SPINE INSTITUTE OF SOUTH FLORIDA. P.A.

Mark S. Eskenazi, M.D. Edward H. Chung, M.D. Bianca Orfanos, PA-C Seth R. Ullian, PA-C

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please Print. All information will be confidential.

Patient Name_____ SS#_____

Home Phone #_____ Cell Phone #_____ DOB_____

Address_____
Street City State Zip

Primary Care Dr._____ Phone #_____

*If this appointment is related to an injury, please provide the information requested below in the appropriate category.

Worker's Compensation_____ Adjuster/Claim Manager_____
Date of Injury Name

Motor Vehicle Accident:_____
Date of Injury

Medication Refill Policy

- Prescription refills are never available on weekends or holidays.
- We require a 72 hour notice for all prescription refills.
- To obtain a refill of your medication, call the office at 561-381-4271.
- To effectively process your request we will need the following information:

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone #: _____

*Controlled substances cannot be refilled by phone and must be in paper form only.

I have read and understand the above policy regarding medication refills.

Signature:_____ Date:_____

ASSIGNMENT OF BENEFITS, AUTHORIZATION TO RELEASE INFORMATION, AND OFFICE INSURANCE POLICY

I hereby assign my insurance policy benefits to Spine Institute of South Florida, P.A. I authorize payment of said benefits to be made directly to Spine Institute of South Florida, P.A.

I further authorize Spine Institute of South Florida, P.A., to release any and all medical and/or financial information to any payor who may be responsible for payment of all or any portion of the benefits.

I authorize Spine Institute of South Florida, P.A., to file my insurance claims for me. I understand that Spine Institute of South Florida, P.A., will file my insurance claims as a courtesy to me, and that I am financially responsible for any and all charges that are not covered by my insurance. I further understand that should my insurance policy, healthcare plan(s), determine that I am not eligible for coverage or that the services provided to me by Spine Institute of South Florida, P.A., are not covered, I agree that I am financially responsible for said services, unless prohibited by law.

Print Patient Name _____ **Patient Signature** _____

Date _____

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PATIENT RECORD OF DISCLOSURES

By signing below you hereby authorize us to disclose information about yourself (or another person for whom you have the authority to sign).

Please list the name or other specific identification of the person(s), or class of persons, authorized to receive your health information:

_____

I hereby authorize Spine Institute of South Florida to disclose my health information in the following ways: Please check all that apply

☐ verbally disclose information on home or cell phone voice mail
☐ fax information to the following number_____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree when you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient:_____

Signature: _____

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name:_____

Date of Birth:_____

SS#:_____

I hereby authorize my medical records to be released to Spine Institute of South Florida, P.A. **Fax 561-381-4273**

___X___ A complete copy of my medical Records

___X___ Copies of the following information:

_____ MRI's

_____ CAT SCANS

_____ X-rays

Signature of Patient or Guardian **Relationship to Patient**

Date

Patient Name_____Age_____

Who is your Internist or Primary Doctor?_____

Please list **EVERY** medication you are currently taking:_____

_____

_____

Are you **ALLERGIC** to any medications: Yes No **If yes, Please list:**_____

_____

Please circle if you have or have had any of the following:

AIDS/HIV	Heart Disease	Asthma
Anemia	Hepatitis	Emphysema
Excessive Bleeding	High Blood Pressure	Ulcers
Cancer (Location/Year) _	Kidney Disease	Epilepsy
_____	Liver Disease	Glaucoma
Diabetes	Parkinsons	Rhematoid Arthritis/Osteoarthritis
Stroke	Abnormal Heartbeat	Osteoporosis
Poor Circulation	Cholesterol	Thyroid Problems

Please list any other medical conditions you have not listed above:

_____

_____

_____

Please list **EVERY** surgery you have had and date of procedure:

_____

_____

_____

Do you currently, or have you had any of the following:

Constitutional Symptons
- Fever
- Chills
- Night Sweats

Integumentary
- Skin Rash
- Persistant Itch
- Psoriasis

Psychologic
- Depression
- Anxiety
- Bipolar Disorder

Neurologic
- Seizures
- Dizzy Spells
- Numbness/Tingling

Genitourinary
- Urine Retention
- Urinary Incontinence
- Urinary Frequency

Respitory
- Wheezing
- Frequent Cough
- Shortness of Breath

Gastrointestinal
- Abdominal Pain
- Nausea/Vomiting

Hematologic
- Blood Clotting Problems
- Swollen Glands

Musculoskeletal
- Joint Pain
- Neck Pain
- Back Pain

Ear/Nose/Throat
- Ear Infections

Eyes
- Blurred Vision

Marital Status:	Single	Married	Divorced	Widowed
Alcohol Use:	Never	Rarely	Moderately	Daily
Tobacco Use:	Never	Quit (Year)	Daily	Packs Per day_____
Employment:	Retired	Working	Occupation:_____	
Hobbies/Sports:	_____			

Have you had any of the following treatments? If yes, please give approximate dates.

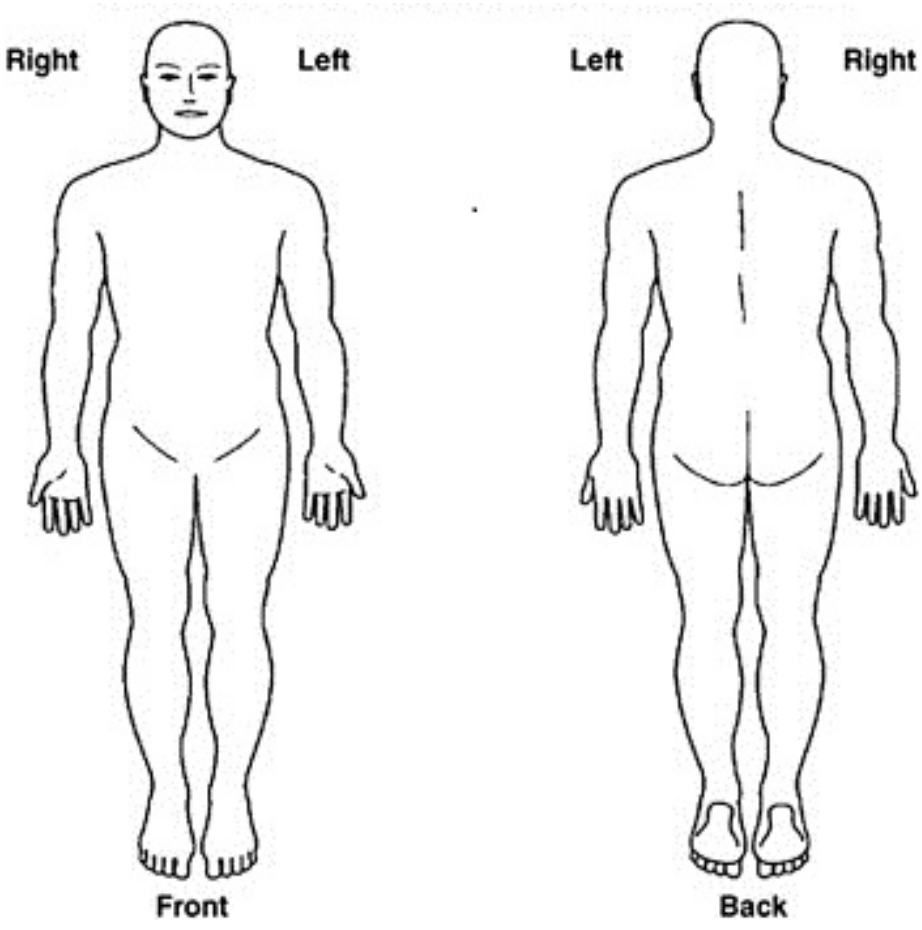
Treatment	Date	Location
Physical Therapy		
Chiropractic		
Epidural Injections		
Facet Injections		
Nerve Blocks		

Have you ever had any of the following tests? If yes, please give date:

X-Ray		
Cat Scan		
MRI		
Bone Scan		
Nerve Test (EMG)		
Myelogram		

Mark the areas on your body where you feel the following sensations:

Aching	^^^^^^^^^^^^	Shooting Pain	//////////////
Tingling	XXXXXX	Numbness	OOOOOO



Patient Name _____ DOB _____ Date _____

Date of accident or Onset of symptoms: _____

Current **PAIN** Medications: Include **EVERY** medication both prescription and non-prescription

Name	Dose	Frequency	For how long have you been taking

Past Pain Medications that you have tried

Name	Dose

Have you tried injections? Yes No If yes:

Name of Facility/Doctor _____

How many injections did you receive in the past 12 months? _____

Did you have any relief? Yes No

Have you tried physical therapy in the last 12 months? Yes No If yes:

Name of Physical Therapy Office/Doctor _____

How often did you go? Per week 1X 2X 3X

_____

Please list activities you cannot perform due to your condition:

_____

_____

_____