NeuSpine Institute | Minimally Invasive Surgery

Phone: 813-333-1186
Fax: 844-691-5928

2700 Healing Way
Suite 300
Wesley Chapel, FL 33543

2445 Country Place Blvd
Suite 102
Trinity, FL 34655

PATIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name:_____Middle Initial: _____
Address: _____
STREET CITY STATE ZIP CODE
Gender: ☐ Male ☐ Female Social Security #: _____ Date of Birth: _____
Home Phone: _____ Cell Phone _____ Work Phone: _____
E-mail: _____ Preferred Method of Contact: ☐ PHONE ☐ E-MAIL
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race/Ethnicity: ☐ American Indian ☐ Hispanic/Latino ☐ Asian ☐ African American ☐ White ☐ Other
Is your visit related to an Auto Accident? ☐ Yes ☐ No

How were you referred? ☐ Primary ☐ Specialty ☐ Law Firm ☐ Friend/Family ☐ Advertising ☐ Other

Referring Physician (if applicable): _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone _____ Work Phone: _____

2. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone _____ Work Phone: _____

PROVIDER HISTORY

Primary Care Physician
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

Cardiologist
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

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INSURANCE INFORMATION

Primary Insurance

☐ ☐ Person Responsible: Self Other Relationship to Patient: _____

Name: _____ DOB: _____ Social Security #: _____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

Secondary Insurance

Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____

Name: _____ DOB: _____ Social Security #: _____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

PHARMACY INFORMATION

Local Pharmacy

Name: _____

Address: _____

_____

Phone Number: _____

Mail Order Pharmacy

Name: _____

Address: _____

_____

Phone Number: _____

HISTORY

Do you smoke?	Y	N	How many per day? _____
Former Smoker?	Y	N	Last used? _____
Do you drink alcohol?	Y	N	How often? _____
Past of drinking alcohol?	Y	N	Last used? _____
Did you ever do Drugs?	Y	N	What kind? _____

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MEDICAL INFORMATION

Please list all medications you are taking or provide a list
(Include over the counter medications)

Name **Dosage** **Directions**

Reason for Medication

Allergies: Yes No (Include Environmental & Food)

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MEDICAL INFORMATION CONT.

List of Surgeries/Hospitalizations

Hospital Name	**Reason**	**Date**

Past Medical History: *(check all that apply)*

Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke or mini-stroke
- ☐ Aneurysm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Abnormal Heart Rhythm

Emphysema or COPD
- ☐ Acid Reflux
- ☐ Ulcerative colitis or Crohn's Disease
- ☐ Kidney failure/problems
- ☐ HIV or AIDs
- ☐ Hepatitis
- ☐ Bleeding or Clotting problems
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

☐ Pacemaker or AICD
☐ Anemia
☐ Headaches
☐ Anxiety
☐ Depression
☐ Asthma
☐ Cataracts
☐ Pneumonia

☐ Cancer
☐ Arthritis
☐ Osteoporosis
☐ Glaucoma
☐ Epilepsy
_____
_____
_____
_____

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ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

I have reviewed NeuSpine Institute LLC Notice of Privacy, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.
Patient requested copy: ☐ Yes ☐ No

_____
Name of Patient *(Please Print)*

_____ _____
Signature of Patient of Legal Guardian Date

Consent for Prescription Reconciliation

I, _____, hereby consent to have my prescription history reconciled via Pharmacy billing.

_____ _____
Signature of Patient of Legal Guardian Date

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment times ☐ Medical Information ☐ Billing/Demographic Info

Do NOT release my information, except to health care providers and...

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

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FINANCIAL AND CONSENT AGREEMENT

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE

PATIENT INFORMATION FORM – FINANCIAL AGREEMENT

1) Services are rendered to the patient, not the insurance company. Our office will file your insurance if proper information is received.
   a) You are responsible for Co-Pays, Deductibles, Non-Covered Services, Co-Insurance and items considered "not medically necessary" by insurance.
   b) For unpaid claims over 45 days, it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
2) It is your responsibility to notify our front desk of any insurance or address changes.
3) You will be responsible for any changes that occur if your current insurance is not communicated at the time of service.
4) Expenses incurred to collect patient-responsible debt may be charged to the patient or guarantor.

PATIENT AUTHORIZATION & CONSENT

I, _____, hereby voluntary consent to medical treatment, including diagnostic producers, surgical and other medical services, provided by NeuSpine Institute LLC or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care.

I, _____, agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

I authorize NeuSpine Institute LLC physicians to submit claims to my insurance for services rendered by my medical providers. I

authorized the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made to NeuSpine Institute LLC physicians for services provided by them.

_____ _____

Signature of Patient of Legal Guardian Date

TO ALL PATIENTS:

In order to provide you with good service, it is of great importance we have your current address and phone number on file. Please be sure to contact us if your phone number and/or address changes. This information will be utilized to remind you of your appointment date and time.

Any cancellation, broken appointments, or no shows in which a 24-hour notice is not provided, after three occurrences, will result in termination from NeuSpine Institute.	The clinic has limited waiting time for your appointment. If you are more than 15 minutes late, your appointment will be rescheduled.
Cancellation/No Show Policy:	Late Arrival Policy:

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If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

I have been informed and understand the policies listed above. I also understand if I fail to provide a 24-hour notice of a broken appointment, I will incur a service charge of $50.00.

_____ _____ _____

Patient/Legal Guardian Printed Name Patient/Legal Guardian Signature Date

NEW PATIENT INFORMATION

Please make sure that a response is written in EVERY SPACE

Name: _____

Previous SPINAL Surgeries:	WHERE:	WHEN:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe what your pain feels like: _____

_____

Does anything make the pain better? _____

_____

Does anything make the pain worse? _____

_____

When did it start? _____
How did this start?_____

_____

Previous Treatment (please answer yes/no and details as applicable)

Physical Therapy _____ When _____ How long _____ Did it help _____
Chiropractor _____ When _____ How long _____ Did it help _____
Acupuncture _____ When _____ How long _____ Did it help _____
Massage Therapy _____ When _____ How long _____ Did it help _____
Pain Management _____ When _____ How long _____ Did it help _____
What did they do? _____
Injections _____ When_____ How many _____ What part of body _____ Did it help_____

Details: _____

Other tests/Doctors: _____

_____

_____

_____

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Name: _____ Date: _____

Pharmacy Name: _____Pharmacy Phone: _____

Have you seen any other providers since your last visit? Yes _____ No _____

Please circle any symptoms you have experienced in the last two weeks :

Constitutional:	Fever	Night sweats	Chills	Appetite Change	Fatigue	Weakness			
Skin:	Swollen glands	Rash	Ulcer	• Laceration	Hives	Bruising	Sores	Hair loss	Itching
Ear, Nose, Throat:	Sore throat	Ear Ache	Sinus drainage	Hoarseness	Loss of hearing	Jaw pain	Neck Pain		
Eyes:	Double vision	Other visual charges	Pain from bright lights	Bling Spots					
Respiratory:	Shortness of breath	Wheezing	Chest pain	Sputum	Cough	Coughing up blood			
Cardiovascular:	Chest pain	Palpitations	Swelling	Fainting	Shortness of breath				
Gastrointestinal:	Nausea	Vomiting	Abdominal Pain	Acid Reflux	Difficulty Swallowing	Choking	Diarrhea		
Genital Urinary:	Painful Urination	Incontinence	Blood in urine	Frequent Urination					
Musculoskeletal:	Redness	Pain	Weakness	Joint Swelling	Prior Fractures				
Neurological:	Fainting	Seizure	Memory loss	Paralysis	Prior head injury	Numbness	Weakness		
Psychological:	Depression	Anxiety	Psychosis	Delirium	Fainting	Seizure	Memory Loss	Paralysis	
Hematological:	Easy Bruising	Bleeding gums	History of blood clots	Nose bleed					
Endocrine:	Heat or cold intolerance	History of Diabetes	Thyroid Disease						

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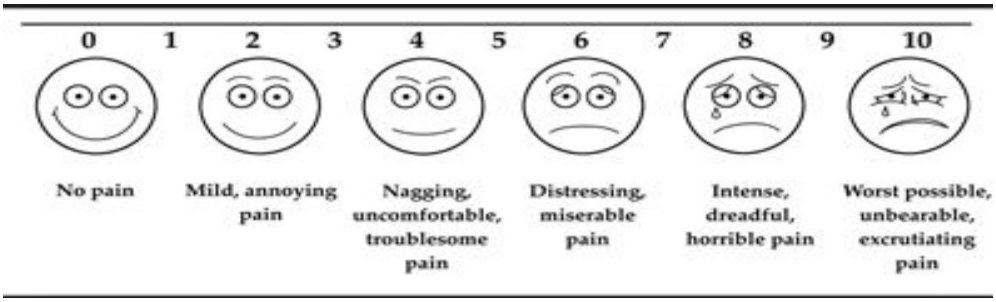
Name: _____

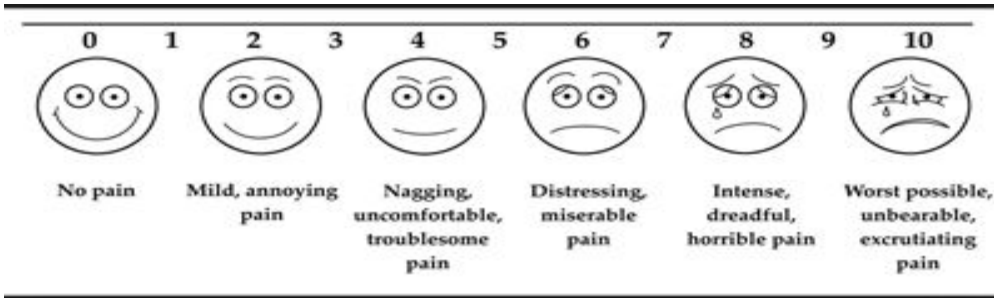
Date: _____

Visual Analogue Scales

Neck Pain

1) Mark your current NECK PAIN based on the scale below

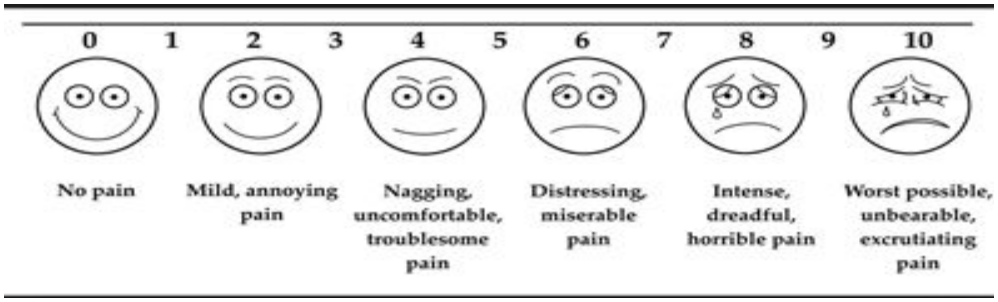




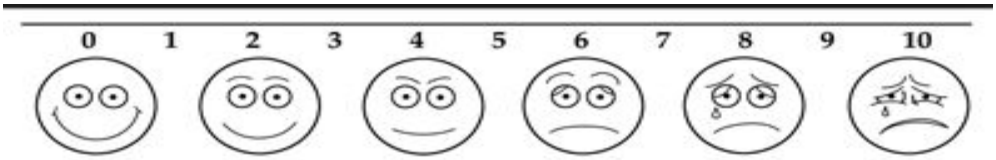
2) Mark your current <u>ARM PAIN</u> based on the scale below

<u>Back Pain</u>

1) Mark your current <u>BACK PAIN</u> based on the scale below



2) Mark your current <u>LEG PAIN</u> based on the scale below



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Name: _____
Date: _____