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: _____ **DOB:**

Social Security Number: _____ **Date of Visit:**

Physician: **Patient Number:**

YOUR INFORMATION	
Primary Insurance: **Member ID:** **Group #:** **Policy Holder:** **Policy Holder DOB:** **Policy Holder SSN: _____**	**Secondary Insurance:** **Member ID:** **Group#:** **Policy Holder:** **Policy Holder DOB:** **Policy Holder SSN: _____**
Primary Residence **Address:** **City/State/Zip:**	**Secondary Residence** **Address:** **City/State/Zip**:
Primary Phone:	**Cell Phone:**
Work Phone:	**Preferred Phone Method: (Circle One)** **Home Cell Email Text Message**
Is this appointment due to motor vehicle accident? YES/ NO	**Injured Body Part:** **Date of Injury:**
Is this appointment due to a slip and fall/Liability? YES/ NO	**Injured Body Part:** **Date of Injury:**
Is this a worker's compensation appointment? YES\ NO	**Injured Body Part:** **Date of Injury:**
Is Case closed? YES/ NO or N/A	**Is an attorney involved? YES/ NO** **Attorney Name:**
Preferred Language:	**Occupation:**
Marital Status:	**Employment Status:** **Employer:**
Ethnicity: Hispanic _____ Non-Hispanic _____ **Race:** Asian _____ African American _____ Caucasian _____ American Native/ Alaskan _____ Other:_____	
How did you hear about us?	
Primary Care Physician:	**Cardiologist (if applicable):**
Referring Physician:	
Do you have Internet Access? Yes or No	**Email Address:**
Emergency Contact: **Ph#:**	**Pharmacy:**

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.

_____ «ApptDate»
Patient Signature

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).
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 my protected health information to the following individual(s):

_____

CONSENT TO CONTACT:
The Practice regularly communicates with its patients regarding appointment reminders, billing inquiries, prescription refills, making referrals, and other general medical & business matters. With respect to these general communications, I give the Practice permission to communicate with me via the following methods **(please check ALL that apply & provide the appropriate phone number or email address):**

☐ Cell phone – by voice or text (_____) _____ - _____

☐ Email _____ @ _____

SPECIAL COMMUNICATIONS:
Additionally, the Practice may wish to inform me of healthcare services or products that it offers or provide me with educational health information, such as a newsletter. By checking the box below, I give the Practice permission to send these communications via the email address provided above.

☐ I authorize the Practice to send email communications as described above.

CONDITIONS FOR USE OF ELECTRONIC OR CELL PHONE COMMUNICATIONS:
I understand that:

1. An automated dialing system may be used to make calls or send text messages to my cell phone number and by providing my cell phone number I am authorizing the Practice to use such automated dialing system to call my cell phone.
2. The Practice is not responsible if emails or texts are received and/or read by others as a result of transmission to the addresses or numbers listed above.
3. I can cancel this permission at any time.

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 _____.

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: Forms are completed within 10-14 business days of receipt and prepayment. The patient must sign a medical release and work status form before the form can be completed. Patients requesting electronic copies of their medical records can obtain them free of charge by accessing their patient portal. Patients requesting paper copies of their medical records must complete a signed release. 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. Patient is responsible for all fees! Records can be picked up with a photo ID; they cannot be mailed. This is to ensure patient confidentiality. X-Ray copies are provided via CD with a signed release form and photo ID. If picked up in the office the charge is $5.00 and if mailed the charge is $10.00 with a request turnaround time of 10-14 business days.

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.

Self-Pay: All new patients without proof of insurance will be required to pay a deposit at time of service in the amount of $310. For follow-up appointments the patient will be required to pay $165 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 fall 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 term mate 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.

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 MEDICAL REGISTRATION

Patient Name: «PatientFullName» DOB: «PatientDOB» Patient #:«PatientNumber»

Date of Visit: «ApptDate»

H: _____
W: _____
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 MEDICAL REGISTRATION

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.

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:

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

Quality:

__ 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

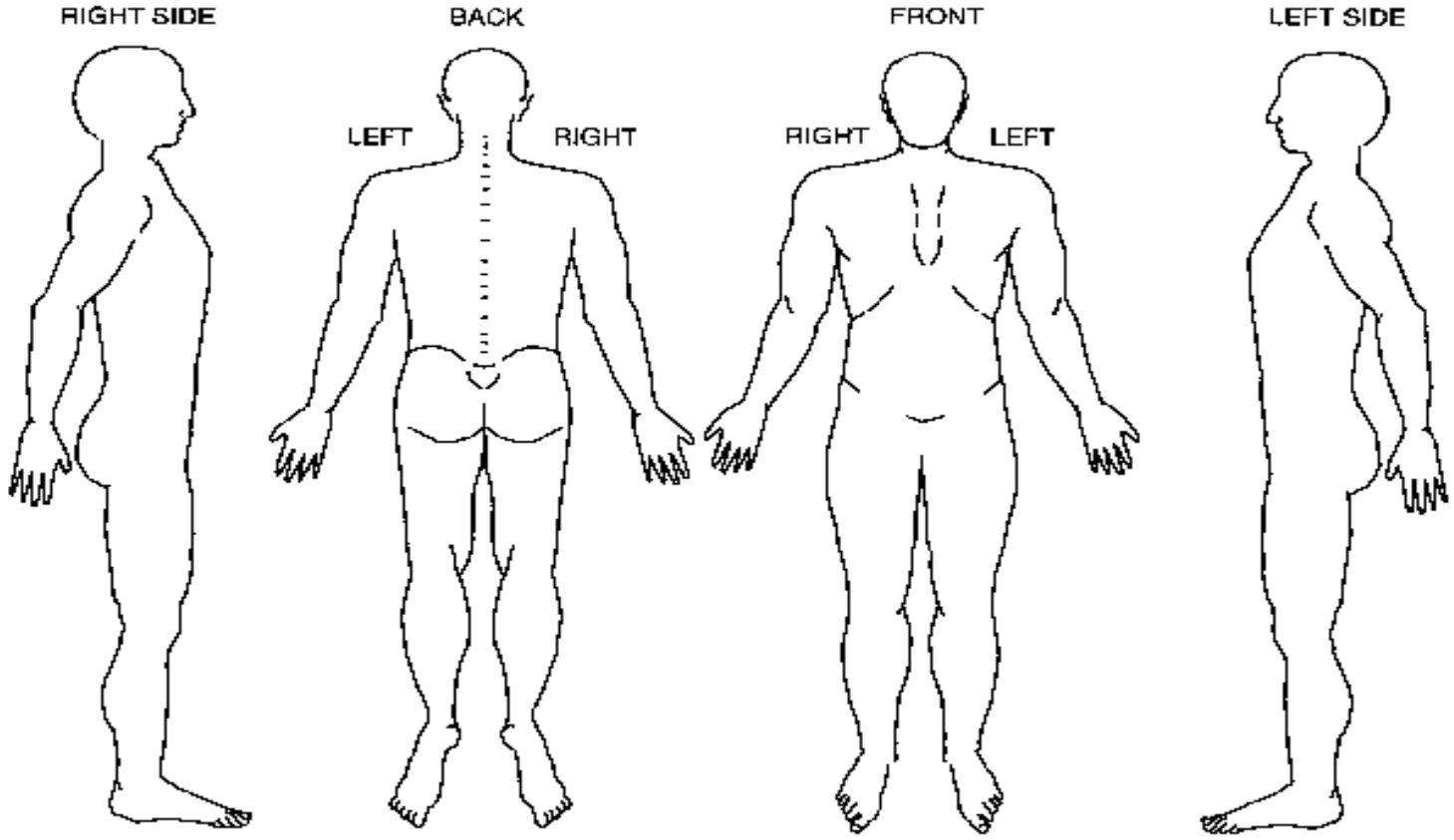
Pain Management: _____Yes _____ No
Radio Frequency Ablation: ____Yes ____ No Epidurals ____Yes ____ No Other:_____

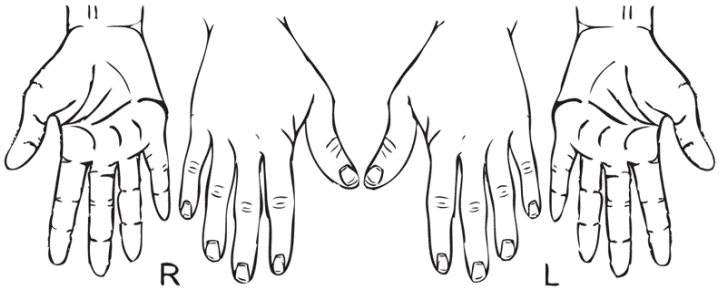
PATIENT MEDICAL REGISTRATION

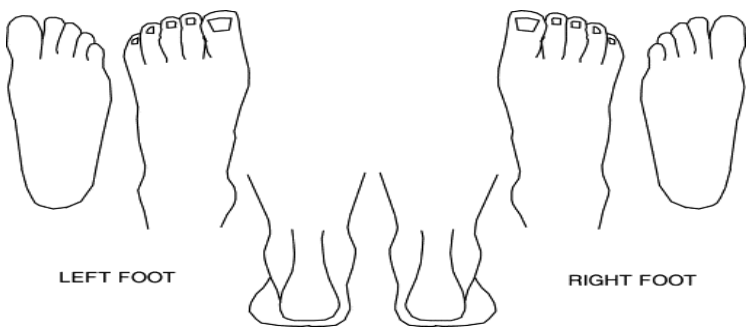
Patient Name: «PatientFullName» DOB: «PatientDOB» Patient #: «PatientNumber»

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» DOB: «PatientDOB» Patient #: «PatientNumber»
Date of Visit: «ApptDate»

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

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		
Date	Surgery Type/ Side	Physician

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName» DOB: «PatientDOB» Patient #: «PatientNumber»
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

_____ **«ApptDate»**

Patient Signature / If minor, Guardian Signature **Date**

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName» DOB: «PatientDOB» Patient #: «PatientNumber»
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

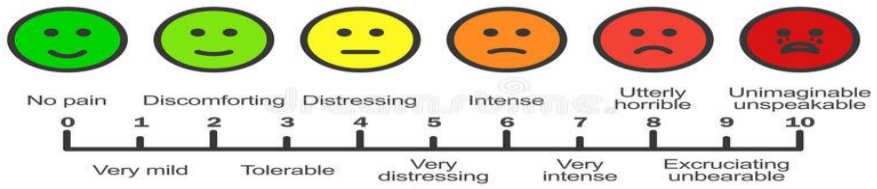
REVIEW OF SYSTEMS

Please check here if no symptoms today: _____
Circle if you have any of the following today:

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

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 

@floridajointandspineinstitute

6325 US Hwy 27 North · Suite 201 · Sebring, FL 33870 · Ph 863-385-2222 · Fax 863-382-8765
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
www.floridajointspine.com