New Patient Information

Pt #____________________

Dr#____________________

Name____ **Date of Birth**______________
Last First Middle Initial

Address____ **SSN**________________

Home Phone_____________________________ **Cell Phone**_______________________________

Referred by_____________________________ **Primary Insurance**_____________________________

Employer______________________ **Address**__________________________ **Phone**________________

Primary Care Doctor __________________________ **Address**__________________________________

Emergency Contact___________________________________ **Relationship**______________________

Your Age________ **You are:** Male Female **Emergency Contact Phone#**_____________________

You are: Right Handed Left Handed **Preferred Pharmacy & location**_________________________

Are you here for a second opinion for treatment? Yes No **Marital Status:** **S** **M** **D** **W**

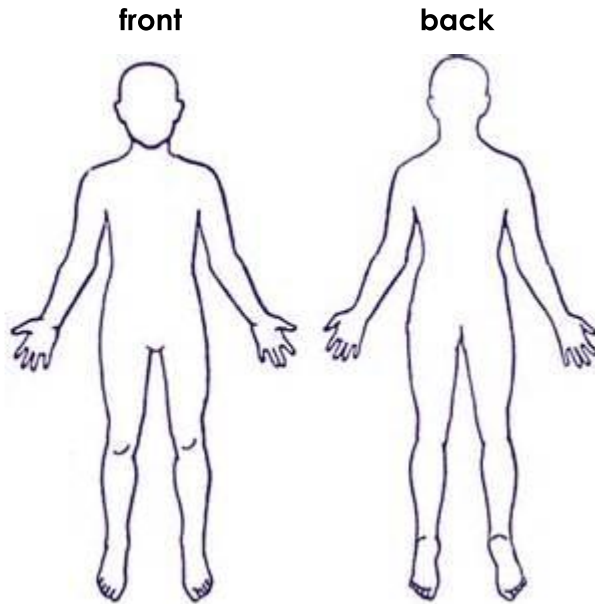
What is your main reason for seeking treatment from us today? ________________________________

____

Height______**ft** _____**in** **Weight**_______**lbs**

Circle on the body where you are experiencing problems:

front **back**



Circle your level of pain NOW:

Back Pain: **Low 0----1----2----3----4----5----6----7----8----9----10 Extreme**

Leg Pain: **Low 0----1----2----3----4----5----6----7----8----9----10 Extreme**

Neck Pain: **Low 0----1----2----3----4----5----6----7----8----9----10 Extreme**

Arm Pain: **Low 0----1----2----3----4----5----6----7----8----9----10 Extreme**

Patient Signature____ **Date**______________________

I attest all information is accurate.

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

New Patient Information

1. When did your current problem begin? ____________________

2. Have you had similar pain in the past? Circle: Yes No If yes, when? ____________________

3. How would you describe the onset of your pain? (circle all that apply)

Suddenly   Lifting   Bending   Twisting   Pulling

Gradually   After a fall   No apparent cause   Date of Accident: ____________________

4. What activities intensify your pain? (circle all that apply)

Lying   Sitting   Exercise(during)   Bending forward   Twisting

Standing   Walking   Exercise(after)   Bending backward   Coughing

5. What reduces your pain? (circle all that apply)

Lying   Sitting   Exercise(during)   Bending forward   Twisting

Standing   Walking   Exercise(after)   Bending backward   Coughing

6. What pain medications and dosages (mg) are you currently taking? (include non-prescription/over-the-counter medicine) **If none, circle: NONE**

____

____

7. What treatments have you tried? (circle all that apply)

Physical Therapy, who? ____________________ Home exercises   Acupuncture   Decompression

Chiropractic, who? ____________________ Protective bracing   Pain Management, who? ____________________

Laser Spine Surgery (LSI in Tampa or Dr. Bonati), when? ____________________

8. Have you been seen by any other doctor for this current pain? **No prior treatment**

Primary Care MD/PA/NP ____________________ Emergency Room(date) ____________________

Urgent Care(date) ____________________ Hospitalized(date) ____________________

9. Any of the following tests? **No test performed**

X-rays(date) ____________________ MRI(date) ____________________ CT Scan(date) ____________________

EMG/NCS(date) ____________________ Other ____________________

10.Have you had surgery for this or similar pain? No Yes

If yes, please list type of surgery, when/where, name of surgeon: ____________________

____

11. Work related injury? No Yes If yes, when? ____________________

12. Are you still working? No Yes If no, last date worked: ____________________

13. Is your pain due to an auto accident? No Yes If yes, when? ____________________

14. Do you have an attorney involved in your injury? No Yes If yes, please provide name, address, and phone number of attorney ____________________

____

Patient Signature: ____________________ **Date:** ____________________

I attest all information is accurate.

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

New Patient Information

15. Review of symptoms: (check all that apply)

☐Unexplained weight loss/gain ☐Change in appetite ☐Mood changes
☐Bladder accidents/Incontinence ☐Arm numbness ☐Fatigue
☐Bowel accidents/Incontinence ☐Leg numbness ☐Stiffness
☐Night sweats ☐New swelling(legs or arms) ☐Joint pain
☐Fever ☐Change in handwriting ☐Poor sleep
☐Genital numbness ☐Difficulty walking ☐Rash
☐Severe nighttime pain ☐New balance problems ☐Bruising/Bleeding
☐Recent infections ☐Difficulty buttoning buttons ☐Blurred vision
☐**Other**____

16. Past medical history: (circle all that apply) **None**

Heart Disease High Blood Pressure Diabetes Kidney Disease Osteoarthritis Liver Disease
Ulcers Lung Disease Thyroid Disease Seizures/Epilepsy Psychiatric Illness
Osteoporosis Acid Reflux High Cholesterol Cancer__________________ Fibromyalgia
Rheumatoid Arthritis Other____

17. Past Surgical History: (circle all that apply)

Lumbar(lower back) Heart Stents Lung Kidney Thyroid Breast
Cervical(neck) Bowel Hernia Gall bladder Prostate Arm/Leg, specify:__________________
Other____

18. Allergies:(circle all that apply/include reaction)

Penicillin_________________________ Sulfa____________________________ Codeine____________________
Iodine___________________________ Other____

19: Current Medications: (include dosage)

____
____
____
____

Are you taking blood thinner? No Yes If yes, circle all that apply/include dosage:
Aspirin____________ Plavix_____________ Coumadin______________ Other____________________________

20. Family History: (blood relatives only) Circle all that apply: None
Cancer Bleeding disorder Stroke Diabetes Cardiac Arthritis Back/Neck pain Other____________

21. Social History: (Please answer all questions)
You are: Single Married Divorced Widowed Separated
You live: **Alone** With others:_______________________ Retirement Home________________________
Occupation:_________________________ Retired Social Security Disability Currently Employed
Job: Sedentary Light Medium Heavy **Have you ever smoked?** No Yes Quit **Packs per day**___ **Yrs**____
Do you drink alcohol? No Yes **What?**_______________ **How much per week?**_________________
Use illicit drugs? No Yes **What?**__________________ **How often?**__________________________
Highest level of education: High school College Graduate school Technical school

Patient Signature____**Date**_____________________

I attest all information is accurate.

NOTICE OF USE OF PRIVATE HEALTH INFORMATION, CONTRACT AUTHORIZING MEDICAL CARE, ASSIGNMENT OF BENEFITS A, AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED

Patient Name:____ **Date:**__________________________

I. Designation of certain relatives, close friends, and other caregivers as my personal representative:

I agree that the practice may disclose certain portions of my health information to a personal representative of my choosing, as such person is involved in my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to this person's involvement with my healthcare or payment relating to my healthcare.

Print Name:____

Print Name:____

Print Name:____

II. Request to receive confidential communications by alternative means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the practice make all communications with me by the alternative means I have listed below:

Home/Cell phone number:

____

□OK to leave message with detailed information.
□Leave message with call back number only.
Work phone number:

____

□OK to leave message with detailed information.
□Leave message with call back number only.

Written communication address:

____

□OK to use detailed information.
□E-mail me at:______________________
Fax Communication:

____

□OK to fax to number listed above.

III. Release of Medical Records:

□ I authorize____to release my images and medical records to F.A.S.T. Florida Advanced Spine and Sports Trauma Centers via fax, E-mail, Postal Mail and PACS.

IV. Acknowledgement of Practice's HIPAA Privacy Notice:

By subscribing my name below, I acknowledge that F.A.S.T. Florida Advanced Spine and Sports Trauma Centers has provided me with a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose), understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

____ ____
PRINT NAME SIGNATURE

F.A.S.T.
Florida Advanced Spine and Sports Trauma Centers

Pt #____________________

Dr#_____________________

NOTICE OF USE OF PRIVATE HEALTH INFORMATION, CONTRACT AUTHORIZING MEDICAL CARE, ASSIGNMENT OF BENEFITS A, AND AGREEMENT FOR PAYMENT OF SERVICES RENDERED.

HIPAA PRIVACY NOTICE:

THE FOLLOWING NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY:

- Your confidential healthcare information may be released to other healthcare professionals within the organization for the purpose of providing you with quality healthcare.
- Your confidential healthcare information may be released to your insurance provider for the purpose of the organization receiving payment for providing you with needed health services.
- Your confidential healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, domestic violence, or a crime.
- Your confidential healthcare information may be released to other healthcare providers in the event of your emergency care.
- Your confidential healthcare information may be released to a public health or federal organization in the event of communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your expressed authorization. You may revoke your permission to release confidential healthcare information at any time.
- You may restrict the disclosure of your protected health information for any services provided whereby you or someone else pays "out of pocket", in full, for the services.
- You may be contacted by the organization to remind you of any appointments.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You may be contacted by the organization for the purpose of raising funds to support the organization's operations. It is your expressed right to opt out of any fund raising communications.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of electronic transmission or paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail, in writing, your complaint to the organization: F.A.S.T. Florida Advanced Spine and Sports Trauma Centers, 2040 Short Avenue, Odessa, FL 33556.
- All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact: Angela Allen, office manager.
- This notice is effective as of 10/16/2013. This date must not be earlier than the date on which the notice is printed or published.