Patient Intake Form

Today's Date: ____________________

Last Name	First Name		Middle	
Birth Date	Age	Sex: M F	Cell phone	
Street Address	City		State	Zip
Social Security No	Home Phone		Work Phone	
Employer	Employer Address			
Spouse Name	Spouse Work Phone			
Spouse Employer/Address				
Spouse Social Security No	Spouse DOB			
Nearest Friend or Relative	Home Phone ( )			
Primary Care Physician **Phone Number**	**Referred By** **Phone Number**			
Email Address	Preferred Language [ ] English [ ] Spanish [ ] Other			

Race: [ ]American Indian/Alaska Native [ ]Asian [ ]Black/African American
[ ]Native Hawaiian/Pacific Islander [ ]White [ ]Other Race [ ]Declined
Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined

Primary Insurance Company	**Phone ( )**
Insurance Co Address	
Insured Person Name	
Insured Person Social Security No	**Insured Person Birth Date**
Your Relationship to Insured Person	**Group #**
Policy / ID #	**Copayment Amount**
Secondary Insurance Company Name	**Phone ( )**
Insurance Co Address	
Insured Person Name	
Insured Person Social Security No	**Insured Person Birth Date**
Your Relationship to the Insured Person	**Group #**
Policy / ID #	**Copay Amount**

Is this injury related to an auto / vehicular accident? ____Yes ____No Work Comp? ____Yes ____No
Do you have an Advanced Care Directive? _____Yes _____No Would you like additional information? _____Yes _____No
Can you name your surrogate? _____Yes _____No

Note: We do not accept auto / vehicular related cases. We only accept Marriott International and Choice Medical Management Workers' Compensation.

If yes above, date of the accident / injury : ____________________ Claim #: ____________________
Adjustor Name: ____________________ Phone: ____________________
Attorney Name and Address: ____________________

Medical and Social History

Patient Name: ____Date: _________ DOB: _________

Please list your current symptoms:____
____

Past Medical History: *Please check if you have been* ***diagnosed with or treated for*** *the following disorders.*

Anemia, Iron Deficiency		Hyperthyroidism	
Angina (Ischemic Chest Pain)		Hypothyroidism	
Arrhythmia (irregular heart rate/ rhythm)		Increased Cholesterol	
Arthritis		Irritable Bowel Syndrome	
Asthma		Murmurs	
Bleeding Disorders		Peripheral Neuropathy	
Brain Mass: Intracranial Mass		Peripheral Vascular Disease	
Cardiovascular Disease		Seizures	
Congestive Heart Failure		Stroke	
COPD		Ulcers	
Diabetes		Cancer: (Please give details)	
Fibromyalgia		Osteoporosis / Osteopenia	
Gastric Reflux		Kidney Disease	
Gout			
High Blood Pressure			

Please explain all checked boxes for the above disorders:

____
____
____
____

Are you Right handed or Left handed? ______Right ______Left

How long have you had your symptoms? __________________________

Conservative Treatment:

Past tests/ treatments for these symptoms: (please check/List all that apply)

☐ **Physical Therapy** Date: _________________________________ Facility ____

☐ **Chiropractic Treatment** Date: ___________________________ Physician ____

☐ **EMG/Nerve Conduction Study** Date: ______________________ Physician ____

☐ **List medications taken for current symptoms:**

____

☐ **Traction** Date: _______________________________________ Facility ____

Spinal Injections: ☐ **Epidural injections** ☐ **Facet blocks** ☐ **Facet Rhizotomies** ☐ **Trigger point injections**

Date(s) ____ Physician/Facility ____________________________

Please list all surgeries and major hospitalizations: (Date/ Procedure)

[ ] ***If none, please check.***

____

____

Medications: List Name, Strength, and how often taken

[ ] ***If none, please check***.

Medication/Prescription Over the counter	Dosage MG	Frequency #Times/ Day	Reason/ Condition Treated	Prescribing Doctor

*****Attach list if you need more space***

List Allergies:

[ ] ***If none, please check.***

Family Medical History:

Any family illness (es)? If so, please explain____

____

____

Social History:

Are you a smoker? _______ If so, how long? __________ How much? ____________ If quit, when? ____________

Do you drink alcohol? ____ Never ____ On Occasion ____ Moderately

Marital Status: ____ Married ____ Divorced ____Single ____Widowed

Occupation: ____

Names of any current specialist/referring doctor:

____

Patient Name: ____ Date: _________ DOB: _________

Symptoms: Please mark Yes or No if you have had the following symptoms in the past **6 month**

Y	N	Constitutional
		Fatigue
		Body Aches
		Fever
		Weight Loss
		Chills

Y	N	Eyes
		Blurred Vision
		Double Vision
		Visual Loss/Change in vision

Y	N	Ears, Nose, & Throat
		Thyroid Mass
		Vertigo
		Sinus Pain
		Sore Throat

Y	N	Cardiovascular
		Chest Pain
		Syncope/Loss of Consciousness
		Lightheadedness
		Irregular Heart Beats
		Lower Extremity Edema/swelling
		Rapid Heart Rate

Y	N	Respiratory
		Shortness of Breath
		Hoarseness
		Wheezing
		Cough

Y	N	Gastrointestinal
		Nausea
		Constipation
		Heartburn
		Vomiting
		Loss of Appetite
		Diarrhea
		Difficult Swallowing
		Abdominal Pain

Y	N	Genitourinary
		Urgency
		Urinary Retention
		Frequency
		Difficulty Voiding
		Incontinence
		Possible Pregnancy
		Skipped Menstrual Cycle

Y	N	Neurologic
		Speech Difficulties
		Seizures
		Loss of balance/Falls
		Memory Difficulties
		Tremors
		Head Injuries
		Tingling or numbness

Y	N	Musculoskeletal
		Joint Pain/Swelling
		Back Pain
		Neck Pain
		Muscular Weakness
		Muscle Pain
		Arm pain
		Leg pain

Y	N	Endocrine
		Unusual Loss of Hair
		Heat Intolerance/cold intolerance
		Decreased Libido

Y	N	Psychiatric
		Anxiety
		Feeling Confused
		Difficulty Sleeping

Patient Name: ______________________________

Account #: ______________________________

D.O.B. ______ / _______ / _______

Doctor: ______________________________

Pharmacy Information

Pharmacy Name: ____

Address: ____

____

Phone Number: (______) ______ - _________

*** We must have this information **BEFORE** you see the doctor ***

Thank You

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPREATIONS

PAGE ONE

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Orlando Neurosurgery (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how/her protected health information is used of disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

____

____

____

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

___________ HIV / AIDS Information
___________ Mental Health Information
___________ Substance Abuse Information
___________ Sexually Transmitted Disease Information
___________ If Patient is under the age of eighteen (18), Pregnancy Information

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

PAGE TWO

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:________________

____
Signature of Patient (or Authorized Representative*)

____
Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

____

____

____

____

____

____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful and your experience in this office being pleasant. The following is our financial policy and we would appreciate you reading this carefully. We will not be able to complete our recommended treatment plan unless you understand and sign this form.

In most cases, we will bill your insurance for you. **Please understand that this is a courtesy to our patients.** Your insurance contract is between you and your insurance company. It is **YOUR** responsibility to understand the terms and benefits, which are a part of your contract. **We do require you to pay your co-payments, co-insurance or deductibles at the time of service.** If you are unsure what your benefits are, you should contact your benefits department for verification prior to your visit with Drs. Baker, Behrmann, Bellew, Field, Hartman, Hellinger, Gandhi, Garg, Jenkins, Ramirez, Sawin or Rosen. **PLEASE NOTE: THIS OFFICE DOES NOT ACCEPT AUTO INSURANCE OR WORKER'S COMPENSATION INSURANCE.**

In the event your insurance requires a referral from your primary doctor, it is **YOUR** responsibility to make arrangements with your primary care doctor's office to get that referral to us prior to your appointment. **If the appropriate referral or authorization is not in our office at the time of your appointment, you will be rescheduled until we receive this referral.** Being a specialist physician, we **cannot** render care to a patient without the authorization of the primary doctor.

If your insurance company has not paid your bill in full within 60 days, you will be expected to take care of that bill. Any balance due from you after your insurance has been paid will be due within 30 days from receipt of your statement. We will always send you a statement once your insurance company has paid its portion. In the event of a large balance due from an operation, we can arrange a payment plan suitable for all parties concerned.

We will try our best to work with you to make paying your bill as easy as possible. We accept cash, checks, Visa and MasterCard.

Diagnostic Films Review for Established Patients:
For those patients who have imaging studies performed after their initial appointment with the physician. You may chose to bring those films and the imaging report to the office for your physician to review without an appointment. When the physician has reviewed the films, he will dictate a letter to you outlining the results and any future treatment plan that may be needed. There is a charge of $50.00 for this service, which will be requested by one of our billing staff over the telephone prior to the review, as this is a non-covered service by your insurance company.

I have read and understand the above policy, and I will adhere to it.
Also, I give my consent at this time to release my medical records and information to my insurance company, any hospital or any other physician involved in my care with Dr. Baker, Dr. Behrmann, Dr. Bellew, Dr. Field, Dr.Hartman, Dr. Hellinger, Dr. Gandhi, Dr. Garg, Dr.Jenkins, Dr.Ramirez, Dr.Reddy, Dr. Sawin or Dr. Rosen. I also authorize payment of medical benefits to my provider.

____
Patient Signature/ Date

Account#:____________

NOTICE TO PATIENTS
OF ORLANDO NEUROSURGERY, P.A.

Regarding the Dispensing of Opioid (Narcotic) Pain Medications

Dear Patient:

In their response to the "Opioid Crisis". The State Legislature of Florida unanimously passed the Controlled Substances Bill (CS/CS/HB 21) on March 9, 2018. This bill was signed into law by Governor Rick Scott on March 19, 2018 and takes effect on July 1, 2018. This new law impacts all Florida Licensed Physicians, regardless of specialty, and their patients.

The Controlled Substances law regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These drugs are often used to treat "acute pain", such as the pain associated with surgery. Examples of Schedule II drugs include pain medications like Percocet (oxycodone) and Dilaudid (hydromorphone). Schedule III drugs include Tylenol + codeine.

This new law mandates the following restrictions for prescriptions used to treat acute (post-surgical) pain:

Schedule II drugs

- Limited to 3-day supply only
- With an "acute pain exception", a 7-day supply can be provided under special circumstances
- All dispensing will be limited to the 14 days immediately post-surgery

Schedule III drugs

- Limited to a 14-day supply
- All dispensing will be limited to the 14 days immediately post-surgery

These new regulations significantly impact the pain management your surgeon and staff are allowed to provide you after surgery. Narcotic pain medications, which have been the staple of post-surgical pain control, are now permitted by law to be dispensed only in small quantities and for a short period of time. We regret any inconvenience and discomfort that these new restrictions may cause you as you recover from your procedure.

Should you have any questions regarding the new Controlled Substances regulations, please ask your surgeon or his staff.

Any comments regarding how this new legislation has impacted you (as a patient recovering from surgery) should be directed to your State Senator of House Representative. A list of these individuals and their contact information will be provided upon request.

FOR THE PATIENT:

I have read and understand this information.

X____________________	X____________________	X____________
Print Name	Signature	Date