No Yes

Full Time                      Part Time                      On disability                      Unemployed                      Retired                      Medically retired

**FAMILY HISTORY:**

If you are adopted and have no knowledge of your family history, please check this box and proceed to the Section #6.

BIOLOGICAL FAMILY HISTORY	IF LIVING		IF DECEASED	
	Age	Health	Age (at death)	Cause
Father				
Mother				
Brother				
Sister				
Son				
Daughter				

HAS ANY BLOOD RELATIVE HAD:			RELATIONSHIP
	NO	YES	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Psych problems	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

**GENERAL MEDICATIONS:**

Drugs recently taken, within the past six months, have you taken (circle No or Yes or Don't Know):

Cortisone.....No Yes Don't know  
 Anticoagulants.....No Yes Don't know  
 Tranquilizers.....No Yes Don't know  
 Hypotensives (high blood pressure medications).....No Yes Don't know

List ALL GENERAL (i.e. NOT for your current spine condition) MEDICATIONS you are *currently* taking

1. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
2. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
3. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
4. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
5. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
6. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
7. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
8. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_

**MEDICATIONS FOR YOUR SPINAL CONDITION**

List ALL PAIN/ANTI-INFLAMMATORIES, etc. you are *currently* taking for your spinal condition

1. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
2. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
3. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
4. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
5. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
6. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
7. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_
8. \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Frequency: \_\_\_\_\_

**ALLERGIES AND SENSITIVITIES:**

Is there a history of any reaction or sickness following injection or oral administration of:

	No	Yes	Don't know	<b>Describe Reaction &amp; Specify Medication</b>
Penicillin or other antibiotics:.....	No	Yes	Don't know	_____
Morphine, codeine, Demerol or other narcotics:.....	No	Yes	Don't know	_____
Novocain or other anesthetics:.....	No	Yes	Don't know	_____
Aspirin, Empirin or other pain remedies:.....	No	Yes	Don't know	_____
Sulfa drugs:.....	No	Yes	Don't know	_____
Tetanus antitoxin or other serums:.....	No	Yes	Don't know	_____
Any other drug or medication:.....	No	Yes	Don't know	_____
Any x-ray contrast material (dye, etc.):.....	No	Yes	Don't know	_____
Seasonal/environmental allergies:.....	No	Yes	Don't know	_____
Any foods, such as eggs, milk, or chocolate:.....	No	Yes	Don't know	_____

## REVIEW OF SYSTEMS:

Do you have, or have you had, any of the following:

### General:

Recent weight gain..... No Yes  
Have you been in good health... No Yes

### Skin:

Acne..... No Yes  
Dry skin/itching..... No Yes  
Eczema..... No Yes  
Rash..... No Yes

### Head-Eyes-Ears-Nose-Throat:

Blurry vision/double vision... No Yes  
Cataracts..... No Yes  
Contact lenses/glasses..... No Yes  
Dizziness..... No Yes  
Ear problems..... No Yes  
Eye problems..... No Yes  
Hearing loss..... No Yes  
Loss of balance..... No Yes  
Neck stiffness..... No Yes

### Breast:

Discharge..... No Yes  
Infection..... No Yes  
Mass/lump..... No Yes  
Surgery..... No Yes

### Cardiac:

Angina..... No Yes  
Cardiac surgery..... No Yes  
Chest pain..... No Yes  
Murmur..... No Yes  
Palpitations..... No Yes  
Shortness of breath..... No Yes  
Swelling of extremities..... No Yes

### Pulmonary:

Asthma..... No Yes  
Frequent cough..... No Yes  
Pain with breathing..... No Yes  
Wheezing..... No Yes

### Urologic:

Dribbling..... No Yes  
Dysuria (pain with urination)... No Yes  
Frequency..... No Yes  
Incontinence..... No Yes  
Hematuria (blood in urine).... No Yes  
History of stones..... No Yes  
Infection..... No Yes  
Nocturia (night time urination) No Yes  
Stress incontinence..... No Yes  
Urgency..... No Yes

### Gastrointestinal:

Abdominal pain..... No Yes  
Appetite change..... No Yes  
Blood in stool..... No Yes  
Change in bowel habits..... No Yes  
Constipation..... No Yes  
Diarrhea..... No Yes  
Gallbladder problems..... No Yes  
Indigestion/heartburn..... No Yes  
Hemorrhoids or piles..... No Yes  
Nausea/vomiting..... No Yes  
NSAID intolerance..... No Yes  
Rectal bleeding..... No Yes  
Ulcers..... No Yes

### Ob-Gyn:

# of pregnancies: \_\_\_\_\_  
# of miscarriages: \_\_\_\_\_  
Date of last Pap smear: \_\_\_\_\_  
Results (negative or positive): \_\_\_\_\_  
Frequency of periods, every \_\_\_\_\_ days  
Any pain with periods..... No Yes  
Menopausal..... No Yes  
(if yes, at what age \_\_\_\_\_)

### Neurological:

Dizziness/fainting spells..... No Yes  
Headaches..... No Yes  
Loss of consciousness..... No Yes  
Memory loss..... No Yes  
Paralysis..... No Yes  
Seizures..... No Yes

### Vascular:

Abnormal bleeding or bruising... No Yes  
Aneurysm..... No Yes  
Are you a Jehovah's Witness... No Yes  
Phlebitis..... No Yes  
Varicose veins..... No Yes

### Endocrine:

Blood transfusion..... No Yes  
Hormone therapy..... No Yes  
Thyroid problems..... No Yes  
Varicose veins..... No Yes

### Immune System:

AIDS..... No Yes  
Diabetes..... No Yes  
History of infections..... No Yes  
Immunosuppressive disorders... No Yes

**Surgery:**

Anesthetic allergy/problem.....	No	Yes
Iodine allergy .....	No	Yes
Postoperative infections.....	No	Yes
Postoperative complications.....	No	Yes
Suture reaction .....	No	Yes
Tape allergy.....	No	Yes
Severe nausea/vomiting after general Anesthesia.....	No	Yes
Waking-up problem after Anesthesia.....	No	Yes

**Musculoskeletal:**

Any other problems other than your reason

For your visit today..... No Yes

**IF YOU ANSWERED "YES" PLEASE SPECIFY**

Arthritis..... No Yes

Joint pain..... No Yes

Joint swelling..... No Yes

Osteopenia..... No Yes

Rheumatoid arthritis..... No Yes

Other pains/problems..... No Yes

Please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other information we should be aware of:

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## PATIENT INFORMATION SHEET

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**THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE SHARED  
PLEASE COMPLETE ENTIRE FORM**

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

MARITAL STATUS: (CIRCLE ONE) MARRIED SINGLE DIVORCED OTHER

SEX: (CIRCLE ONE) MALE FEMALE

**EMPLOYER INFORMATION:**

COMPANY: \_\_\_\_\_ CITY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

WORK RELATED? YES NO AUTO: YES NO OTHER: \_\_\_\_\_

---

### INSURANCE INFORMATION

---

INSURANCE COMPANY: \_\_\_\_\_

POLICY/ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_

RELATIONSHIP TO INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

INSURED'S EMPLOYER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

INSURED'S SOCIAL SECURITY #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ INSURED'S DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

---

SECONDARY INSURANCE COMPANY: \_\_\_\_\_

POLICY/ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_

RELATIONSHIP TO INSURED: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

INSURED'S EMPLOYER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

INSURED'S SOCIAL SECURITY #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ INSURED'S DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

---

REFERRED BY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PREFERRED PHARMACY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.**

**WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.**

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**OFFICE POLICY ON PAYMENT:**

It is our policy to require payment of all office charges that are not covered by your insurance carrier, unless prior arrangements have specifically been made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18% per annum) or a \$2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

**INSURANCE POLICY:**

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. **We are not a provider of Medi-Cal therefore you are responsible for any balance on your account.**

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I authorize and assign to Silicon Valley Spine Institute, Inc any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to Silicon Valley Spine Institute, Inc in accordance with the standard and customary charges incurred during my period of treatment.

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:**

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: \_\_\_\_\_  
Patient, Parent, or Guardian

DATE: \_\_\_\_\_

PARENT/GUARDIAN

ADDRESS \_\_\_\_\_ Phone: \_\_\_\_\_

---

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_



**Jeffrey D. Coe, MD**  
Orthopaedic Spine Surgeon  
**Michael W. Cluck, MD, PhD**  
Orthopaedic Spine Surgeon  
**Konrad H. Ng, MD**  
Physical Medicine & Rehabilitation  
**Renee V. Wall, PA-C**  
Physician Assistant  
**Lauren M. Bradley, PA-C**  
Physician Assistant

Spinal Reconstructive Surgery  
Minimally Invasive Spinal Surgery  
Spinal Disc Arthroplasty Surgery  
Adult and Pediatric Spinal Deformity Surgery  
Cervical Spine Surgery  
Therapeutic and Diagnostic Spinal Injections  
Electrodiagnosis

221 East Hacienda Ave  
Suite A  
Campbell, CA 95008

Tel: (408) 376 3300  
Fax: (408) 374 8830

## Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

\_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_



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## PATIENT RECORD OF DISCLOSURES

(THIS DOES NOT APPLY TO INDUSTRIAL INJURY/WORKERS' COMPENSATION PATIENTS)

I wish to be contacted in the following manner (check all that apply):

Home Telephone:

- O.K. to leave message with detailed information
- Leave message with call-back number only
- Neither of the above DO NOT CALL ME AT HOME

Written Communications:

- O.K. to mail my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number: \_\_\_\_\_

Work Telephone:

- O.K. to leave message with detailed information
- Leave message with call-back number only
- Neither of the above DO NOT CALL ME AT WORK

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date of Birth



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 Orthopaedic Spine Surgeon  
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**DISCLOSURE ACKNOWLEDGEMENT AND CONSENT**

**(THIS DOES NOT APPLY TO INDUSTRIAL INJURY/WORKERS' COMPENSATION PATIENTS)**

\_\_\_\_\_  
 Patient's Name

\_\_\_\_\_  
 Date of Birth

I, \_\_\_\_\_ acknowledge and consent for Silicon Valley Spine Institute or any representatives to disclose and discuss personal health and billing information to the following people:

\_\_\_\_\_  
 Name Relationship

\_\_\_\_\_  
 Name Relationship

\_\_\_\_\_  
 Name Relationship

In the event that I wish to rescind this, I will write and notify Silicon Valley Spine Institute.

\_\_\_\_\_  
 Patient's signature Date



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### Silicon Valley Spine Institute Medication Refill Policy

- Refills will be made only during regular office hours.
- Allow 2-3 business days for all refill requests to be processed.
- Refills will not be made at night, on holidays or weekends.
- Refills will not be made if I "run out early."
- I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- All refill requests must be faxed by your pharmacy by 10:00am Friday, anything faxed after that time will not be filled.
- Refills will not be made as an "emergency" on Friday afternoon.
- Prescriptions will not be filled by the on-call physician.

Please have your pharmacy fax a refill request to our office. Refills will be processed within 2-3 business days and faxed to your pharmacy.

Certain medications require a hand written scrip every time a refill is needed. In this case please call our office and let us know 2-3 business days before you run out so the physician will be able to write a new prescription for you.

Remember, your physician is in surgery 2-3 days a week and will not always be able to write the new prescription/refill your medication on the day it is requested.

I have been fully informed and will comply with the medication refill policy established by Silicon Valley Spine Institute.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_