SOUTH PALM
PATIENT INFORMATION SHEET

DATE: _____

Patient Information

PATIENT'S NAME: (Last) First M.Init.

LOCAL ADDRESS….Street Unit/Apt. #

City State Zip Code

HOME PHONE: (LOCAL #) CELL PHONE:
( ) ( )

SEX… ☐ MALE ☐ FEMALE

DATE OF BIRTH: AGE:

SOCIAL SECURITY #:

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW (ER)

PERMANENT ADDRESS: (*if different from local above*) Unit/Apt #

City State Zip Code

PHONE NUMBER: (Permanent Location) ( )

EMERGENCY CONTACT #: ( )
NAME: RELATION:

FAMILY PHYSICIAN: PHONE NUMBER:
( )

CARDIOLOGIST: ( )

REFERRED BY?

PREFERRED PHARMACY:
NAME OF PHARMACY:
LOCATION (CITY & CROSSROADS):

Race/Ethnicity

☐ Black or African American
☐ Asian
☐ American Indian or Alaskan Native
☐ White (this includes all Hispanic or Latino)
☐ Prefer not to participate

Gender Identity

☐ I identify as Male
☐ I identify as Female
☐ I identify as other:_____

Sexual Orientation

☐ I am a heterosexual
☐ I am a homosexual
☐ Decline to specify

Are you being represented by an Attorney? Yes ___ NO _____

FIRM & ATTORNEY'S NAME:

ATTORNEY'S Address…Street Suite/Unit

City State Zip Code

ATTORNEY'S PHONE: FILE/CASE #
( )

Provide your E-mail address to allow you to access your medical records

e-mail: _____

Do you have an Advanced Directive (i.e., Living will, etc.)
☐ Yes ☐ No

THE **STATE** IN WHICH ACCIDENT OCCURRED:	
DATE OF INJURY:	_ **AUTO ACCIDENT** _ **AT WORK** _DRIVER _PASSENGER _PEDESTRIAN

Complete if ***AUTO OR WORK*** Injury

WILL YOU BE CLAIMING THIS INJURY UNDER YOUR EMPLOYER'S WORKERS COMPENSATION INSURANCE? ☐ YES ☐ NO

DESCRIBE HOW THE INJURY OCCURRED…

Authorization for Treatment:

I hereby give my permission to ***South Palm OrthoSpine Institute*** to evaluate and treat as deemed medically necessary.

SIGNED: _____

PATIENT'S NAME: _____

What is the main reason for your visit today? (Please check all that apply.)

❑ Back pain ❑ Leg pain (LT / RT) ❑ Neck pain ❑ Arm / Shoulder pain (LT / RT)
❑ OTHER :(describe):_____

Date of onset: _____ ❑ No ❑ Yes

Did your current spine problem result from any of the following? (Please check all that apply.)

❑ No Apparent Cause ❑ Car Accident (date: _____) ❑ Work Injury (date: _____)
❑ Sports Injury (date:_____) ❑ Other (Please Specify) _____

Current Employment status: ❑ Retired ❑ Disabled ❑ Homemaker ❑ Employed: Occupation: _____

Current Work status: ❑ Full-Time ❑ Job Task: _____ ❑ Part-Time ❑ with-out limitations
❑ with limitations (list limitations:_____ duration:_____)

Describe your current pain. Check all that apply: ❑ **NO PAIN**

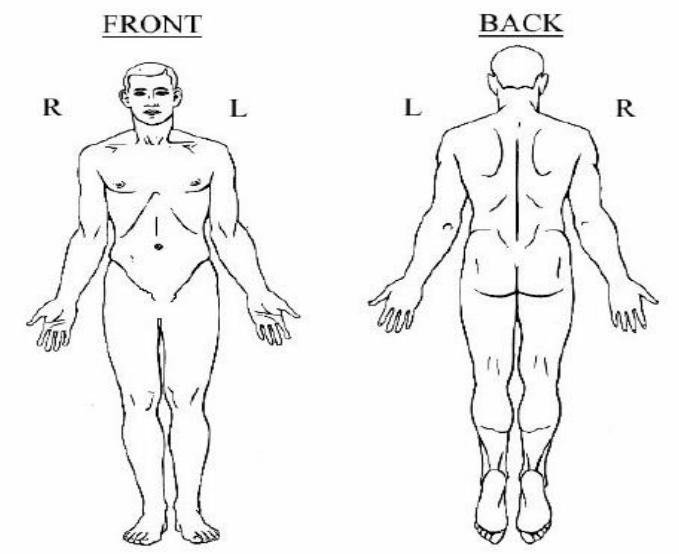
❑ Electric shocks ❑ Tingling ❑ Cramping ❑ Throbbing ❑ Pins / needles ❑ Numbness
❑ Aching ❑ Pulling ❑ Dull ❑ Burning ❑ Weakness
❑ Shooting ❑ Sharp/stabbing ❑ Sore ❑ Other:(describe):_____

Is your pain: ❑ ALL THE TIME (constant) ❑ HAS FLARE UPS (intermittent)

Use of assisted device: ❑ NONE ❑ CANE ❑ WALKER ❑ WHEELCHAIR

WHAT MAKES IT WORSE: ❑ WALKING ❑ SITTING ❑ STANDING ❑ ADL'S (Activities of daily living)
❑ DRIVING ❑ RESTING ❑ SLEEPING ❑ OTHER: _____

Have you had any treatments for your current pain? (Circle all that apply) Chiropractor / Physical therapy / Injections



Which sensations you are feeling?
Please use the scale below to indicate
Mark these drawings according to where you hurt.

/ / / Stabbing

XXX Burning
+ + + Aching
= = = Numbness
0 0 0 Pins & Needles

From 0 to 10, what is your currently pain range?

(0 = no pain, 10 = unbearable):_____

Have you had any injections? (circle one): Facet blocks/ Epidurals / Transforaminal blocks

Have you had any imaging studies in the past year? (MRI/CT/X-rays) Yes / No

PATIENT'S NAME: _____

Current Medical History

HEIGHT WEIGHT ☐ RIGHT HANDED ☐ LEFT HANDED

_____

ALLERGIES TO MEDICATION (List): ☐ NONE KNOWN

_ NOT APPLICABLE

__DIABETIC (☐ INSULIN ☐ TYPE ll) __BLOOD THINNERS __MORPHINE PUMP __RHEUMATOID ARTHRITIS

__HEART (☐ PACEMAKER, ☐ DEFIBRILLATOR, ☐ STENTS) __OSTEOARTHRITIS __OSTEOPOROSIS

HISTORY OF CANCER? YES _____ NO_____TYPE:_____.

PAST SURGICAL HISTORY: All Types… ☐ **NONE**

TYPE	APPROX DATE	DOCTOR	FACILITY PERFORMED

FAMILY HISTORY: Please list age, general health, deceased or living…

	Mother	Father	Sister(s)	brother(s)
AGE:				
HEALTH:				

CAUSE OF DEATH (IF APPLICABLE):_____

CHILDHOOD ILLNESSES…. ☐ NONE **(List unusual illnesses such as rheumatic fever, polio, heart murmur, etc.)**

ALCOHOL USAGE: ☐ NONE ☐ Occasional ☐ Moderate ☐ Excess

SMOKING: ☐ NEVER ☐ NO - Not now…Quit ____years ago, Smoked _____packs/day for _____ years.

☐ YES - If yes, number of Packs/day _____ and, number of years ____?

OTHER INFORMATION PERTINENT TO YOUR CARE? ☐ **NONE (IF YES, PLEASE LIST)**

PATIENT NAME: _____

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS: Have you / or are you being treated for the following:

1. ENDOCRINE: **Include dates**
- O Diabetes
- O Thyroid disorders
- O Night sweats
- O Recent change in weight or appetite

2. SKIN AND HEMATOLOGIC: **Include dates**
- O Frequent infections
- O Varicosities
- O Coagulation disorders
- O Anemia

3. CNS: **Include dates**
- O Unusual headaches/ Migraines
- O Loss of consciousness
- O Epilepsy
- O Head trauma
- O Seizure disorders
- O Stroke
- O Loss of memory
- O Vertigo
- O Syncope
- O Paralysis
- O Numbness/tingling in extremities

4. EYES: **Include dates**
- O Glaucoma
- O Cataracts

5. EARS: **Include dates**
- O Buzzing or ringing in ears (tinnitus)
- O Earache
- O Discharge from ears

6. NOSE AND MOUTH: **Include dates**
- O Difficulty Speaking
- O Sinus problems
- O Unusual bleeding

7. BREASTS: **Include dates**
- O Masses
- O Cystic Condition
- O Past biopsy or surgery

8. RESPIRATORY: **Include dates**
- O Asthma
- O Bronchitis
- O Emphysema
- O Pneumonia
- O Tuberculosis

9. CARDIOVASCULAR: **Include dates**
- O Angina chest pain
- O Heart Attack
- O Murmurs
- O Hypertension
- O Stroke
- O Palpitations
- O Peripheral edema
- O Claudication
- O Poor circulation
- O Congestive heart failure
- O Phlebitis
- O Cramping of legs when walking

10. GASTROINTESTINAL: **Include dates**
- O Constipation
- O Enteritis
- O Vomiting blood
- O GI Bleed
- O Bright red blood per rectum
- O Jaundice
- O Hepatitis
- O Diverticulitis
- O Gallbladder disease
- O Peptic or duodenal ulcer disease.

11. UROLOGY: **Include dates**
- O Pain on urination
- O Frequency
- O Urgency
- O Decreased stream
- O Kidney stones
- O Incontinence
- O Bladder infections
- O Blood in urine
- O Syphilis
- O Gonorrhea

12. RHEUMATOLOGY: **Include dates**
- O Fibromyalgia
- O Gout
- O Psoriatic Arthritis
- O Rheumatoid Arthritis
- O Osteoporosis
- O Sjogrens Syndrome
- O Systemic Lupus Erythematosus
- O Ankylosing Spondylitis

IF CONDITION NOT MENTIONED, PLEASE SPECIFY BELOW:

_____.

_____.

_____.

South Palm OrthoSpine Institute

Patient Consent for Use and Disclosure
of Protected Health Information

I _____ hereby give my consent for **South Palm OrthoSpine Institute** to use and disclose **protected health information** (PHI) about me to carry out **treatment, payment and health care operations** (TPO). (The Notice of Privacy Practices provided by **South Palm OrthoSpine Institute** describes such uses and disclosures more completely.)

I have the right to review the **Notice of Privacy Practices (HIPAA)** prior to signing this consent. **South Palm OrthoSpine Institute** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **15300 Jog Road, #108, Delray Beach, FL 33446.**

With this consent, **South Palm OrthoSpine Institute** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **South Palm OrthoSpine Institute** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **South Palm OrthoSpine Institute** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **South Palm OrthoSpine Institute** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that my "Protected Health Information" including demographic information such as address, social security, insurance or any personal medical history whatsoever will not be violated. I affirm that I am more than twenty-one (21) years of age.

By signing this form, I am consenting to allow **South Palm OrthoSpine Institute** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **South Palm OrthoSpine Institute** may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Print Patient's Name	Date

Authorized release of my medical record to :

_____	_____
Name	Relationship
_____	_____
Name	Relationship

SOUTH PALM ORTHOSPINE INSTITUTE

Dear Valued Patients:

You would be surprised to know how many people do not know what kind of benefits they have with their Insurance Companies.

We will bill your insurance company, **if we are current provides in your plan**. However if for any reason we are unable to be reimbursed from your insurance company, all monies owed will become your responsibility.

Any patient that is seen or treated in our office, without prior authorization from their **HMO group**, is responsible for full payment at the time of the visit.

If you need to use a specific lab or x-ray facility, you must notify a nurse before the service is rendered.

We will attempt to get the most benefit from your Insurance Company; however, we will need your assistance. Please supply us with your most recent information and make us aware should changes arise in your policy. Prior to your next appointment, please contact your Insurance Company to be sure that we are on your Plan and that your coverage is current. **THIS IS YOUR RESPONSIBILITY, NOT OURS!!!!!!** Any service that is rendered by this office, that is not a covered benefit of your insurance policy, is your responsibility to pay.

Please be aware that all co-payments and deductibles are due at the time of service.

By signing below, you are stating that you understand this important component of our Office Policy.

As always, thank you for choosing South Palm OrthoSpine Institute.

_____ _____

Signature Date