

## Texas Spine Consultants

3900 Junius St. #705  
Dallas, TX 75246  
214-370-3535

Last : PLOCK  
Patient ID : 42157  
First : ROBERT

Credit Card - Sale

--- Approved ---

Response Message : APPROVAL  
Response Code : 000

Jul 24 2013 4:39:35 PM

Card Type : MC  
Card Holder Name : ROBERT PLOCK  
Card # : \*\*\*\*\*4413

Auth Amount : \$40.00  
Auth Code : 685861

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO MY CARD HOLDER AGREEMENT.

X  
\_\_\_\_\_  
(Signature)

Thank you for your payment



## Follow Up Note

**Date of Exam:** 7/24/2013  
**Patient Name:** Robert Plock  
**Date of Birth:** 07/26/1968

### Past History:

**Surgical History:**  
No Surgical History Reported

**Family History:**  
Father has history of hypertension and diabetes. Mother has history of diabetes. Sibling has history of hypertension and diabetes.

**Social History:**  
Patient is right handed. Patient consumes alcohol. Patient consumes caffeine.

**Allergies:**  
No Known Drug Allergies

### **Review of Systems:**

Constitutional:	Patient has history of weakness, weight loss or gain and fatigue.
Eyes:	Patient has history of blurred vision.
HEENT:	Patient has history of earaches, hay fever, nosebleeds and frequent sore throats.
Cardiovascular:	No chest pains or palpitations or high blood pressure
Respiratory:	No shortness of breath or cough
Gastrointestinal:	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary:	No dysuria or hematuria
Musculoskeletal:	Patient has history of Joint Pain, muscular weakness, stiffness and muscular pain.
Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic:	No bruising, swollen glands or anemia
Immunological:	Patient has history of skin rashes.

**History:**

Thoracic:

**Exam:**

GEN: Appears stated age. Not in any acute distress.

PSYCH: Cooperative and appropriate. Alert and oriented times three.

HEAD: Normocephalic and atraumatic.

EYES: Extraocular movements intact.

ENT: Gross visualization of ears, nose and mouth show no significant abnormalities.

RESP: Patient shows no signs of difficulty breathing.

NEURO: No acute neurological changes noted from previous visit.

No acute changes noted from previous visit.

**Impression:**

SCIATICA

**Plan:**

Thoracic: The patient

**Medications Prescribed:**

Norco 5-325 mg - tablet QTY: 120

TRAMADOL HCL 50 MG 1 tablet TABLET QTY: 180

FLEXERIL 10 MG 1 TABLET QTY: 90

IBUPROFEN 800 MG TABLET QTY: 90



Andrew Park, MD

Electronically signed on 7/24/2013 4:22:58 PM

# Patient Information

DOCTOR OF RECORD  
Andrew E Park MD

TSC

PATIENT NAME (First Name, Middle Initial, Last Name) <b>Robert Plock</b>		PATIENT ID (Office Use Only) <b>42157</b>	Mobile <b>(214) 799-7775</b>	Work <b>(214) 275-4195</b>	THIRD PHONE (MOBILE)
ADDRESS <b>6827 Latta Parkway</b>		DATE OF BIRTH <b>07/26/1968</b>	SOCIAL SECURITY NUMBER <b>456-53-3292</b>	SEX (M or F) <b>[X]M [ ]F</b>	MARITAL STATUS <b>[X]Married [ ]Single [ ]Other</b>
CITY, STATE, ZIP <b>Dallas, TX 75227</b>	AGE <b>44 yrs</b>	EMERGENCY CONTACT PERSON <b>Clarence Abner</b>		RELATIONSHIP TO PATIENT <b>Friend</b>	CONTACT PHONE <b>214 799-7774</b>
EMPLOYER <b>Spencer A/C Heating</b>	OCCUPATION <b>HVAC Tech</b>		PATIENT E-MAIL ADDRESS		
REFERRING DOCTOR NAME & ADDRESS <b>Christensen M.D., William T 3434 Swiss Ave, Suite 206 Dallas, TX 75204 (214) 828-5775 (214) 828-5777</b>					
PRIMARY CARE DOCTOR NAME & ADDRESS					
RACE			ETHNICITY		

## Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name) <b>Robert Plock</b>		Mobile <b>(214) 799-7775</b>	Work <b>(214) 275-4195</b>	THIRD PHONE (MOBILE)
ADDRESS <b>6827 Latta Parkway</b>		DATE OF BIRTH <b>07/26/1968</b>	SOCIAL SECURITY NUMBER <b>456-53-3292</b>	
CITY, STATE, ZIP <b>Dallas, TX 75227</b>	SEX (M or F) <b>[X]M [ ]F</b>		PATIENT'S RELATION TO RES <b>SELF</b>	
EMPLOYER <b>Spencer A/C Heating</b>	OCCUPATION <b>HVAC Tech</b>		RESP PARTY ID (Office Use Only) <b>44032</b>	

## Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)

☒ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

INSURANCE COMPANY NAME <b>United Healthcare - UMR</b>	COPAY AMOUNT <b>\$40 Co-Pay</b>	INSURED'S NAME (First Name, Middle Initial, Last Name) <b>(Same as Patient)</b>		
INSURANCE COMPANY ADDRESS <b>P.O. Box 30541</b>		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP <b>Salt Lake City, UT 84130</b>	INSURED'S DATE OF BIRTH	PRIMARY PHONE (HOME)	SECONDARY PHONE (WORK/CELL)	
INSURANCE COMPANY PHONE NUMBERS <b>Home (888) 339-7280</b>	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER <b>13280912</b>	INSURED'S GROUP # <b>76-410892</b>	INSURED'S EMPLOYER		INSURED'S OCCUPATION

## Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)

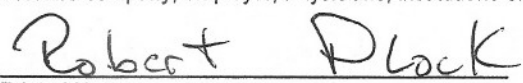
☐ Patient (same as above) ☐ Responsible Party (same as above) ☐ Other (complete below)

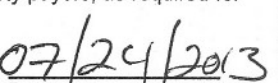
INSURANCE COMPANY NAME		INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS		INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH	PRIMARY PHONE (HOME)		SECONDARY PHONE (WORK/CELL)
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED	
INSURED'S POLICY NUMBER	INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

## Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

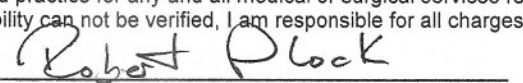
  
Signature of Patient / Parent / Guardian

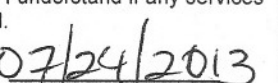
  
Printed Name

  
Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

  
Signature of Patient / Parent / Guardian / Insured

  
Printed Name

  
Date

Are you here to see: ☐ Dr. Viere ☒ Dr. Park ☐ P.A.

Name: Robert P. Clark Date: 07/24/13 Allergies: \_\_\_\_\_

Initial injury caused by: \*\*\*ON THE JOB INJURY\*\*\*: YES or NO (please circle one)

☐ Unknown ☐ Fall ☐ Lifting ☒ MVA on 01/25/13 (Driver or Passenger (please circle one))

☒ Here for recheck/follow up

☒ Here for Medication Refills

☐ Here for referral for my insurance co.

☒ Need a work/school release or excuse

☐ Need the attached forms filled out

☐ Here for test results: MRI Myelo/CT Discogram FCE Bone Scan EMG (please circle one)

Other concerns I would like to discuss:

Surgery - Method to correct the  
L5@S1

CHIEF COMPLAINT: Please X, check or circle all the items that apply below and mark the drawing using the key.

Mark all that apply:

Key: Ache/Sore: >>>> Dull: DDDDD Sharp: SSSSS

Throbbing TTTT Numb: NNNN Cramping: CCCC

Pressure: PPPPP Tingling: xxxxx Pins/Needles: oooo

Stabbing: ///// Burning: BBBB Shooting: +++++

changes a lot

Are you getting:

☐ Better

☐ Worse

☒ Unchanged

Pain is:

☒ Constant

☒ Good/Bad Days

Pain is better when:

☐ Lying

☐ Sitting

☐ Standing

☐ Walking

☐ Leg elevation

☐ Arm Elevation

☐ Changing Position

☐ Heat

☐ Cold

Dominant Hand:

☒ Right ☐ Left

Height: 5' 11"

Weight: 198 lbs.

Neck Pain: Circle Level

1 2 3 4 5 6 7 8 9 10

Minor Moderate Severe

Pain in arm(s)

☐ worse than

☐ same as

☒ less than

Pain in Neck

Upper Back Pain:

Circle Level

1 2 3 4 5 6 7 8 9 10

Minor Moderate Severe

Lower Back Pain: Circle Level

1 2 3 4 5 6 7 8 9 10

Minor Moderate Severe

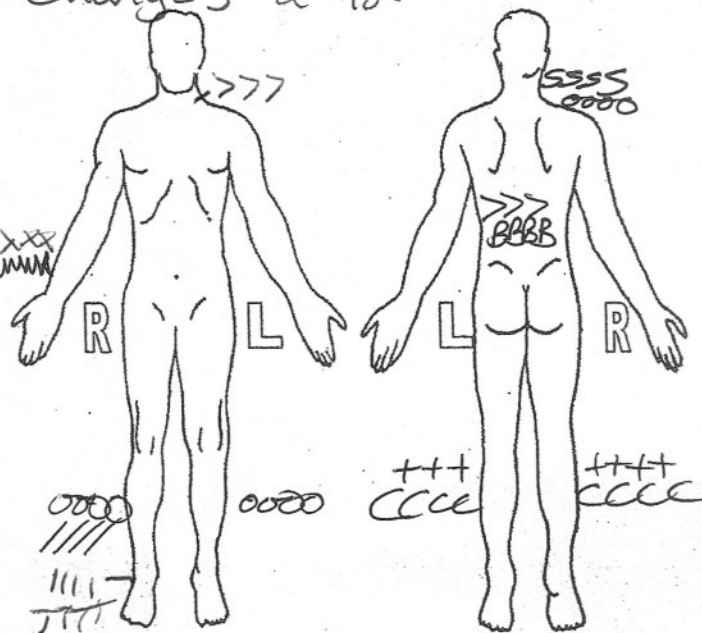
Pain in leg(s)

☒ worse than

☐ same as

☐ less than

Pain in back



Front

Back

Pain is worse with: (check all that apply) ☒ Bending to brush teeth ☒ Activity ☒ Rest ☐ Coughing ☐ Soft Chair ☐ Hard Chair  
☐ Doing Homework ☐ Lying on side with knees bent ☒ Riding in car ☒ Driving Car ☒ Computer/TV ☒ Overhead Work

PMH: Since last office visit: New medical problems (none)

New Surgeries (none)

New Medications (none)

New Allergies (none)

Tattoos: #

On blood thinner: ASA PLAVIX COUMADIN LOVENOX AGGRENOX

FMH: New family medical history (none)

Environmental: Exposure to 2<sup>nd</sup> hand smoke at home: YES NO

Social History: Alcohol (none) Tobacco (none) Packs per day / years Quit

History of alcohol addiction: History of drug addiction:

Working: ☐ Full time ☐ Part time ☐ Student ☐ Retired ☐ Medical Leave ☐ Disabled ☐ Homemaker

ROS: Change in bowel/bladder control: (none)

Any: ☐ Weight Gain lbs. ☐ Weight loss lbs. ☐ Fever ☐ Chills ☐ Rash ☐ Shortness of Breath

☐ Chest Pain ☐ Numbness/Tingling in extremities ☐ Joint Pain ☐ Visual Problems ☐ Difficulty Swallowing





**Date** 7/24/2013

**Provider:** Andrew Park, MD

**DEA#:** BP7773852

**DPS#:** 30128714

**Phone:** (214) 370-3535

**Patient Name:** Robert Plock

**Patient DOB:** 7/26/1968 **Sex:** M

**Address:** 6827 Latta Parkway Dallas, TX 75227

**R<sub>x</sub>**

Norco 5-325 mg - tablet QTY: 120(one hundred twenty) REFILLS: 1

May substitute generic equivalent.

**INSTRUCTIONS:** Sig 1 tab PO q6 hrs prn pain, Max 4/day

TRAMADOL HCL 50 MG 1 tablet TABLET QTY: 180 (one hundred eighty)REFILLS:

1

May substitute generic equivalent.

**INSTRUCTIONS:** Take one tablet every 6 hours as needed for pain

FLEXERIL 10 MG 1 TABLET QTY: 90(ninety) REFILLS: 2

May substitute generic equivalent.

**INSTRUCTIONS:** 1 tab PO q 8 hrs prn spasm

IBUPROFEN 800 MG TABLET QTY: 90(ninety) REFILLS: 0

May substitute generic equivalent.

**INSTRUCTIONS:** Take 1 PO Q 8 hrs. MAX 3/day

*Handwritten signatures:*  
Amy Swain  
Dorpan MD

Texas Spine Consultants, LLP  
3900 Junius St., Suite 705  
Dallas, TX 75246