

PATIENT MEDICAL REGISTRATION

New Patient Checklist

Patient's Name: «PatientFullName»

DOB: «PatientDOB»

Patient # «PatientNumber»

_____ Identification Card/Insurance Card(s) obtained & *scanned properly*

_____ Insurance Set Correctly/ Eligibility Verified

_____ Verified authorization/Referral Information/Ailment created

_____ **** *Deductible/Copay collected***

_____ E-mail address obtained and invite to portal has been sent.

_____ Complete referral source field

_____ ***All required forms filled out/signed/dated***

Employee's Signature: _____ Date: _____

***** Packets must be completed, signed & scanned in order to proceed with treatment**

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Social Security Number: _____

Date of Visit: «ApptDate»

Physician: «ApptProviderName»

Patient Number: «PatientNumber»

YOUR INFORMATION					
Primary Insurance: «PlanName» Member ID: «ClaimMemberID» Group #: «GroupNumber» Policy Holder: «SubscriberName» Policy Holder DOB: «SubscriberDOB» Policy Holder SSN: _____	Secondary Insurance: «SecPlanName» Member ID: «SecPlanClaimMemberID» Group#: «SecPlanGroupNumber» Policy Holder: «SecPlanSubscriberName» Policy Holder DOB: «SecPlanSubscriberDOB» Policy Holder SSN: _____				
Primary Residence Address: «PatientAddrLine1» «PatientAddrLine2» City/State/Zip: «PatientAddrCSZ»	Secondary Residence Address: City/State/Zip:				
Primary Phone: «PatientPhoneNumber»	Cell Phone: «PatientMobilePhone»				
Work Phone: «PatientWorkPhone»	Preferred Phone Method: (Circle One) <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 25%;">Home</td> <td style="text-align: center; width: 25%;">Cell</td> <td style="text-align: center; width: 25%;">Email</td> <td style="text-align: center; width: 25%;">Text Message</td> </tr> </table>	Home	Cell	Email	Text Message
Home	Cell	Email	Text Message		
Is this appointment due to motor vehicle accident? YES/ NO	Injured Body Part: _____				
Is this appointment due to a slip and fall/Liability? YES/ NO	Date of Injury: _____				
Is this a Worker's Compensation appointment? YES/ NO	Injured Body Part: _____				
Is Case closed? YES/ NO or N/A	Date of Injury: _____				
Is an Attorney involved? YES/ NO	Attorney Name: _____				
Preferred Language: _____	Occupation: _____				
Marital Status: «PatientMaritalStatus»	Employment Status: «EmploymentStatus»				
Employer: _____	Ethnicity: Hispanic _____ Non-Hispanic _____				
Race: Asian _____ African American _____	Caucasian _____ American Native/ Alaskan _____				
Other: _____	Primary Care Physician: _____				
Cardiologist (if applicable): _____	Referred Physician: «RefProviderFirstLastName»				
Do you have Internet Access? Yes or No	Email Address: «PatientEmail»				
Emergency Contact: _____	Ph# _____				
Pharmacy: «PatPharmacyName»	«PatPharmacyPhone»				

IF PATIENT IS A MINOR:

PARENT/LEGAL GUARDIAN NAME: _____ SSN#: _____ DOB: _____ PHONE: _____

ADDRESS:

Insurance and Authorization
(Please read and sign below)

I hereby authorize Florida Joint & Spine Institute, P.A. to furnish information to insurance carriers concerning my illness and treatments and understand that I am responsible for any amount not covered by insurance. I authorize any holder of medical or other information about me to release to the social security administration and health care financing administration or its intermediaries or carriers, or to the billing agent of this Physician or supplier. I permit a copy of this authorization to be used in place of the original, and this as a direct assignment of my rights and benefits under the applicable insurance policy to Florida Joint & Spine Institute, P.A. Payment is expected at the time professional services are rendered. We will wait up to sixty (60) days for payment from your insurance company. If the insurance company has not paid within sixty (60) days, we will expect the balance in full from you at that time. We accept cash, check, Visa, Mastercard, American Express, Discover, and Care Credit. In the event that any litigation is required to collect the sums due from you under this agreement, Florida Joint & Spine Institute, P.A. shall be entitled to recover from you, all its legal costs and expenses, including reasonable attorney fees, before trial, at trial and in any appellate proceedings. In the event that the account is delinquent, all collection agency fees will be the responsibility of the guarantor. I authorize Medicare crossover secondary insurance payments to the provider who accepts assignment (medigap). I hereby authorize payment directly to the named doctor of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment, and authorize release of any information relating to this claim. I have read and stated financial policy of Florida Joint & Spine Institute, P.A. and agree to abide by the terms as stated above.

Your signature acknowledges that you have read and understand the Terms and Conditions set by Florida Joint & Spine Institute, P.A.

Patient Signature

«ApptDate»

PATIENT MEDICAL REGISTRATION

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my individually identifiable health information and medical record information by **Florida Joint & Spine Institute, P.A.** in order to carry out treatment, payment or health care operations. You are encouraged to review The Practice's Notice of Privacy Practices for a more complete and detailed description of the potential release and use of such information, and have the right to review such Notice prior to signing this form.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. However, **Florida Joint & Spine Institute, P.A.** is not required to agree to such restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **Florida Joint & Spine Institute, P.A.** reserves the right to change their Notice and Practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Florida Joint & Spine Institute, P.A.** change their Notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I, «PatientFullName», consent to receiving emails, texts, (SMS), auto-dialed and/or artificial or pre-recorded message to my cellular phone or to any telephone number or email provided by me to Florida Joint & Spine Institute or its affiliates and their agents including, without limitation, any account management companies and independent contractors including debt collectors. I understand that consenting to the above is not required before I receive service from Florida Joint & Spine Institute.

RESTRICTIONS: I wish to have the following restrictions to the use or disclosure of my health information:

RELEASE OF INFORMATION: I hereby authorize Florida Joint & Spine Institute, P.A. to release information regarding my treatment to the following individual(s):

_____ I do **NOT** give my permission to Florida Joint & Spine Institute, P.A. to leave **ANY** medical information related to my treatment to anyone other than myself.

MESSAGES: I hereby authorize Florida Joint & Spine Institute, P.A. to leave messages regarding office visits and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s):

Method:	Phone Number w/Area Code:
Home Phone	
Cell Phone	
Work Phone	
Other (specify):	

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Florida Joint & Spine Institute, PA Notice of Privacy Practices. I understand it is my responsibility to notify the practice in writing of any changes to the above information. I have read and understand the terms of this consent. By signing below, I am "only giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

«PatientFullName» _____
Printed Name

_____ Social Security Number

_____ Patient/Authorized Representative Signature

_____ Relationship to Patient

«ApptDate» _____
Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____.

PATIENT MEDICAL REGISTRATION

Florida Joint & Spine Institute, P.A. Financial Policy

Thank you for choosing Florida Joint & Spine Institute, P.A. as your health care provider. We are committed to the success of your treatment. The medical services provided by our office are services you have elected to receive which imply a financial responsibility on your part.

Our office verifies all insurances prior to your first appointment. The information obtained from the patient's insurance carrier is not a guarantee of payment. It is only a review of the patient benefits. Upon our receipt of the insurance company claim payment, our office will address any discrepancies that arise due to incorrect information provided at the time of benefit verification. Ultimately, payment for services rendered is the patient's responsibility.

Forms of payment: Forms of payment accepted are cash, check, Care Credit, American Express, Discover, MasterCard or Visa debit or credit cards, HSA and FSA.

CareCredit: CareCredit is a dedicated resource available to our patients for use when paying for procedures not covered by insurance. CareCredit offers a 6 month no interest plan for amounts above \$200. For more information, please contact one of our office staff or call 1-800-365-8295. You may also apply online at www.carecredit.com. Patients having procedures who do not qualify for Care Credit have the option of making monthly payments until the amount is paid in full. Please keep in mind, the procedure will not be scheduled or performed until the balance is paid in full!

Accident Insurance: Our office does not accept or file accident insurance. This includes, but is not limited to, school insurance, homeowner's insurance, and private plans.

Automobile Insurance: Any incident involving an automobile must be filed under the patient's automobile insurance carrier. This includes non-collision accidents such as closing a car door on a finger or sustaining an injury while lifting a load out of a car trunk. Patients having additional personal/group insurance will be required to file the automobile insurance as their primary insurance and the personal/group insurance as their secondary insurance. Patients that only have automobile insurance will be considered a Self-Pay Patient. It is unlawful to bill automobile claims to a patient's personal/group insurance until all automobile insurance benefits have been exhausted. Since, Florida is a "no fault" state, the patient will be responsible for providing our office with the following information prior to scheduling an appointment: patient's auto insurance information, claim adjustor's name and contact number, claim number, date of accident, and health insurance information. Prior to scheduling your appointment, our office will contact your insurance company to verify benefits. As of January 1, 2013, Florida law states that if you are injured in an accident you are required to obtain medical treatment within 14 days or there is NO PIP COVERAGE FOR ANY MEDICAL BENEFITS!

Collections: If you fail to pay your account, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorneys' fees that we incur in such collection efforts.

Co-Payments: Co-payments are collected at the time of registration. Patients who are unable to pay their copayment may not be seen. Our practice is obligated to collect co-payments by your insurance company.

Deductibles / Coinsurance: Patients with deductibles will be required to pay a deposit at check in. The remaining balance, coinsurance and or deductible will be collected at check-out based upon the insurance allowable. Patient credits will be applied to the next visit or refunded if no other appointment is necessary.

Referrals: If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the written and/or electronic referral prior to scheduling an appointment. If a referral is not obtained prior to your appointment, the appointment will be cancelled until a referral is provided.

Minors: Minors will not be treated without a parent/guardian present. In matters of child custody, Florida Joint & Spine will bill the insurance carrier for the parent signing the consent forms. The parent signing the consent for services will be responsible for any outstanding balance, unless a court order is provided stating otherwise.

Medical Records & Insurance Form Completion: Patients may obtain a summary of each visit free of charge by accessing their patient portal account. All other requests will require a signed consent. Patients may request to have their records sent to them via mail or email. Radiology images will be provided on disc with a signed consent and valid photo Id. There will be a \$5 fee if picked up or \$10 fee if mailed to the patient. Allow 10-14 business days for processing. The following fees apply to all forms: FMLA (Family Medical Leave) = \$30, All other forms 1 page or less = \$15, All other forms 2 pages or more = \$35. Forms will not be completed without pre-payment and a signed consent on file. Patient is responsible for all fees! Allow 10-14 business days for processing.

Medicare Supplement Insurance: We are a participating provider with the Medicare Part B program; and as such we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% and your annual deductible are the patient's responsibility by federal law.

Non-Covered: Patients are required to make payment for any balance not covered by the insurance plan. If you are unsure whether a service is covered by your plan, ultimately it is your responsibility to contact your insurance company to review your benefits.

No-Show: A \$30 established patient or a \$75 in-office procedure no show fee will be applied to the patient's account when the patient has not given our office adequate notice (more than 24 hours) of an office appointment cancellation. Two no show appointments will result in a letter to the patient and primary care physician. Three no show appointments will result in termination of care. If a patient who has not established with the practice misses their first appointment on two separate occasions, they will not be scheduled for any further appointments.

Refunds: Patients will be refunded any overpayment once all claims on the account have been processed and the patient has been released from care. The accounts payable department will issue a refund check in a timely manner.

PATIENT MEDICAL REGISTRATION

Self-Pay: All new patients without proof of insurance will be required to pay a deposit at time of service in the amount of \$285. For follow-up appointments the patient will be required to pay \$150 at time of service. All new fracture care patients will be required to pay a deposit at the time of service in the amount of \$650. For follow-up appointments the patient will be required to pay \$200 at the time of service. Patients scheduled for injections and other office procedures may be required to pay additional amounts at time of service. PATIENTS SHOULD BE AWARE THIS IS ONLY A DEPOSIT! THE TOTAL CHARGES MAY BE MORE OR LESS THAN THE INITIAL DEPOSIT COLLECTED. Any remaining balance for the visit will be collected at check out.

Surgery Cancellation Fee: Patients, who cancel their surgery with less than 48 hours' notice will be charged a \$200.00 fee for the late cancellation. Surgery will not be rescheduled until the fee is paid.

Surgery Pre-payment: Patients are required to pay their portion of the surgical fee two (2) business days prior to the surgery. Patients unable to pay may be required to have their surgery rescheduled.

Travelers Insurance for International Patients: Any international patients who have Canadian, International health care insurance or traveler's insurance, automatically become Self Pay patients. The patient will be responsible for charges at the time of service. It is the patient's responsibility to file their claim with the insurance company. Our office would be happy to assist you with this.

Worker's Compensation: If a patient is injured on the job, it must be reported to the employer unless the patient is worker's compensation exempt. The initial appointment is to be handled through the worker's compensation adjuster. If the employee is worker's compensation exempt, you must provide a copy of the State exemption. Any non-participating worker's compensation carrier will be required to sign our worker's compensation agreement before making any appointments for the patient. The adjuster will be required to provide any non-English speaking patient with a translator.

Physician Phone Calls: When calling the office to speak with your doctor or another member of the office we will do our best to return your phone call within 48 hours. Since we are not an urgent care clinic, if you have an emergency, we advise that you go to your nearest emergency room.

Psychological Evaluation: Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or spinal cord stimulator trials. We reserve the right to discontinue care if you fail to obtain an evaluation as requested.

Staff: We require our staff to address our patients with the professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document your record and depending on the severity of the situation, you may be discharged from the practice.

Acknowledgment

Insurance Authorization and Assignment:

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Florida Joint & Spine Institute, PA. for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration, health care financing administration its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128b of the social security act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Your signature acknowledges that you have read, understand, and agree to the above financial policies as well as the insurance authorization.

I understand that it is my responsibility to inform Florida Joint & Spine, P.A. of any changes in my health insurance information and/or contact information. I understand and accept the terms of this Financial Policy.

«PatientFullName»

Printed Name

«PatientDOB»

Date of Birth

Patient/Legal Representative Signature

Relationship to Patient

«ApptDate»

Date

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #:«PatientNumber»

Date of Visit: «ApptDate»

H: _____

W: _____

PATIENT MEDICAL REGISTRATION

BP: _____

P: _____

BMI: _____

Chief Complaint

Reason for visit:

Location of your pain:

____ Head ____ Shoulder ____ Mid Back ____ Leg ____ Ankle/Foot ____ Wrist/Hand

____ Neck ____ Headaches ____ Low Back ____ Knee ____ Hips/Buttocks ____ Arm

History of Present Illness

Date of injury or symptom onset: _____

Please describe how you injured yourself:

Please describe your current symptoms:

Date of Visit: «ApptDate»

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

“0” means no pain and “10” is the worst pain you can imagine.

PATIENT MEDICAL REGISTRATION

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its best: 0 1 2 3 4 5 6 7 8 9 10

Which of the following best describes the character of your pain:

Timing:

Quality:

Continuous, steady, constant
 Rythmic, periodic, intermittent
 Brief, momentary, Transient

Throbbing
 Aching
 Sharp

Burning
 Tingling/ numbness
 Dull

Superficial
 Deep

What makes your pain worse? _____

What makes your pain better? _____

How long/far can you sit? Sit _____ Stand _____ Walk _____

Since your injury how is your pain? Better Same Worse

If your pain has changed, what percentage? 10 20 30 40 50 60 70 80 90 100%

Have you had any loss of bowel or bladder control? Yes No

Previous Treatment

Have you had treatment since your injury? Yes No Have you been to the ER for this? Yes No

Have you had any of the following tests or procedures performed?

X-rays _____ MRI _____ Epidurals _____ CT Scan _____ EMG _____

Other (please explain) _____

Medical:

Dr. _____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Medication given _____
Treatment provided _____

Chiropractic: Yes No

Dr. _____ Date of 1st visit _____ Last visit _____
Diagnosis given _____
Frequency: Every Day Three times a week Two times a week Weekly
Has it helped? Yes No

Physical Therapy: Yes No

Therapist: _____ Date of 1st visit _____ Last visit _____
Has it helped? Yes No Home exercise program given? Yes No

Pain Management: Yes No

Radio Frequency Ablation: Yes No Epidurals Yes No Other: _____

PATIENT MEDICAL REGISTRATION

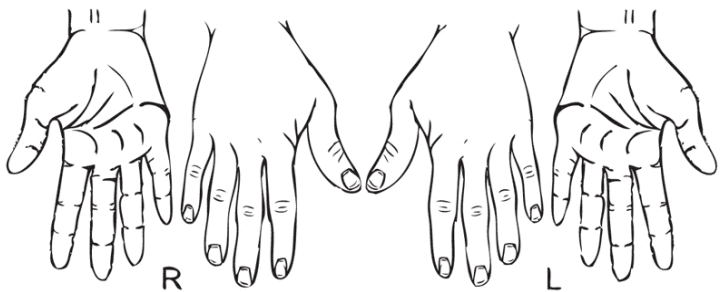
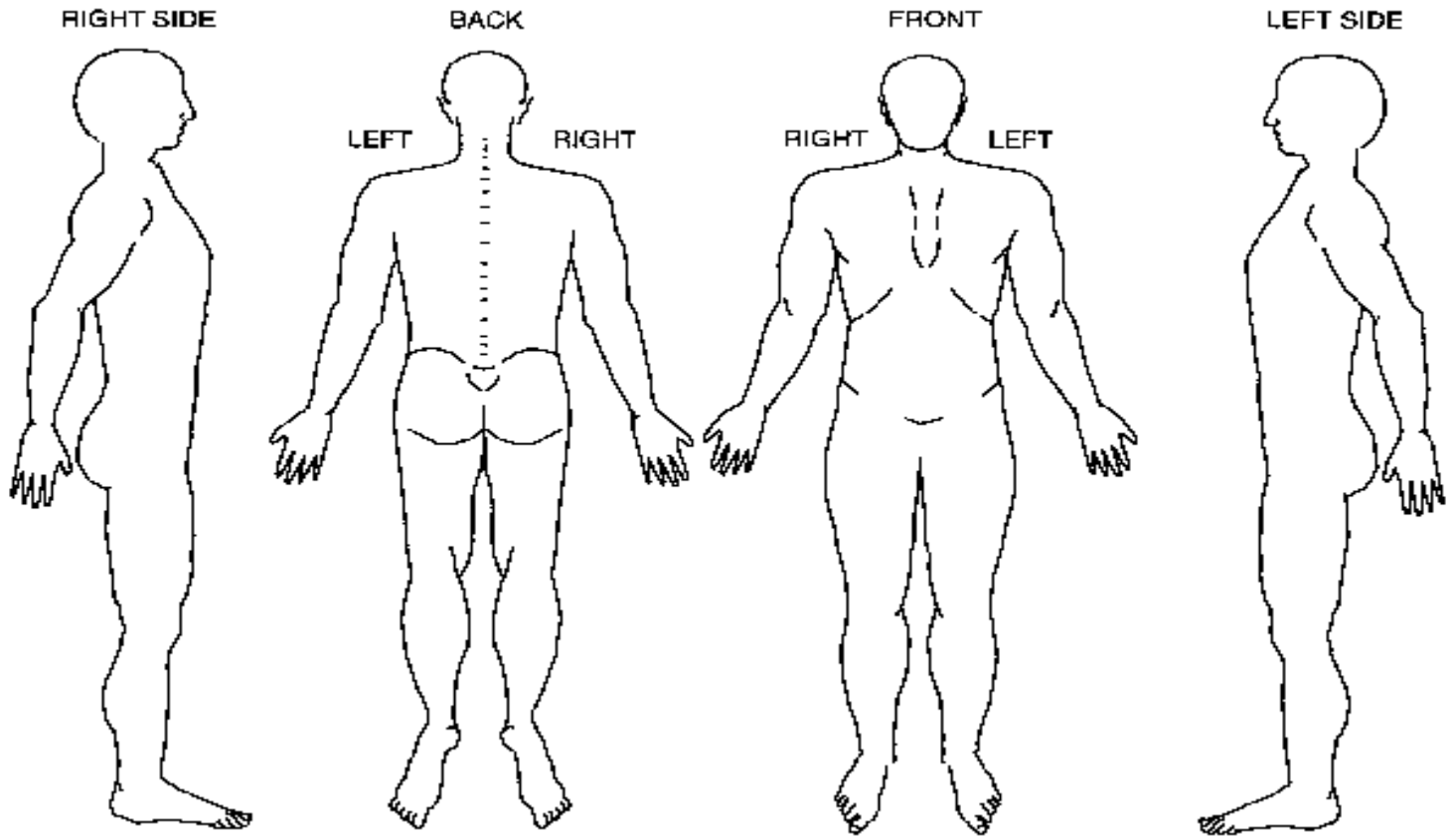
Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

Date of Visit: «ApptDate»

Mark on the areas on your body where you feel the described sensations. Use the Symbols listed. Mark the areas of the radiating pain or numbness as well. Include all affected areas.



Numbness 000

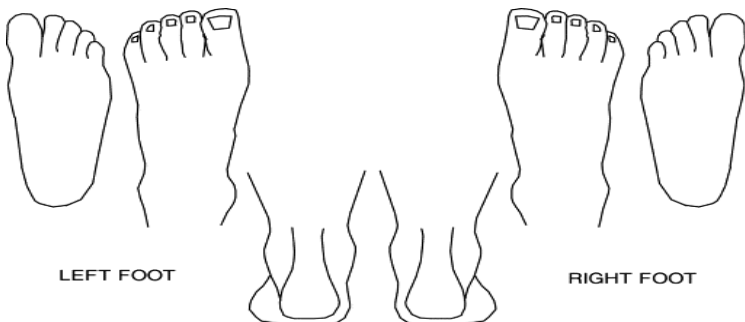
Tingling ::::

Burning XXX

Stabbing/sharp ////

Aching ^^^

Cramping ***



PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

Date of Visit: «ApptDate»

YOUR MEDICATIONS

No Medications _____ List all the medications you take, both prescription and nonprescription below:

Medication or Brand Name	Dose	Medication or Brand Name	Dose

Preferred Pharmacy: «PatPharmacyName»

Pharmacy Phone: «PatPharmacyPhone»

YOUR ALLERGIES

No Allergies _____ Indicate all the allergies you have to medications and/or food & describe reaction below:

Common reaction include - Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble breathing

YOUR FAMILY HISTORY

Family History Unknown _____

Mother	Father	Sister	Brother
Alive & Well	Alive & Well	Alive & Well	Alive & Well
Cancer- Type _____	Cancer- Type _____	Cancer- Type _____	Cancer- Type _____
CVA/Stroke	CVA/Stroke	CVA/Stroke	CVA/Stroke
Diabetes	Diabetes	Diabetes	Diabetes
Hypertension	Hypertension	Hypertension	Hypertension
Other: _____	Other: _____	Other: _____	Other: _____

YOUR SOCIAL HISTORY

Tobacco Use: Current _____ Former _____ Never _____

Type: _____

Packs/Day: _____

Years Used: _____

Have you Ever tried to quit? Yes _____ No _____

Alcohol Use: Yes _____ No _____ Former _____

Type (Circle): Beer _____ Wine _____ Liquor _____

Frequency: _____

Amount per Sitting: _____

Last Drink: _____

Caffeine Use: Yes _____ No _____

Type: _____

Daily Amount: _____

PREVIOUS VACCINES

Influenza Vaccine: Yes _____ No _____ Date: ___/___/___

Pneumovax Vaccine: Yes _____ No _____ Date: ___/___/___

Tetnus: Yes _____ No _____ Date: ___/___/___

SUBSTANCE ABUSE

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)

Alcohol _____ Cocaine _____ Heroin _____ IV Drugs _____ Marijuana _____ Other _____

(Specify): _____

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName»
Date of Visit: «ApptDate»

DOB: «PatientDOB»

Patient #: «PatientNumber»

YOUR PAST MEDICAL HISTORY			
Disease Type:		Disease Type:	
Hypertension	Blood Thinners	Hernia	Anemia
Kidney Disease	Angina Pectoris	Peripheral Vascular Disease	Bipolar Disorder
Heart Disease - I or II	COPD	Anxiety	Herniated Disc
Diabetes	GERD	Depression	Thyroid Disorders
Osteoarthritis	GOUT	Stroke	High Cholesterol
Osteoporosis	Sleep Apnea	DVT/Blood Clots	Seizure Disorders
Rheumatoid Arthritis	Prostates Disorders	Ulcers	Pulmonary Embolism
Cancer- Type: _____	Pneumonia	AIDS/HIV	Other: _____
Hepatitis - Type: _____	Hearing Loss	Scoliosis	None: _____

YOUR PAST SURGICAL HISTORY			
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No Surgical History

Surgery Type:	Year of Surgery:	Surgery Type:	Year of Surgery:
Appendectomy	___/___/___	Prostate	___/___/___
Hysterectomy	___/___/___	Pacemaker	___/___/___
Cholecystectomy	___/___/___	Open Heart/By-Pass	___/___/___
Tonsillectomy	___/___/___		___/___/___
Cataracts	___/___/___	Other:	___/___/___

PAST ORTHOPEDIC SURGICAL HISTORY				
----------------------------------	--	--	--	--

Hip Replacement - RT / LT	N/A	___/___/___	Fracture Care-Type_____ N/A	___/___/___
Knee Replacement - RT / LT	N/A	___/___/___	Reverse Shoulder Replacement- RT / LT N/A	___/___/___
Rotator Cuff Repair - RT / LT	N/A	___/___/___	Total Shoulder Replacement - RT / LT N/A	___/___/___
MAKOplasty - RT / LT	N/A	___/___/___	Hip Pinning - RT/ LT N/A	___/___/___
ORIF - Type_____ N/A		___/___/___	Carpal Tunnel - RT / LT N/A	___/___/___
Kyphoplasty - Site_____ N/A		___/___/___	Other:_____	___/___/___

Any additional surgical Information:

Back Surgery		
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Date	Surgery Type/ Side	Physician

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

PATIENT MEDICAL REGISTRATION

Date of Visit: «ApptDate»

Have you been in the Emergency Room for treatment of your pain? Yes No		
Worker's Compensation Case? Yes No		
Auto Accident? Yes No		
Represented by Attorney? Yes No		Attorney's Name: Phone:
Lawsuit Pending? Yes No		Case Manager's Name: Phone:
COMPLETE THIS BOX ONLY IF YOU WERE INVOLVED WITH AN AUTO ACCIDENT		
Were you wearing a seatbelt? Yes No	Were you the driver? Yes No	Were you the passenger? Yes No
Did you lose consciousness? Yes No If Yes, for how long?		
Briefly Describe the accident:		
How Much damage was done to your vehicle? \$		
How long after the accident did the pain begin?		
Did you experience pain in the same location previous to this accident? Yes No		
If Yes, Please explain:		

YOUR ATTESTATION

I attest that the above information is complete and accurate as it will be utilized as part of my care and treatment plan

Patient Signature / If minor, Guardian Signature

«ApptDate»
Date

Patient Name: «PatientFullName»

DOB: «PatientDOB»

Patient #: «PatientNumber»

PATIENT MEDICAL REGISTRATION

Date of Visit: «ApptDate»

Have you scheduled or Have had a COVID Vaccine? YES NO If yes, When was 1st Dose: _____ 2nd Dose: _____

Vaccine Scheduled For: _____

Would you like a copy of your Office visit summary for today? _____ Yes _____ No

Do you have an advanced care plan in place? _____ Yes _____ No

REVIEW OF SYSTEMS

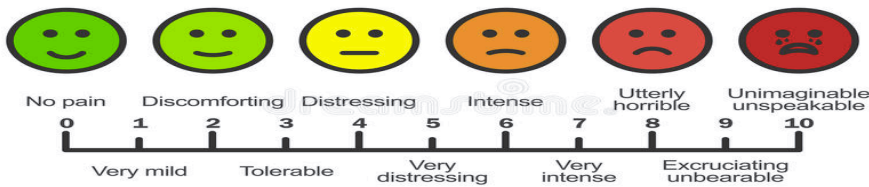
Please check here if no symptoms today: _____

Circle if you have any of the following today:

General	Cardiovascular	Metabolic	Skin
Fever Weakness Weight Gain or Weight Loss	Palpitations / Murmur Leg Swelling / Edema Syncope / Fainting	Cold Intolerance Heat Intolerance	Rash Skin Infections Skin Lesions Itchy Skin
Ears, Nose &	Gastrointestinal	Neurological	Blood Disorders
Blurred Vision Nosebleeds Headaches Vertigo /Dizziness	Constipation Diarrhea Nausea Vomiting	Difficulty Walking Dizziness Poor Coordination Muscle Weakness	Bleeding Bruising
Respiratory	Urinary	Psychiatric	Endocrine
Difficulty Breathing Recent Infections Wheezing	Difficulty Urinating Frequent Urination Blood in Urine	Anxiety Depression Insomnia	Excessive Thirst Excessive Sweating

Circle the number that corresponds to the severity of your pain on a scale of 0-10.

“0” means no pain and “10” is the worst pain you can imagine.



Patient Signature: _____

Date: _____

PATIENT MEDICAL REGISTRATION

Dear Patient,

Florida Joint and Spine Institute has selected MyHealthRecord.com for your patient portal access. You will be able to access your medical records anytime, anywhere, manage your office appointments, talk privately with your care team and receive the best care possible.

At your convenience you can view your health record, exchange secure messages with your healthcare provider, request and manage appointments, request your medical records, request a prescription refill, and pay your bill online.

Once you are signed up for your patient portal, **send your healthcare providers a confirmation email letting them know that you have successfully registered for the portal.**

If you have any questions please call us at 863-385-2222 and we will assist you.

Once you receive your email invite to our new patient portal:

- Click on the link to open the portal
- Make sure you are using the google Chrome or Firefox browser
- Type in your name, date of birth and zip code
- Choose a user name, password and security questions
- Accept registration disclaimer
- Click on My Message, click new
- Choose your provider. Select question type...asks a medical question. Let us know you have signed up and/or ask us any questions you may have.
- Click send
- You will receive a Welcome email once completed successfully.

Thank you,
Florida Joint & Spine Team

Please use the following internet address to educate yourself and look up information pertaining to diagnosis in your chart problem list or assessment. <http://orthoinfo.aaos.org/>



appt@floridajointspine.com

<https://myhealthrecord.com>



[@FloridaJointAndSpine](#)



[@FLjointspine](#)



[Instagram@floridajointandspineinstitute](#)

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1204 Carlton Avenue · Lake Wales, FL 33853 · Ph 863-676-9523 · Fax 863-676-1654
70 second street SE 2nd floor · Winter Haven, FL 33880 · Ph 863-299-3210 · Fax 863-299-2968
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