



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 #: _____

1988 Gulf to Bay Blvd., Clearwater, FL 33765

P (727) 953-8090 F (727) 953-8088

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 involved in providing this detailed 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 deferralment 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

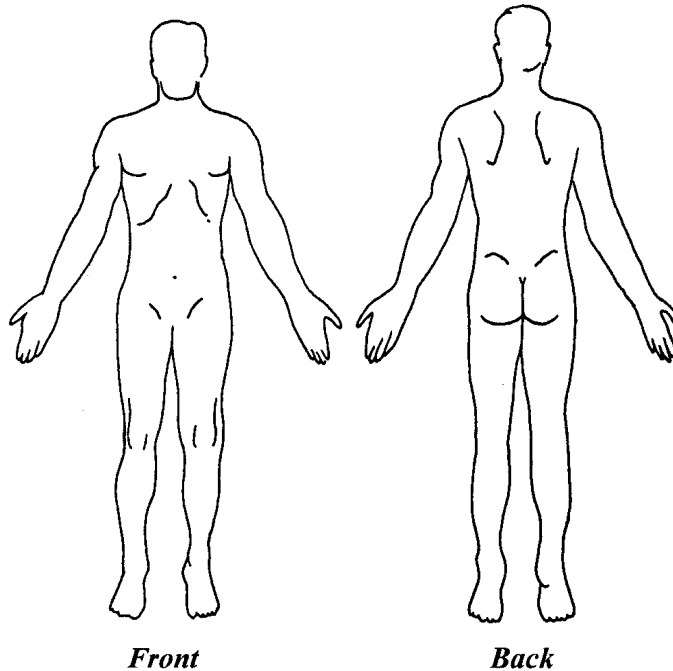
Massage Therapy resolved better worse no change/unimproved

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.



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)

- | | | | |
|---|---|---|---|
| <u>General health:</u>
<input type="checkbox"/> Change in appetite
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Sleeping problems | <u>Respiratory:</u>
<input type="checkbox"/> Productive cough
<input type="checkbox"/> Non-productive cough
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing | <u>Musculoskeletal:</u>
<input type="checkbox"/> Limitation of use of any joint, including the back
<input type="checkbox"/> Muscle pain
<input type="checkbox"/> Pain in back
<input type="checkbox"/> Pain in neck
<input type="checkbox"/> Painful joints
<input type="checkbox"/> Stiffness in joints
<input type="checkbox"/> Swelling of joints
<input type="checkbox"/> Weakness | <u>Psychological:</u>
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Unexpected weight change |
| <u>Hent:</u>
<input type="checkbox"/> Blurred vision
<input type="checkbox"/> Loss of vision
<input type="checkbox"/> Ringing in the ears
<input type="checkbox"/> Frequent nosebleeds | <u>Gastrointestinal:</u>
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting | <u>Neurological:</u>
<input type="checkbox"/> Falling down
<input type="checkbox"/> Headache
<input type="checkbox"/> Loss of bladder control
<input type="checkbox"/> Loss of bowel control
<input type="checkbox"/> Numbness
<input type="checkbox"/> Weakness | <u>Endocrine:</u>
<input type="checkbox"/> Neck has enlarged
<input type="checkbox"/> Increased thirst |
| <u>Cardiovascular:</u>
<input type="checkbox"/> Blacking out or fainting
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Irregular heartbeats
<input type="checkbox"/> Leg cramps
<input type="checkbox"/> Swelling of ankles | <u>Genitourinary:</u>
<input type="checkbox"/> Decreased sex drive
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Change in urinating pattern
<input type="checkbox"/> Frequency in urination | | <u>Hematologic:</u>
<input type="checkbox"/> Bleeds excessively after injury
<input type="checkbox"/> Bruises easily
<input type="checkbox"/> Masses in neck |

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

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