SPINEPAIN
& ORTHOPEDIC
INJURY CENTER
RESTORING FUNCTION

Patient Demographics

Please complete the information below.

Patient Information

Patient Name: _____
Patient Address: _____
Home Phone: _____ **Cell Phone:** _____
Social Security Number: _____
Email: _____

Guarantor Information

Responsible Party: _____
Guarantor Address: _____
_____
Guarantor Phone: _____

Primary Insurance

Carrier: _____
ID #: _____ **Group:** _____
Subscriber: _____ **Subscriber's DOB:** _____

Secondary Insurance

Carrier: _____
ID #: _____ **Group:** _____
Subscriber: _____ **Subscriber's DOB:** _____

Employer Information

Employer: _____
Employer Address: _____
Employer Phone: _____

Emergency Contact Information

Primary Contact: _____
Home Phone: _____ **Cell Phone:** _____

I certify that the above information is correct.

Signature: _____ **Date:** _____

28050 US Highway 19 N, Ste. 100, Clearwater FL 33761
Phone (727) 210-2225 Fax: (727) 210-0880

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Patient name: _____ **Date:** _____
Primary Care Physician: _____ **Referring Physician:** _____
Pharmacy Name and Location: _____
DOB _____ **Age** _____ **Sex** _____ **Weight** _____ **Height** _____ ☐ **Right-handed** ☐ **Left-handed**
Marital Status ☐**Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Briefly state the **reason for your visit** and the **body part(s) affected** (i.e. arm, leg, neck, back, knee, hip, etc.)?

_____
_____
_____
_____

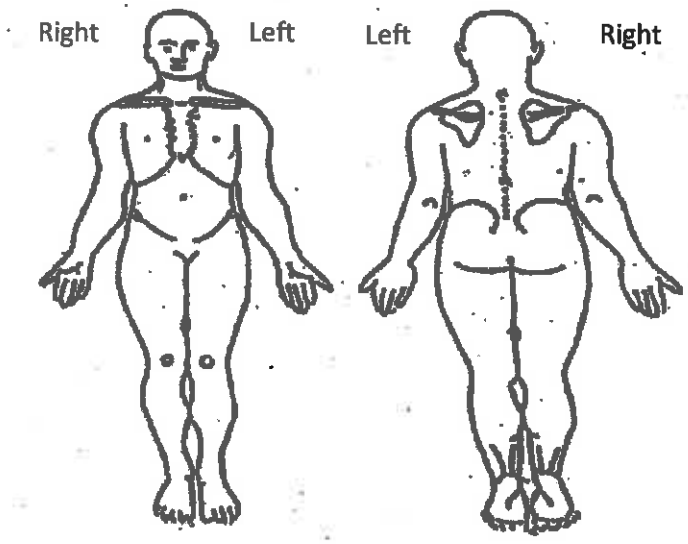
Is the **reason for today's visit** related to?

☐ Car or Bike Accident Date: _____
☐ Slip or Fall Accident Date: _____
☐ Job Injury Date: _____

How would you **describe the pain?**

Type of Pain	Location	Type of Pain	Location
Burning		Pressure	
Cramping		Sharp	
Dull, aching		Shooting	
Numbness		Stabbing	
Pins, needles		Throbbing	
Other, please specify:			

Please mark an **(X)** where you are currently having pain.



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If you have NECK pain, what percentage is in your neck _____% and into your arm _____%?
If you have BACK pain, what percentage is in your back _____% and into your leg _____%?

How long has your CURRENT problem existed? _____
Have you experienced this problem before? ☐ Yes ☐ No
If yes, when did it occur and how long did it last? _____
Do you need assistance walking? ☐ Yes ☐ No
If yes, what type of support (i.e. walker, cane, other)? _____
Do you wear a back or neck brace? ☐ Yes ☐ No
If yes, what type? _____
Have you fallen in the past one year? ☐ Yes ☐ No
If yes, how many falls and were you injured in any of the falls? _____
Do you feel unsteady when walking? ☐ Yes ☐ No
Do you worry about falling? ☐ Yes ☐ No

Circle the **current level of pain** that you are experiencing.

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

What makes the pain **WORSE**? (check all that apply)

☐ Walking
☐ Standing > 15 minutes
☐ Sitting
☐ Riding in a car
☐ Lying on stomach
☐ Lying on back
☐ Lifting
☐ Coughing
☐ Moving from sitting to standing
☐ Cold/damp weather
☐ Bowel movement
☐ Twisting

What makes the pain **BETTER** or EASES the pain? (check all that apply)

☐ Sitting
☐ Standing
☐ Adjustments
☐ Medications, specify: _____
☐ Lying down
☐ Massage
☐ Stretching
☐ Heat
☐ Ice
☐ Avoiding strenuous activities

What **previous conservative measures** have been taken? (check all that apply)

☐ Activity modification
☐ Yoga/relaxation
☐ Cortisone injections
☐ Physical therapy
☐ Other, specify: _____
☐ Acupuncture
☐ Bracing
☐ Home exercise program
☐ Surgical intervention
☐ Aquatic/Pool therapy
☐ Chiropractic treatment
☐ Massage
☐ TENS therapy

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Please check the items that you are **currently experiencing**.

√	Signs & Symptoms	√	Signs & Symptoms
	Night sweats		Diarrhea
	Fever or chills		Incontinence of bladder
	Unplanned weight loss		Incontinence of bowel
	Unplanned weight gain		Urination frequency, urgency
	Easy bruising		Back pain
	Easy bleeding		Neck pain
	Rashes		Joint pain (knee, elbow, hip, shoulder, etc.)
	Low platelet count		Muscle spasm
	Changes in vision, taste, hearing, smell		Loss of consciousness or blackouts
	Difficulty breathing		Memory loss
	Shortness of breath		Muscle weakness
	Wheezing		Seizures
	History of Tuberculosis		Trouble walking
	Palpitations (awareness of fast heart)		Dizziness
	Chest pain		Headaches
	Abdominal pain		Difficulty falling or remaining asleep
	Nausea		Difficulty concentrating
	Vomiting		Other, please specify

What **treatments** have been completed and how many times was it administered?

√	Treatment	Helpful	# of Treatments	Dates of treatments
	Epidural steroid injection	Yes/No		
	Facet injection	Yes/No		
	Sacroiliac injection	Yes/No		
	Hip injection	Yes/No		
	Radiofrequency ablation	Yes/No		
	Nucleoplasty	Yes/No		
	Vertebroplasty	Yes/No		
	Trigger point injection	Yes/No		
	Nerve blocks	Yes/No		

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Past Medical History

- ☐ Serious infection
- ☐ High Blood Pressure
- ☐ Bleeding Disorder
- ☐ Bowel Disorder
- ☐ Multiple Myeloma
- ☐ Stroke
- ☐ Lupus
- ☐ COPD
- ☐ Asthma
- ☐ Parkinson Disease
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ HIV/AIDS
- ☐ Drug/Alcohol Addiction
- ☐ Misuse of prescription drugs
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Attention Deficit Disorder
- ☐ Diabetes
- ☐ Thyroid
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Pulmonary Embolism (PE)
- ☐ Pacemaker, defibrillator, stents
- ☐ Blood thinners (i.e. Plavix, Coumadin)
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Cancer, specify: _____
- ☐ Heart Disease, specify: _____
- ☐ Hepatitis, specify: _____
- ☐ Immunocompromised, specify: _____
- ☐ Psychiatric problems, specify: _____
- ☐ Ulcers, specify if ***bleeding***: _____

List any related imaging

Test	Date of Test	Test	Date of Test
X-ray		Myelogram	
CT scan		Dexa Scan	
MRI		Discogram	
Nuclear Bone Scan		Arthrogram	
EMG/NCS (Nerve study)		Other, specify:	

List all **MEDICATIONS**

Medication Name	Dose (milligrams, grams)	How often/How many times per day	How Long

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Drug Allergies

Drug	Type of Reaction

List all surgeries

Type	Date	Outcome

List all previous physicians for this problem (primary care, chiropractor, surgeons, etc.)

Name	Specialty	Treatment/Testing

Family History

Relation	Age	Alive	Deceased	Medical History or Cause of Death
Father				
Mother				
Sibling 1				
Sibling 2				

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Work Status and Education

Highest Level of Education _____
Occupation _____
Current work status:

☐ Full Duty ☐ Light Duty ☐ Off Duty per Physician
☐ Unemployed ☐ Retired

If you are not on full-duty work status:

How long have you been off work? _____
Have you had a work capacity assessment? ☐ Yes ☐ No
Are you disabled through Social Security? ☐ Yes ☐ No

Drug, Alcohol and Tobacco Use

Have you ever been treated for drug or alcohol addiction? ☐ Yes ☐ No
If yes, provide specific treatment information (i.e. substance abused, treatment dates).
_____
Do you currently consume alcoholic beverages? ☐ Yes ☐ No
If yes, indicate quantity per day:
Beer _____ Wine _____ Liquor _____
Have you ever used tobacco products? ☐ Yes ☐ No
If yes, indicate start date _____, and stop date, if applicable _____
Do you currently use tobacco products? ☐ Yes ☐ No
If yes, indicate quantity per day:
Cigarettes _____ Cigars _____ Chewing Tobacco _____

What **medication** have you ever taken and were they helpful?

Medication	Helpful	Medication	Helpful	Medication	Helpful
Tylenol	Yes/No	Hydrocodone/Vicodin	Yes/No	Zanaflex	Yes/No
Advil	Yes/No	Percocet/Oxycodone	Yes/No	Morphine	Yes/No
Ibuprofen	Yes/No	Oxycontin	Yes/No	Methadone	Yes/No
Celebrex	Yes/No	Duragesic	Yes/No	Cymbalta	Yes/No
Mobic	Yes/No	Dilaudid	Yes/No	Lyrica	Yes/No
Naproxen	Yes/No	Tylenol #3	Yes/No	Neurontin	Yes/No
Skelaxin	Yes/No	Soma	Yes/No	Topamax	Yes/No
Flexeril	Yes/No	Baclofen	Yes/No	Trazadone	Yes/No

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Lee Ann Brown, D.O

Family Physician Information

Please list all names and addresses of you family physician and or referring physician so we may keep them informed of your progress while you are under our care.

FAMILY PHYSICIAN:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

REFERRING PHYSICIAN:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

_____ _____

Patient Signature Date

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Lee Ann Brown, D.O

Authorization for Release of Medical Information
(Please Print)

Patient Name:_____ Today's Date:_____

Social Security Number:_____ Date of Birth:_____

- I hereby authorize SpinePain & Orthopedic Injury Center to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution/facility to which I may be referred to assist with my care.
- Additionally, I authorize SpinePain & Orthopedic Injury Center to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution/facility to assist in my care.

Signature of Patient, Guardian, or Personal Representative:

_____

Date:_____

Thank you for choosing SpinePain & Orthopedic Injury Center to provide your medical care.

Phone (727) 210-2225 Fax (727) 210-0880

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Lee Ann Brown, D.O

Disclosure Document

I, _____, hereby authorize SpinePain & Orthopedic Injury Center to use or disclose the following protected information: (specifically describe the information to be used or disclosed, including, but not limited to, meaningful description such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

_____
_____
_____
_____
_____

The protected health information may be disclosed: (insert name of person or entity that may have or receive the information)

_____
_____
_____

This protected health information is being used or disclosed for the following purposes: (List specific purposes here. The patient may indicate that the information to be released is "at the patient's request" if the patient does not choose to provide an explanation of the purpose of the request)

_____
_____
_____

This authorization shall be in force and effective until: _____

Patient Signature: _____ Date: _____

Patient Name: «PName» Chart Number: «PNumber»

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Lee Ann Brown, D.O

Notice of Privacy Practice

*** This notice describes how your health information may be used and disclosed, and how you can access this information. Please review carefully. ***

At SpinePain & Orthopedic Injury Center, we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act require us to continue to maintain your privacy, to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we will want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your medical records to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copies, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (727) 210-2225.

Patient Signature:_____ Date:_____

Patient Name: Chart Number: «PNumber»

SPINEPAIN
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Lee Ann Brown, D.O

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between SpinePain & Orthopedic Injury Center (SpinePain) and the Patient who is receiving medical Services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services are rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the patient as the Responsible party must:

- Inform SpinePain of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each visit.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.

Returned Check Policy

If a payment is made on an account by check and the check is returned as Non-sufficient funds(NSF), Account closed(AC), or refer to Maker(RTM), the patient or the responsible party will be responsible for the original check amount in addition to a $35.00 Service Charge.

No Show Fee

A 24 hour notification is required for cancellation of all appointments. In the event notification is not received, a $25.00 No Show Fee will be charged for all in office visits and a $50.00 No Show Fee will be charged for surgery center visits.

Non-Payment Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands SpinePain has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or the patient's responsible party understands that they are responsible for all costs of collection.

By signing below, you are to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)_____

Patient's Signature _____

Responsible Party Name (Please Print) _____

Responsible Party Signature _____

Patient Name: «PName» **Chart Number: «PNumber»**