NeuSpine Institute | Minimally Invasive Surgery

2700 Healing Way
Suite 300
Wesley Chapel, FL 33543

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

2445 Country Place Blvd
Suite 102
Trinity, FL 34655

PATIENT INFORMATION

Today's Date: _____

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

How were you referred? ☐ Primary ☐ Specialty ☐ Friend/Family ☐ Advertising ☐ Other (please specify)

Referring Physician (if applicable): _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE
Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____
Address: _____
STREET CITY STATE ZIP CODE
Home Phone: _____ Cell Phone: _____ Work Phone: _____

PROVIDER HISTORY

Primary Care Physician:
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

Cardiologist:
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

Other:
Name: _____ Phone Number: _____

Address: _____
STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

Primary Insurance
Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

Secondary Insurance
Person Responsible: ☐ Self ☐ Other Relationship to Patient: _____
Name: _____ DOB: _____ Social Security #: _____
Insurance Company: _____ ID Number: _____
Insurance Phone: _____ Group #: _____

PHARMACY INFORMATION

Local Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

Mail Order Pharmacy
Name: _____
Address: _____
_____
Phone Number: _____

FINANCIAL AND CONSENT AGREEMENT

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

PATIENT INFORMATION FORM – FINANCIAL AGREEMENT

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

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

MEDICAL INFORMATION

Please circle:

Do you smoke cigarettes? Yes No How many per day? _____
Are you a former smoker? Yes No Last used? _____
Do you drink alcohol? Yes No How often? _____
Do you participate in recreational drug use? Yes No What kind? _____

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name	Reason	Date

MEDICATIONS

Please list all medications you are taking or provide a list
(Include all over the counter medications and medications taken within the last month)

Name	Dosage	Directions	Reason for Medication

If you are not currently taking any medications, please write **N/A.**

Please list all allergies and symptoms if known:

_____

_____

If you do not have any allergies, please write **N/A.**

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

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke or mini-stroke
- ☐ Aneurysm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Abnormal Heart Rhythm
- ☐ Pacemaker or AICD
- ☐ Anemia
- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Cataracts
- ☐ Emphysema or COPD
- ☐ Acid Reflux
- ☐ Ulcerative colitis or Crohn's Disease
- ☐ Kidney failure/problems
- ☐ HIV or AIDs
- ☐ Hepatitis
- ☐ Bleeding or Clotting problems
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Pneumonia

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

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

Patient requested copy: ☐Yes ☐No

_____ _____ _____

Name of Patient *(Please Print* Signature of Patient of Legal Guardian Date

Consent to Release Medical Information to Personal Representative

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

☐ Appointment times ☐ Medical Information ☐ Billing/Demographic Info

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

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____ , _____ _____

Name Relationship Name Relationship

_____ _____

Signature of Patient of Legal Guardian Date

PATIENT AUTHORIZATION & CONSENT

I hereby voluntary consent to medical treatment, including diagnostic producers, surgical and other medical services, provided by NeuSpine Institute LLC or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

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

_____ _____

Signature of Patient of Legal Guardian Date

TO ALL PATIENTS:

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

Cancellation/No Show Policy:

Any cancellation, broken appointments, or no shows in which a 24-hour notice is not provided, after three occurrences, will result in termination from NeuSpine Institute.

Late Arrival Policy:

The clinic has limited waiting time for your appointment. If you are more than 15 minutes late, your appointment will be rescheduled.

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

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

_____ _____ _____

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

NEW PATIENT INFORMATION

Please make sure that a response is written in EVERY SPACE

Name: _____

Previous SPINAL Surgeries:

WHERE:	WHEN:	WHO:
_____	_____	_____
_____	_____	_____
_____	_____	_____

When did it start? _____

Was there an event/injury that caused your pain to start?

_____

_____

What makes your pain worse? _____

_____

What makes your pain feel better? _____

_____

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

Bracing therapy _____ When _____ How long _____ Did it help _____
Physical Therapy _____ When _____ How long _____ Did it help _____
Chiropractor _____ When _____ How long _____ Did it help _____
Acupuncture _____ When _____ How long _____ Did it help _____
Massage Therapy _____ When _____ How long _____ Did it help _____
Pain Management _____ Doctor's name: _____ When _____
How long _____ Did it help _____
What did they do? _____
Injections _____ What part of body _____What kind _____
When_____ How many _____ Did it help_____
Previous evaluated by spinal surgeon?(If so, who?) _____
Other tests/Doctors:

_____

_____

Are you on any blood thinners such as aspirin? _____

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Name: _____ Date: _____

Pharmacy Name: _____Pharmacy Phone: _____

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

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

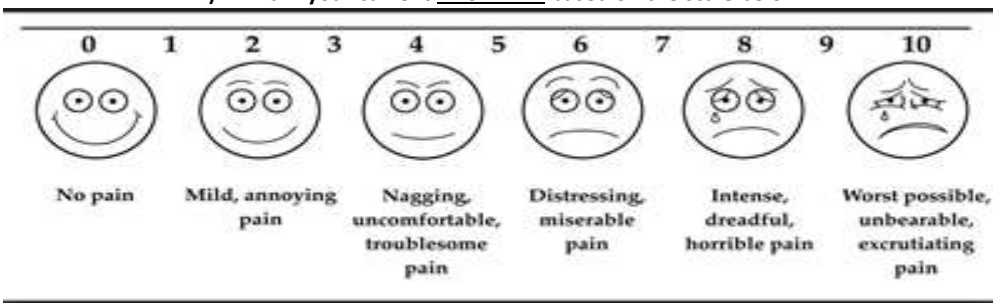
Constitutional:	Fever	Night sweats	Chills	Appetite Change	Fatigue				
Skin:	Swollen glands	Rash	Ulcer	Laceration	Hives	Bruising	Sores	Hair loss	Itching
Ear, Nose, Throat:	Sore throat	Ear Ache	Sinus drainage	Hoarseness	Loss of hearing	Jaw pain	Neck Pain		
Eyes:	Double vision	Other visual changes	Pain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

Name: _____
Date: _____

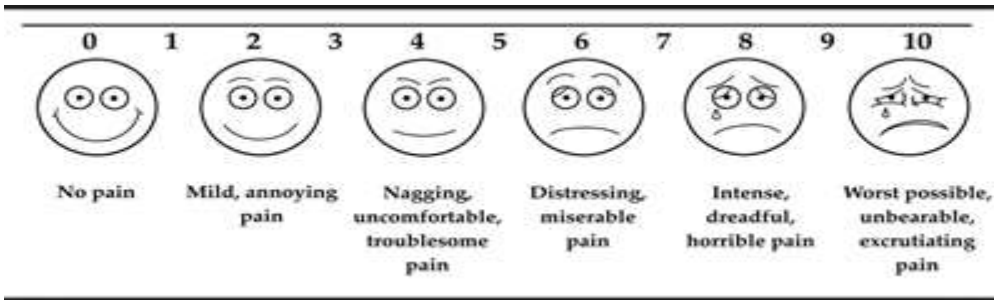
Visual Analogue Scales

Neck Pain

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



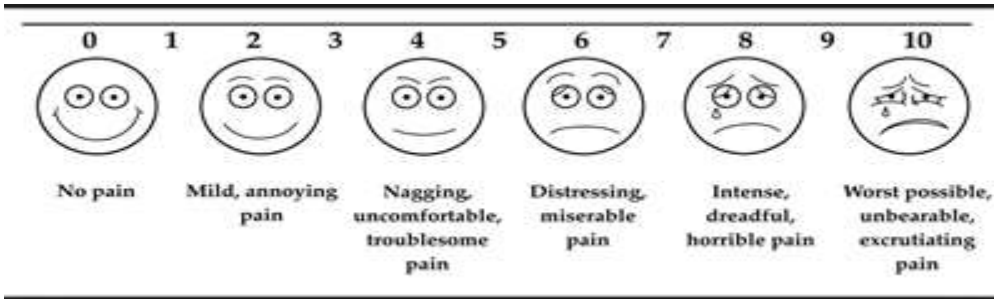
2) Mark your current ARM PAIN based on the scale below



Back Pain

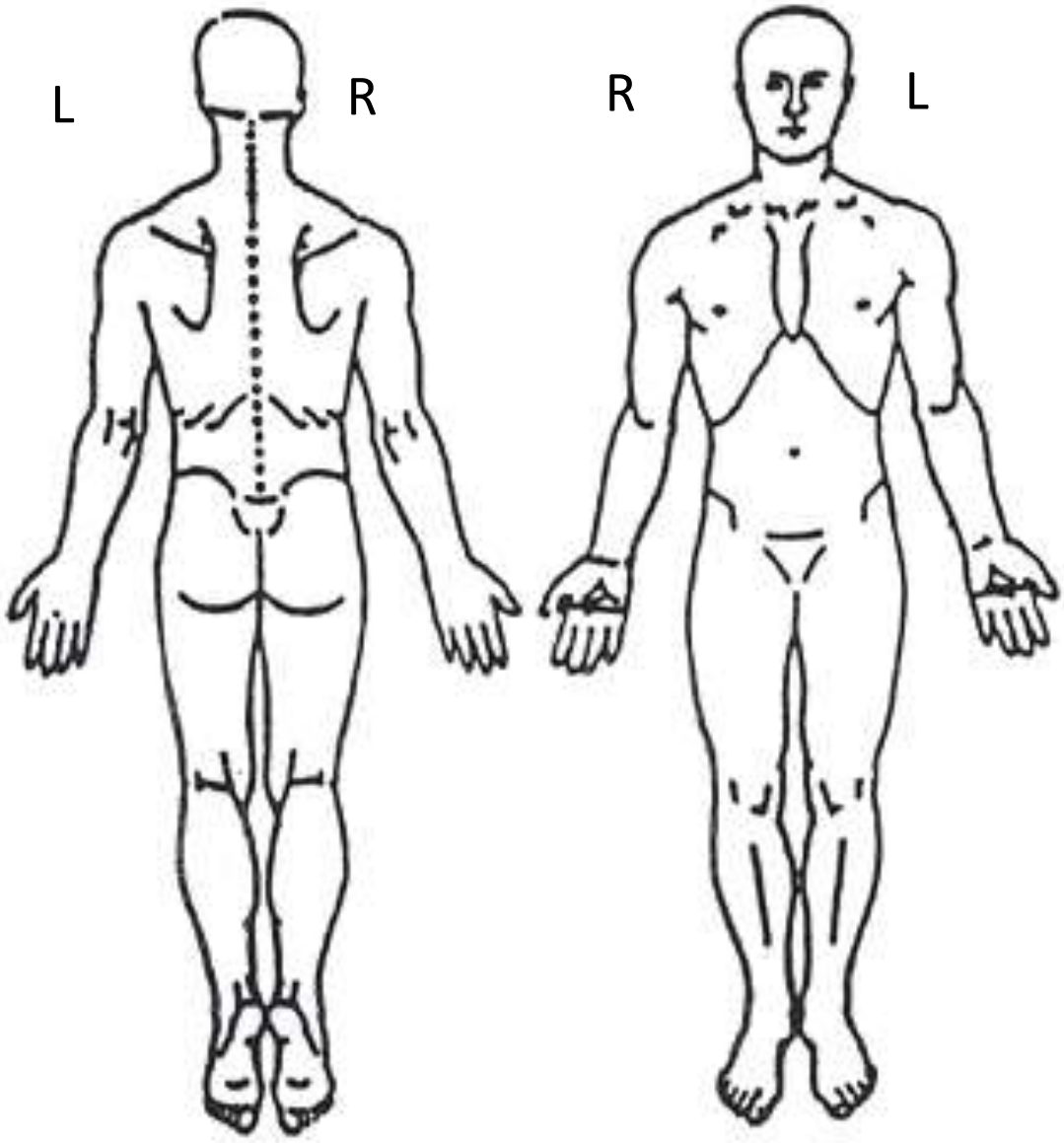
1) Mark your current BACK PAIN based on the scale below

2) Mark your current LEG PAIN based on the scale below



What area is the most bothersome (neck, right am, left arm, back, right leg, left leg): _____

Name: _____
Date: _____



Please color in the area with the following:

Red: Burning
Blue: Numbness
Yellow: Stabbing Pain
Green: Weakness
Brown: Aching