COMPREHENSIVE SPINE INSTITUTE

New Patient Information

Patient Name: _____ Date: _____
Social Security #: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Primary Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Occupation: _____ Employer: _____

Preferred contact method: ☐ Home phone ☐ Cell Phone ☐ Email ☐ Other: ____

Name of Emergency Contact: _____
Relationship: _____ Phone: _____

How did you hear about us? _____

Referring Physician: _____ Phone: _____
Primary Physician: _____ Phone: _____

Did your injury occur at work? ☐ Y ☐ N If yes, date of accident? _____
Is your injury from an auto accident? ☐ Y ☐ N If yes, date of accident? _____
Are you represented by an attorney? ☐ Y ☐ N
Attorney name: _____ Phone: _____

Primary Insurance Company: _____
Address: _____
Name of Insured: _____ Relationship to patient: _____
Group #: _____ ID #: _____
Subscriber's Date of Birth: _____ Subscriber's SS #: _____

Secondary Insurance Company: _____
Address: _____
Name of Insured: _____ Relationship to patient: _____
Group #: _____ ID #: _____
Subscriber's Date of Birth: _____ Subscriber's SS #: _____

Comprehensive Spine Institute
Patient Authorization Form

HIPAA Privacy Notice
I understand that I am able to request a copy of the Comprehensive Spine Institute's Notice of Privacy Practices.

By initialing I have read and understand the above _____

Authorization to Release Information
I consent to the use or disclosure of my protected health information by the Comprehensive Spine Institute (CSI) as may be necessary to other healthcare providers (such as referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or insurance companies for the purpose of diagnosing or providing treatment to me, or obtaining payment for my health care bills from the Comprehensive Spine Institute.

By initialing I have read and understand the above _____

Comprehensive Spine Institute Disclosures
I acknowledge that I have been notified that the providers at CSI may be involved in education, research, development, and/or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore; the providers may benefit directly or indirectly from such educational, research, development, and/or consulting relationships. The above does not conflict with my best interest as a patient at CSI. I desire to enter into a doctor-patient relationship with a provider at the Comprehensive Spine Institute.

By initialing I have read and understand the above _____

Financial Agreement & Payment Policy
I understand that I am financially responsible for services rendered by Comprehensive Spine Institute providers. I also understand that few insurance carriers cover all costs for services rendered. CSI will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at the Comprehensive Spine Institute.

By initialing I have read and understand the above _____

Insurance Appeals
In order to comply with federal guidelines regarding ERISA and the medical appeal process, I give CSI permission to represent my medical appeal process if necessary.

By initialing I have read and understand the above _____

Authorization for Treatment
I hereby authorize the medical staff of the Comprehensive Spine Institute to render medical services and treatments as deemed necessary.

By initialing I have read and understand the above _____

Authorization to Disclose Personal Health Information
I authorize the discussion and release of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By initialing I have read and understand the above _____

By signing, I have read, understand, and agree to comply with the Comprehensive Spine Institute's policies so noted in the Privacy Practices Notice.

Signature: _____ **Date:** _____

Printed Name: _____

Comprehensive Spine Institute

Authorization for Release of Information from Medical Records

Physician's Name: _____

Address: _____

_____

Phone: _____ Fax: _____

The following individual has requested that his or her medical records be released and forwarded to our office:

Patient Name: _____

DOB: _____ **SSN:** _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records contained within your file.

Please release the records to:

Comprehensive Spine Institute

1988 Gulf to Bay Blvd.

Clearwater, FL 33765

Phone (727) 953-8090

Fax (727) 953-8088

I hereby authorize the release of all necessary medical records to be forwarded as soon as possible to the physician listed above. I understand that under state and federal confidentiality provisions, only the specified information can be released to the above specified facility. I also understand that I may revoke this release of information at any time, providing that I make a written notification to this effect, but that revocation has no effect on action already taken.

Patient's Signature: _____ **Date:** _____

Comprehensive Spine Institute
Form Fee Agreement

The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involed in providing this deatiled information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO CHARGE:

- Worker's Compensation requested Disability & Work Status forms
- Auto Insurance Carrier requests for Work Status & Treatment plans

$1.00/page

- Copies of your medical records

$20.00

- Disabled Parking Applications

$50.00/form

- Credit Card deferrment forms
- Private Disability Insurance Forms
- School Educational Disability or Limitation forms
- Family Medical Leave Act (FMLA) forms

$50.00-$500.00

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. Functional Capacity Evaluation Testing may be necessary prior to, or in addition to the narrative report. The fee for FCE test is determined by the facility where the testing is completed.

_____	_____	_____
Patient Name (Print)	Signature	Date

Spine History & Physical

Patient Name: _____ **DOB**: _____ **Age:** _____

Sex (please circle)**:** M F Right handed or Left Handed **Height:** _____ **Weight:** _____

Work Status: Working Not Working Student Disabled Retired **Occupation:** _____

Chief Complaint:

Where is the pain located? _____ ☐ Midline ☐ Right of Midline ☐ Left of Midline

Have you had neck/back symptoms or injury before? ☐ No ☐ Yes **(when?)**_____

_____

Have you ever had previous neck or back surgery? ☐ No ☐ Yes **(when?)** _____

_____

What is the quality (description) of the pain?

☐ aching ☐ crushing ☐ pins and needles ☐ sharp ☐ throbbing
☐ burning ☐ dull ☐ pressure ☐ stabbing ☐ other: _____

On a scale of 1-10 (1 being little pain and 10 being intolerable) **my pain is a** _____

Is your pain present constantly? ☐ Yes ☐ No

How long have you had the pain? _____ **weeks** _____ **months** _____ **years**

Is there referred (radiating) pain, numbness, or tingling? ☐ No ☐ Yes

Referred pain to _____
Referred numbness to_____
Referred tingling to_____

Setting in which the pain *first* occurred: (What were you doing when pain occurred?)

☐ *bending over* ☐ *reaching* ☐ *standing* ☐ *throwing* ☐ *straining to push*
☐ *climbing stairs* ☐ *running/jogging* ☐ *sneezing* ☐ *straining to lift* ☐ *twisting*
☐ *coughing* ☐ *having sex* ☐ *squatting* ☐ *straining to pull* ☐ *walking*

☐ Trauma (accident or injury), briefly describe_____

☐ Other, briefly describe_____

List any factors that aggravate the pain: ☐ *lying down* ☐ *climbing stairs* ☐ *coughing* ☐ *driving*
☐ *head movements* ☐ *low back movements* ☐ *sitting* ☐ *sneezing* ☐ *standing* ☐ *walking*

☐ *other aggravating factors*_____

List any factors that relieve the pain: ☐ *applying cold* ☐ *applying heat* ☐ *lying down* ☐ *sitting down*
☐ *massaging area* ☐ *walking/moving around* ☐ *other relieving factors*_____

Please note any factors that go along with the pain: ☐ *bladder dysfunction* ☐ *bowel dysfunction*
☐ *dizziness* ☐ *fever* ☐ *weakness* ☐ *pain not previously described*_____

List any previous tests related to this problem (in the last 12 months**)**
☐ *CT scan* ☐ *EMG* ☐ *Myelogram* ☐ *Discogram* ☐ *MRI* ☐ *X-ray* ☐ *None*

List any previous treatments in the past 12 months (and their effectiveness on the pain):

Medications:

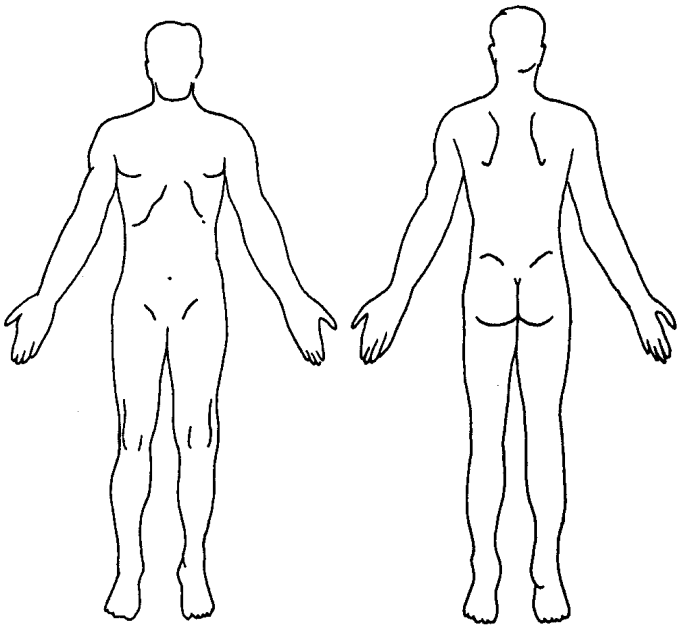
Prescription Medication (name) _____ ☐ effective ☐ non-effective

Over-the-counter Medication _____ ☐ effective ☐ non-effective

Advil/Motrin/aspirin (circle all that apply) ☐ resolved ☐ better ☐ worse ☐ no change/unimproved

Acupuncture	☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Massage Therapy	☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Chiropractic Care	☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Injection Therapy	☐ resolved	☐ better	☐ worse	☐ no change/unimproved
Physical Therapy	☐ resolved	☐ better	☐ worse	☐ no change/unimproved

Please mark the location(s) of your pain on the diagrams below with an "X." If whole areas are painful, please shade in the painful area.



Front ***Back***

Current Medications:

Please list any medications you are currently taking:

Name of Medication	Dosage	How Often Taken

Pharmacy Preference (include location): _____

Allergies:

Are you allergic to any Medication? _____ Yes _____ No. If yes, please list below:

Name of Medication	Type of Reaction

Are you allergic to any of the following? (check all that apply):

☐ Adhesive tape ☐ Iodine ☐ Latex ☐ Contrast dye

Past Health History:

Mark if you have ever been diagnosed with any of the following:

☐ Cancer: Type _____
☐ Migraine headache
☐ Angina
☐ Heart attack
☐ High blood pressure
☐ High cholesterol
☐ Asthma
☐ COPD
☐ GERD
☐ Hepatitis: Type _____
☐ Kidney Disease
☐ Kidney Stones
☐ Arthritis
☐ Degenerative bone disease
☐ Osteoporosis
☐ Epilepsy
☐ Stroke
☐ Anxiety
☐ Depression
☐ Diabetes: Type _____
☐ Thyroid dysfunction
☐ Anemia
☐ AIDS
☐ HIV

Past Surgical History:

Please list any previous surgeries you have had (including dates): _____

_____

_____

Do you have a pacemaker? ☐ Yes ☐ No **Any metal implants? ☐ Yes ☐ No**

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If yes, please list type of problem: _____

Social History:

Mark your tobacco use:

☐ Never used ☐ Cigarettes ☐ Smokeless Tobacco ☐ Cigars ☐ Former smoker (date quit): _____

Give the closest amount of cigarettes you smoke in an average day:

☐ ½ pack ☐ 1 ½ pack
☐ 1 pack ☐ 2 packs ☐ other: _____

Alcoholic Beverages – A drink is 1 shot of liquor or 1 glass of wine or bottle/can of beer.

☐ Less than 12 drinks/year ☐ 4-14 drinks/week
☐ 1-13 drinks/month ☐ >2 drinks/day

Do you use drugs recreationally? ☐ Yes ☐ No If yes, list drug(s): _____

Dependency or addiction to drugs now or in the past? ☐ Yes ☐ No If yes, to what? _____

Review of systems: (mark all that apply)

General health:
☐ Change in appetite
☐ Dizziness
☐ Fatigue
☐ Sleeping problems

Hent:
☐ Blurred vision
☐ Loss of vision
☐ Ringing in the ears
☐ Frequent nosebleeds

Cardiovascular:
☐ Blacking out or fainting
☐ Chest pain
☐ Irregular heartbeats
☐ Leg cramps
☐ Swelling of ankles

Respiratory:
☐ Productive cough
☐ Non-productive cough
☐ Shortness of breath
☐ Wheezing

Gastrointestinal:
☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting

Genitourinary:
☐ Decreased sex drive
☐ Blood in urine
☐ Change in urinating pattern
☐ Frequency in urination

Musculoskeletal:
☐ Limitation of use of any joint, including the back
☐ Muscle pain
☐ Pain in back
☐ Pain in neck
☐ Painful joints
☐ Stiffness in joints
☐ Swelling of joints
☐ Weakness

Neurological:
☐ Falling down
☐ Headache
☐ Loss of bladder control
☐ Loss of bowel control
☐ Numbness
☐ Weakness

Psychological:
☐ Anxiety
☐ Depression
☐ Unexpected weight change

Endocrine:
☐ Neck has enlarged
☐ Increased thirst

Hematologic:
☐ Bleeds excessively after injury
☐ Bruises easily
☐ Masses in neck

Patient's Signature: _____Date: _____

Scanned signature(s) shall suffice as the legal signature(s)