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

Medication History

Please list all current medications including alternative and non-prescription medications. Make a new entry anytime a medication's dosage or frequency changes. If a medication is listed and has been discontinued, entered in the date the medication was discontinued in the "end date" section. If you start a new medication, create a new entry.

Patient Name: «PatientFullName» **DOB: «PatientDOB»**

Start Date	Medication Name	Dose	Frequency	Prescribing Practitioner	Reason for Medication	End Date

PATIENT MEDICAL REGISTRATION

Patient Name: «PatientFullName» **DOB:** «PatientDOB»

Social Security Number:_____ **Date of Visit: «ApptDate»**

Physician: «ApptProviderName» **Patient Number:** «PatientNumber»

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 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.

_____
Patient Signature

Date_____

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).
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.

_____ _____
Printed Name Social Security Number

_____ _____
Patient/Authorized Representative Signature Relationship to Patient

_____
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: 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.

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 $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»

Right-handed Left handed

Daytime Phone_____Night Phone: _____

Name of Primary Care Physician:_____Name of referring Physician _____

Phone #: _____Fax #: _____

List other physicians that your records should be sent to:

Doctor:_____Doctor:_____

Phone #:_____Phone #: _____

Fax #:_____Fax #: _____

CAUSES OF YOUR PAIN: PLEASE ANSWER ALL QUESTIONS

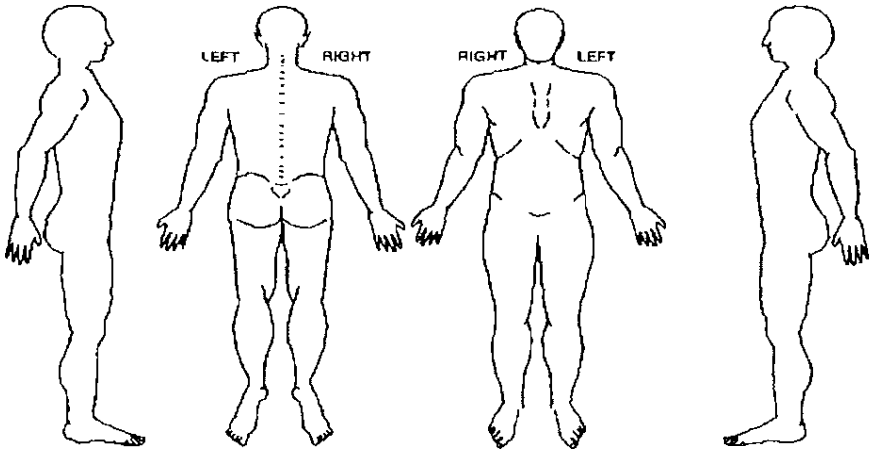
Event(s) surrounding the onset of your pain	Date Pain Began	Pain intensity today
_____	_____	Better Same Worse
_____	_____	Better Name Worse
_____	_____	Better Same Worse
_____	_____	Better Same Worse

I believe my pain is due to (write description online provided):

- The effects of treatment (medication, surgery, radiation, etc.) _____
- My primary disease (meaning the disease currently being treated): _____
- A medical condition unrelated to my primary disease: _____
- Pain is related to a Motor Vehicle or work accident: _____

PAIN DESCRIPTION

On the Diagram, shade in the areas where you feel pain. Put on X on the area that hurts the most.



PATIENT MEDICAL REGISTRATION

PAIN DESCRIPTION continued

Check all the things that make your pain **worse:**

☐ Sitting ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Walking ☐ Exercise

☐ Lifting ☐ Bending ☐ Other

Check all the things that make your pain **better:**

☐ Sitting ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Walking Exercis☐

☐ Lifting ☐ Bending ☐ Other

Please rate your pain by circling the one number that best describes your pain at its **worst in the last week.**

0 1 2 3 4 5 6 7 8 9 10

No pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain at its **best in the last week:**

0 1 2 3 4 5 6 7 8 9 10

No pain as bad as you can imagine

Please rate your pain by circling the one number that best describes your pain **right now:**

0 1 2 3 4 5 6 7 8 9 10

as bad as you can imagine

No pain

For the following, check Yes or No if that word applies to your pain: **(Please add location of pain next to each symptom)**

Aching	☐ YES	☐ NO	_____	Burning	☐ YES	☐ NO	_____
Throbbing	☐ YES	☐ NO	_____	Exhausting	☐ YES	☐ NO	_____
Shooting	☐ YES	☐ NO	_____	Tiring	☐ YES	☐ NO	_____
Stabbing	☐ YES	☐ NO	_____	Nagging	☐ YES	☐ NO	_____
Gnawing	☐ YES	☐ NO	_____	Numb	☐ YES	☐ NO	_____
Sharp	☐ YES	☐ NO	_____	Miserable	☐ YES	☐ NO	_____
Tender	☐ YES	☐ NO	_____	Unbearable	☐ YES	☐ NO	_____

Circle the one number that describes how, during the past week, pain has interfered with your:

General Activity:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

Mood:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

PATIENT MEDICAL REGISTRATION

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

PAIN DESCRIPTION continued

Concentration and thinking:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Normal Work: (includes both work outside the home and housework)
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Relationships with other people:

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Sleep:
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely Interferes

Enjoyment of life: 0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

PAIN TREATMENT(S)

How many physicians have been involved in the treatment *of your* pain?
☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6- 10 ☐ 11-15 ☐ 16 or more
If you have treated with another physician, please let us know who and when.

_____

_____

How many emergencies room visits have you had in the past year for pain?
☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-10 ☐ 11-15 ☐ 16 or more If so, where?

_____

_____

Check all other methods you use to relieve your pain:
☐ Warm Compresses ☐ Cold Compresses ☐ Relaxation Techniques ☐ Distraction ☐ Medication
☐ Rest ☐ Other _____

PAIN TREATMENT(S) continued

PATIENT MEDICAL REGISTRATION

Check the nerve blocks, injections or procedures that have been performed. II you've had a procedure, but you don't remember what it was called, please choose "other".

	How Many	Dates Performed
☐ Cervical (neck) epidural steroid injection	_____	_____
☐ Lumbar epidural steroid injection	_____	_____
☐ Caudal epidural steroid injection	_____	_____
☐ Lumbar Facet joint block	_____	_____
☐ Cervical Facet joint block	_____	_____
☐ Stellate ganglion block	_____	_____
☐ Lumbar sympathetic block	_____	_____
☐ Trigger point injection	_____	_____
☐ Discogram	_____	_____
☐ Occipital nerve block	_____	_____
☐ Spinal cord stimulator	_____	_____
☐ Intrathecal lump	_____	_____
☐ Other _____	_____	_____

Are you currently in Physical therapy? NO YES If yes are you getting relief? NO YES
If so where and how long?

_____

PAIN MEDICATION

Do you have some form of pain now that requires medication every day? NO YES
Did you take any pain medication in the last 7 days? NO YES
Do you feel you need to take more of the pain medication than your doctor has prescribed? NO YES
Check the box that pertains to you:
How do you prefer to take pain medication?
☐ On a regular basis ☐ Only when necessary ☐Do not take pain medications

How do you take pain medication over a 24-hour period?
☐ Not every day ☐ 1- 2 times a day ☐3-4 times a day ☐ 5-6 times a day ☐More than 6 times per day

How long have you been on opioid pain medications?
☐ 0-1 year ☐ 1-2 years ☐ 3-4 years ☐ 5-6 years ☐ 6-7 years ☐ 8-9 years ☐ 10 + years

What @» relief do your opioid pain medications provide?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No relief Complete relief

Are your medications kept in a safe place? NO YES Where?_____ Do you feel you need to receive further information about your pain medications?No YES

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

Date of Visit: «ApptDate»

PATIENT MEDICAL REGISTRATION

PAIN MEDICATIONS CONTINUED

Past Pain Medications continued: Have you ever taken the following pain-related medications in the PAST? Do not list current medications on this page.

	YES	NO	Why did you stop?		
Kadian	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Lidoderm Patch or cream	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Lyrica	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Methadone	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Mobic (Meloxicam)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
MS Contin (Morphin)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Neurontin (Gabapentin)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Nucynta (Tapentadol)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Opana (Oxymorphone)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Percocer (Oxycodone)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Oxaydo	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Oxycontin	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Robaxin	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Skelaxin	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Soma	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Suboxone	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Toradol	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Ultram (Tramadol)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Voltaren Gel	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Zanaf Sex (Tizanidine)	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working
Xtampza	☐	☐	☐ Side Effect(s)_____	☐ Didn't Work	☐ Stopped working

Have you ever had an allergy or serious reaction to any food or medications including shellfish, Latex, or IVP Dy☐Yes ☐ No. If yes, please describe:

_____

_____

_____

HOSPITALIZATION AND SURGICAL HISTORY

Please list with dates all surgeries or procedures you have had under anesthesia (including tooth extractionsand tonsillectomy) as well as any problems with each:

_____

_____

_____

Have you ever been hospitalized? ☐Yes ☐ No If yes, explain

_____

_____

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: _____

REVIEW OF SYSTEMS

SELF			FAMILY MEMBER		
		When			Who
Heart Attack	Yes No		Heart Attack	Yes No	
High Blood Pressure	Yes No		High Blood Pressure	Yes No	
Stroke	Yes No		Stroke	Yes No	
Asthma	Yes No		Asthma	Yes No	
Diabetes	Yes No		Diabetes	Yes No	
Epilepsy or seizure	Yes No		Epilepsy or seizure	Yes No	
Cancer	Yes No		Cancer	Yes No	
Chest Pain at rest	Yes No		FEMALE PATIENT ONLY:		
Heart murmur	Yes No				
Anemia	Yes No		Do you think you are pregnant? Yes No		
Bleeding Time	Yes No				
Difficulty in Breathing	Yes No		Do you use contraceptives? Yes No		
Shortness of Breath	Yes No				
Abnormal Chest X-ray	Yes No		If Yes, What type? _____		
Jaundice or Hepatitis	Yes No				
Ulcer	Yes No				
Glaucoma	Yes No		Date of your last menstrual cycle: _____		
Urine Retention	Yes No				
Fianting	Yes No				

Patient Signature: _____ Date: _____

PATIENT MEDICAL REGISTRATION

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

PAST MEDICAL HISTORY

High blood pressure?	Yes	No	
Heart disease?	Yes	No	
Heart attack?	Yes	No	
CHF?	Yes	No	
Stroke?	Yes	No	
Chest Pain?	Yes	No	
High Cholesterol?	Yes	No	
Arrhythmia?	Yes	No	
Smoker?	Yes	No	
Asthma?	Yes	No	
COPD?	Yes	No	
Emphysema?	Yes	No	
Liver disease?	Yes	No	
Kidney disease?	Yes	No	
Ulcers?	Yes	No	
GERD?	Yes	No	
PUP?	Yes	No	
Diabetes?	Yes	No	If yes, what type? _____
Cancer?	Yes	No	If yes, what type? _____
Thyroid disease 2	Yes	No	
Anxiety?	Yes	No	
Depression?	Yes	No	
Osteoarthritis?	Yes	No	
Rheumatoid arthritis?	Yes	No	
Bleeding disorders?	Yes	No	

Any other past or current medical history not noted above?

PATIENT MEDICAL REGISTRATION

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

SOCIAL HISTORY

What is your involvement in social activities?

0 1 2 3 4 5 6 7 8 9 10

No involvement actively involved

Is this a change since the onset of your pain? NO YES

Do you currently smoke? NO YES If Yes: Packs per day_____ for how many years: _____

Where you a smoker in the past? NO YES If Yes: for how many years?_____Year you quit: _____

0r you use Alcohol? NO YES. If yes, on average, how many drinks do you have per week?

a) 3 or less b) 4-7 c) 8-12 d) 13 or moreWas there ever a time in your life when you may have had an alcohol problem? NO YES

Did you ever, or do you now, use street drugs including Marijuana? NO YES

If yes, list _____

Have you ever been addicted to prescription drugs? NO YES

Does anybody in your family have a history of drug misuse/addiction? YES NO

Have you ever been in a treatment program for alcohol or drug abuse? YES NO

If YES explain: _____

What is your present marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Do you have children? NO YES If yes, how many?_____Boys_____ Girls _____

What are the ages of your children? _____

Check the highest level of education completed.

☐Grade school ☐ High school ☐ GED ☐ some college ☐ College graduate ☐ Trade school ☐ Bachelors ☐ Masters

Are you currently employed? NO YES

WORK

If yes: What do you do: _____ How many hours per day? _____

If no: How long have you been out of work? _____ What was your occupation? _____

How do you spend your day? _____

Is unemployment due to your pain? NO YES

Have you ever been in the military? NO YES

Are you able to do household chores? NO YES

List your

Hobbies:_____

_____

_____

_____

PATIENT MEDICAL REGISTRATION

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

- Are you currently taking any blood thinning medications such as Aspirin, Coumadin, Plavix, Vitamin E, etc.?

☐ Yes ☐ NO

If you answered yes, please tell us which *blood* thinning medications you are currently taking:

_____
_____

If you answered yes, what doctor is managing your blood thinners?

_____

- Do you have a Pacemaker*?

☐ Yes
☐ No

- Do you have a Defibrillator?

☐ Yes
☐ No

- Would you like to discontinue using opioids?

☐ Yes
☐ No

Patient Signature: _____

PATIENT MEDICAL REGISTRATION

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

Pharmacy Information

Patient Name: _____

Patient's Email: _____

Pharmacy Name: **Preferred Pharmacy:«PatPharmacyName»**

Pharmacy Address: _____

Pharmacy City: _____

Pharmacy State and Zip Code: _____

Pharmacy Phone Number: **Pharmacy Phone: «PatPharmacyPhone»**

Pharmacy Fax: _____

Prescription History Consent

I give my consent to have Florida Joint and Spine Institute to obtain my prescription history from external sources.

Date: _____

Patient or Authorized Person's Signature _____

PATIENT MEDICAL REGISTRATION

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

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates *low* risk for future opioid abuse, a score of 4 to 7 indicates a moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

INSTRUCTIONS: Mark each box that applies, in the column that corresponds with your gender.

	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disorder		
ADD, OCD,bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals:		

Name:_____Date: _____

Questionnaire developed by Lynn R Webster, MD to asses risk of opioid addiction

Webster LR, Webster R Predicting aberrant behaviors in Opioid-treated patients preliminary validation of the Opioid risk too'. Pain Med 2005; 6 (6): 4 32

PATIENT MEDICAL REGISTRATION

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

Date of Visit: «ApptDate»

OSWESTRY PAIN DISABILITY QUESTIONAIRE

This questionnaire has been designed to give your Physician information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

SECTION 1 — PAIN INTE NSITY

- I can tolerate the pain that I have without the use of medication.
- The pain is bad but I can manage without taking pain medication.
- Pain medication gives me complete relief from pain. Pain medication gives me moderate relief from pain. Pain medication gives me very little relief from pain
- Pain medication has no effect on the pain and I don't use it

SECTION 2 — PERSONAL CARE (Dressing)

- I can take care of myself normally without an increase in pain
- I can look after myself normally but it increases in pain
- It is painful to take care of myself, requiring me to be slow and careful
- I need some help but manage most of my personal care. I need help every day in most aspects of self-care
- I do not get dressed. I wash myself with difficulty and stay in bed

SECTION 3 - LIFTING

- I can lift heavy weights without increasing my pain. I can lift heavy weights but it does increase pain
- Pain prevents me from lifting heavy weights off the floor, manage able if conveniently Coca ted.
- Pain prevents me from lifting heavy objects off the floor, but I can manage light to medium weights.
- I can lift only very light weights
- I cannot lift or carry anything at all

SECTION 4 — WALKING

- Pain does not prevent me from walking any distance. Pain prevents me from walking more than one mile. Pain prevents me from walking more than 1/2 a mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches
- I am in bed most of the time.

SECTION 5 — SITTING

- I can sit on any chair as long as I want
- I can only sit in my favorite chair as long as I like Pain prevents me sit ting more than one hour.
- Pain prevents me from sitting more than30 minutes. Pain prevents me from sit ting more than 10 minutes. Pain prevents me from sit tang at all

SECTION 6• STANDING

- I can stand as long as I like without increasing my pain I can stand as long as I like but it i increases my pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 - SLEEPING

- Pain does not prevent me from sleeping well. I can sleep well only using medication.
- Even with medication, I have |less than 6 hours of sleep.
- Even with medication, I have less than 4 hours of sleep.
- Even with medication, I have less than 2 hours of sleep.
- Pain prevents me from sleeping at all

SECTION 8 - SEX LIFE

- My sex life is normal and causes no increases in my pain.
- My sex life is normal but causes some increase in my pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by my pain.
- My sex life is nearly absent because of my pain.
- Pain prevents any sex life at all.

SECTION 9 – SOCIAL LIFE

- My social life is norm al and does not increase my pain
- My social life is normal but increases my pain.
- My pain has no effect on my social life apart from limiting my more energetic interests, such as dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home. I have no social life because e of my pain

SECTION 10 - T RAVELING

- I can travel anywhere without t increasing my pain.
- I can travel anywhere but it increases my pain.
- My pain is bad but I manage trips over two hours.
- My pain restricts me to journeys of less than one hour.
- My pain restricts me to short, necessary trips under 30 minutes.
- My pain prevents me traveling except to my medical appointments or to the hospital **/Printed Name:_____**

PATIENT MEDICAL REGISTRATION

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

Medical Outcomes Study Questionnaire SF-36

This survey asks you for your views about your health. This information will help keep track of how you feel and how well you're able to do your usual activities. Thank you for completing thissurvey! For each of the following questions, please circle the number that best describes your answer.

1. In general, would you say your health is:

Excellent	1
Very good	2
Good	3
Fair	4
Poor	S

2. Compared to one year ago, would you say your health is:

Much better than one year ago	1
Somewhat better than one year ago	2
About the same	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

3. The following items are about activities you might do during a typical day. Does your healthnow limit you in these activities? If so, how much? (Circle one number on each line).

	Yes, limited a lot (1)	Yes, limited a little (2)	No, not limited at all (3)
Vigorous activities such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, orplaying golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing **several** flights of stairs	1	2	3
Climbing **one** flight of stairs	1	2	3
Bending, kneeling, or stooping	1	2	3
Walking **more than a mile**	1	2	3
Walking **several blocks**	1	2	3
Walking **one block**	1	2	3
Bathing or dressing yourself	1	2	3

PATIENT MEDICAL REGISTRATION

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

4. During the past 4 weeks, have you had any of the following problems with your work orother regular daily activities as a result of **your physical health? (Circle one number on each line).**

	Yes (1)	No (2)
Cut down the amount of time you spend on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the **kind** of work or other activities	1	2
Had **difficulty** performing the work or other activities (for example, ittook extra effort)	1	2

5. In the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed oranxious)? **(Circle one number on each line).**

	Yes (1)	No (2)
Cut down the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't do work or other activities as **carefully** as usual	1	2

6. **During the past 4 weeks,** to what extent has your physical health or emotional problemsinterfered with your normal social activities with family, friends, neighbors or groups?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7. How much bodily pain have you had during the **past 4 weeks?**

None	1
Very mild	2
Mild	3
Moderate	4
Severe	S
Very Severe	6

PATIENT MEDICAL REGISTRATION

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

8. **During the past 4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

These questions are about how you feel and how things have been with you **during the last 4 weeks.** For each question, please give one answer that comes closest to the way you've been feeling. **(Circle one number on each line).**

9. How much of the time during the **past 4 weeks...**

	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel Full of pep?	1	2	3	4	5	6
Have you Been a very nervous person?	1	2	3	4	5	6
Have you felt So down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt Calm and peaceful?	1	2	3	4	5	6
Did you have A lot of energy?	1	2	3	4	5	6

	All of the time	Most ofthe time	A good bitof the time	Some ofthe time	A little ofthe time	None ofthe time
Have you felt Downhearted and blue?	1	2	3	4	5	6
Did you feel Worn out?	1	2	3	4	5	6
Have you Been a happy person?	1	2	3	4	5	6
Did you feel Tired?	1	2	3	4	5	6

10. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?**(Circle one number).**

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

11. How **TRUE** or **FALSE** is each of the following statements for you? **(Circle one number oneach line).**

	Definitely True	Mostly true	Don't know	Mostly False	Definitely false
I seem to get sick a little easier than other people.	1	2	3	4	5
Iam as healthy as anybody I know	1	2	3	4	5
I expected my health to get worse	1	2	3	4	5
My health is excellent	1	2	3	4	5

Patient Name:_____Date: _____

PATIENT MEDICAL REGISTRATION

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

Have you scheduled or Have had a COVID Vaccine? YES NO If yes, When was 1st Dose: _____ 2nd Dose: _____
Vaccine Scheduled For: _____
Do you think you are pregnant? Yes No

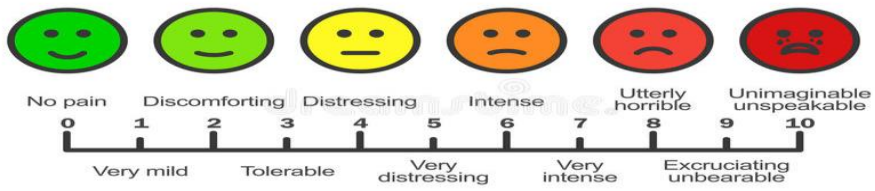
REVIEW OF SYSTEMS

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

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

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

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