Back / Neck
Medical Questionnaire

Applicant Name: _____**Applicant ID Number:**_____

Please answer all questions thoroughly. Omissions or incomplete responses could result in a request for medical records and a delay in processing of this application. Use separate sheet of paper if necessary.

1. What is the specific diagnosis of your back/neck condition?_____

2. Please provide the location of your problem area (upper, lower, lumbar, T3, etc.)._____

3. How many times have you been treated for back or neck pain in the past 3 years?
Please complete below.

DATE OF VISIT	PHYSICIAN/ CHIROPRACTOR'S NAME	ADDRESS	TYPE OF TREATMENT
mo/yr _____			
mo/yr _____			
mo/yr _____			

4. Have you been hospitalized, had surgery or been evaluated in an emergency room or urgent care facility for this condition? ☐**YES** ☐**NO** If YES, please indicate in the space provided

DATE OF VISIT	NAME OF FACILITY	ADDRESS	TYPE OF TREATMENT
mo/yr _____			
mo/yr _____			

5. Please list all medications taken for this condition in the space provided.

MEDICATION NAME	DOSAGE & FREQUENCY	DATE PRESCRIBED	DATE DISCONTINUED	PRESCRIBING PHYSICIAN
		mo/yr _____	mo/yr _____	
		mo/yr _____	mo/yr _____	
		mo/yr _____	mo/yr _____	

6. Please clarify if your condition primarily due to muscle, disc, vertebral, curvature, arthritis or other?
_____
_____
_____

7. Have you ever been told you have a herniated or bulging disc? ☐**YES** ☐**NO** If YES, please explain.
_____
_____

8. Have you ever had surgery recommended for your condition? ☐**YES** ☐**NO** If YES, please explain.
_____
_____

9. Do you now or have you ever used any kind of brace or supportive device, or had any plates, rods or screws implanted? ? ☐**YES** ☐**NO** If YES, please explain. _____
_____
_____

Signature:_____**Date:**_____
Applicant or Parent/Guardian

Health Net
A Better Decision

Underwriting Department
Health Net of Arizona, Inc.
1230 W. Washington Street, Suite 401, Tempe, Arizona 85281
For assistance, please call 1-888-463-4875, Option 2