Dear Patient,

Thank you for making an appointment at Florida Spine Care Center. **In order to have any prescriptions filled, we must have your pharmacy address and phone number where indicated on the paperwork below.**

We would like to remind you to bring all original films and studies that you have previously had performed. This includes MRI’s, Myelograms, CT Scans and/or x-rays. **Many facilities are giving disks with this information instead of the actual films. Dr. Broom prefers the actual films**) unfortunately, if your diagnostic tests are not with you or sent prior to your appointment, it may be necessary to reschedule.

Please do not forget to bring your copays or referrals if applicable. Payment arrangements should have been discussed while making your appointment. If you have any questions or concerns, please feel free to contact our billing department prior to your appointment at (407)481-2244.

Thank you and we look forward to meeting you!!!

The Staff of Florida Spine Care Center

****Please note: Parking is located on and around Orange Avenue. If you wish to utilize the parking garage located in the rear of the building, there is a charge of $4.00. Since this is run independently from our practice, we are unable to validate or reimburse you for this fee. Thank You.

Continue to Forms Below
### Florida Spine Care Center / Surgical & Non Surgical Spine Care

#### Patient Information
- **Please Print - All Unshaded Areas**

#### Patient Details
- **Name First-Middle-Last**: [Name]
- **Email**: [Email]
- **Age**: [Age]
- **Today's Date**: [Date]
- **Race**: [Select Race]
- **Sex**: [Select Sex]
- **Social Security Number**: [Number]
- **City**: [City]
- **State**: [State]
- **ZIP**: [ZIP]
- **Home Phone**: [Number]
- **Work Phone**: [Number]
- **Mobile Phone Number**: [Number]
- **Marital Status**: [Select Status]
- **Date of Birth**: [Date]
- **Employer Name and Address**: [Address]
- **City-State-Zip**: [Address]
- **Occupation**: [Occupation]
- **Pharmacy Name**: [Name]
- **Pharmacy Address**: [Address]
- **Pharmacy Phone Number**: [Number]

#### Spouse or Responsible Party (If Not Patient)
- **Name First-Middle-Last**: [Name]
- **Relationship**: [Relationship]
- **Social Security Number**: [Number]
- **Home Phone**: [Number]
- **Work Phone**: [Number]
- **City**: [City]
- **State**: [State]
- **ZIP**: [ZIP]
- **Employer Name and Address**: [Address]
- **City-State-Zip**: [Address]
- **Occupation**: [Occupation]

#### Nearest Relative Not Living With You
- **Person to Contact in Emergency (Next of Kin)**
- **Their Relationship to You**: [Relation]
- **Home Phone**: [Number]
- **Work Phone**: [Number]
- **City-State-Zip**: [Address]

#### Medical Complaint and Prior Treatment
- **Explain**: [Explanation]
- **Duration**: [Duration]
- **Date of Accident**: [Date]
- **Place of Accident**: [Location]
- **Still Working**: [Yes/No]
- **Date Stopped Working**: [Date]
- **How Did Accident Happen?**: [Details]
- **Prior Treatment**: [Details]
- **By Whom**: [Person]
- **Prior X-Rays**: [Yes/No]
- **When**: [Date]
- **How Did You Hear About Us?**: [Source]
- **Intended Physician**: [Name]
- **Referring Person - So We Can Thank Them**: [Contact]
- **Referring Physician**: [Name]
- **Address/Phone**: [Details]
- **Pediatrician/Family Physician**: [Name]
- **Address/Phone**: [Details]

#### Insurance Information
- **Insurance Company**: [Name]
- **Phone**: [Number]
- **HMO**: [Yes/No]
- **COPAY**: [Amount]
- **PPO**: [Yes/No]
- **COPAY**: [Amount]
- **Insured Person**: [Name]
- **Group/Employer Name**: [Company]
- **Address/Phone**: [Details]
- **Policy #:**: [Number]
- **Authorization #:**: [Number]
- **Claim #:**: [Number]

#### Secondary Carrier
- **Insurance Company**: [Name]
- **Phone**: [Number]
- **HMO**: [Yes/No]
- **COPAY**: [Amount]
- **PPO**: [Yes/No]
- **COPAY**: [Amount]
- **Insured Person**: [Name]
- **Group/Employer Name**: [Company]
- **Address/Phone**: [Details]
- **Policy #:**: [Number]
- **Authorization #:**: [Number]
- **Claim #:**: [Number]

#### Medicare Authorization to Release Information and Assignment of Benefits
- **I authorize the release of all medical information necessary to process this claim and am entitled to any medicare benefits to Michael J. Brown, M.D., PA. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be signed and is to be considered an original. I agree to be financially responsible for all charges that I may incur for non-covered services as explained to me by the physician. I have read this information and understand it.**

#### Signature (Parent if Minor)
- **Date**: [Date]

#### Pharmacy Name
- **Pharmacy Address**: [Address]
- **Pharmacy Phone Number**: [Number]

#### Provider Signature
- **Date**: [Date]
**FLORIDA SPINECARE CENTER**

**MEDICAL HISTORY**

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Sex</th>
<th>Race</th>
</tr>
</thead>
</table>

### HEALTH HISTORY OF THE PATIENT

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Heart Trouble</th>
<th>High Blood Pressure</th>
<th>Diabetes</th>
<th>Arthritis</th>
<th>Gout</th>
<th>Seizures</th>
<th>Mental Illness</th>
<th>Kidney Trouble or Stones</th>
<th>Cancer</th>
<th>Bleeding Disorders</th>
<th>Alcoholism</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### FAMILY HISTORY

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Heart Trouble</th>
<th>High Blood Pressure</th>
<th>Diabetes</th>
<th>Arthritis</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### REVIEW OF SYSTEMS

Have you recently had or do you now have:

- Reading Glasses
- Change of Vision
- Loss of Hearing
- Ear Pain
- Hoarseness
- Nosebleeds
- Difficulty Swallowing
- Morning Cough
- Shortness of Breath
- Chills or Fever
- Heart or Chest Pain
- Abnormal Heartbeat
- Badly Swollen Ankles
- Calf Cramps with Walking
- Poor Appetite
- Toothache
- Gum Trouble
- Nausea or Vomiting
- Stomach Pain
- Ulcers
- Frequent Bleeding
- Frequent Loose Bowel Movements
- Blood in Bowel Movements
- Frequent Constipation
- Hemorrhoids
- Frequent Urination (pass water)
- Burning on Urination
- Difficulty Starting Urination
- Difficulty Stopping Urination
- Get Up Every Night to Urinate
- Frequent Headaches
- Blackouts
- Seizures
- Frequent Rash
- Hot or Cold Spells
- Recent Weight Change
- Nervous Exhaustion
- Insomnia
- Depression
- Nervous Tension
- Women Only:
  - Irregular Periods
  - Vaginal Discharge
  - Frequent Spotting

### SOCIAL HISTORY

- Most Recent Occupation

### Medical History Details

- Surgical Procedures (include approx. dates):
- Current Medications and Dosage:
- Allergies to Medicines: (None

### Tobacco and Alcohol Use

- Smoke packs per day
- Alcohol: Never
- Occasional
- Moderate to Heavy
- Drug Overuse: None
- Presently
- Past Problem
SPINE PAIN ASSESSMENT

Please describe when and how your pain began:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

What is your current occupation?

____________________________________________________________________

____________________________________________________________________

Are you currently employed? □ Yes □ No
If so, how long have you been with your current employer? ____________

____________________________________________________________________

Please check all that apply:
□ I have been working around the pain
□ I am currently on light duty
□ I have been unable to work for the past ___ months because of the pain.

If your pain occurs in different locations, list them in order of severity with 1 being the most troublesome, 2 less so, etc. Please draw a line through those that do not apply.
___ Headaches
___ Neck
___ Shoulder and/or arms
___ Between shoulder blades
___ Low Back
___ Buttocks and/or legs

Patient Name________________________
Date of Birth _______________________
Exam Date ________________________

Does your pain interfere with sleep? □ Yes □ No

I am having pain:
□ Constantly
□ Occasionally, about ___ hours per day
□ Infrequently, about ___ times per week
□ Rarely, about ___ times per month

Usually my pain is worse: (choose one)
□ When I first get up.
□ As the day progresses.
□ At night in bed.
□ At different times.

What increases the pain? Check all that apply.
□ Bending
□ Lifting
□ Twisting
□ Sitting for a while. How long? ___
□ Standing for a while. How Long? ___
□ Coughing
□ Sneezing
□ Straining during bowel movements
□ Getting in or out of a chair or car
□ Lying in bed
□ Walking. How long can you walk before pain stops you? ____________
□ Other_____________________

Do you smoke?
□ Yes ____ Packs per day for ____ years.
□ No
List the physicians who have evaluated your present condition:

__________________________

__________________________

__________________________

List any treatment that you have had for your current pain. Star those that have helped:

☐ None
☐ Physical Therapy
☐ Exercise
☐ Chiropractic
☐ Medications
☐ Electrical Stim/TENS
☐ Injections
☐ Surgery
☐ Other

Please list all previous back or neck surgeries. Give approximate dates, location and surgeon.

__________________________

__________________________

__________________________

Did your symptoms improve following surgery?

☐ Yes. For how long? ____________

☐ No

What medications are you currently taking for pain?

Medication: ____________________________ #/Day #/Week

__________________________

__________________________

Rate Your Pain on a scale of 1-10
At Best: 0 1 2 3 4 5 6 7 8 9 10
At Worst: 0 1 2 3 4 5 6 7 8 9 10
Using the appropriate symbol, mark the area(s) on your body where you feel each of the following sensations:

Numbness

Pins and Needles

Burning

Aching

Stabbing

The line below represents the intensity of the pain you are experiencing. Please mark at the position on the scale which indicates how much pain you are feeling at this time.

No Pain

Worst Pain Ever

I certify that the information provided in this medical questionnaire is true and correct to the best of my knowledge.

Patient Signature

Date

Witness Signature

Date
FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Florida SpineCare Center firmly believes that a good doctor/patient relationship is based upon understanding and open communication.

This practice will file all insurance claims to your primary and secondary carriers. Our practice will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services. Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits. If you request your insurance company to pay you directly, we will require full payment when services are rendered.

Our fees are usually considered to fall within the acceptable range determined by each carrier. This does not apply to companies who reimburse based on an arbitrary “Usual and Customary” schedule of fees, which bears no relationship to the current standard and cost of care in this area. You will be responsible for any portion of your bill which is denied or not paid by your insurance carrier.

By law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier, as we feel it is necessary to work together to resolve any insurance problem.

Payment is expected at the time of service on all self-pay patients. Also, please be prepared to pay the unpaid insurance percentage, your co-insurance, or any outstanding deductible when services are rendered.

Each month, you will receive a monthly statement which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, we will mail a reminder notice, indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

We will be forced to pursue further collection action on any patient refusing to remit payment after 91 days of notice, unless pending insurance or financial arrangements have been made.

Our staff is ready and willing to make every effort to assist you with your questions. PLEASE do not hesitate to ask us. We are here to help you.

(407) 481-2244

I understand the above policy and agree that, after any contractual arrangements between Florida SpineCare Center and the insurance carrier are satisfied, I am ultimately responsible for the balance on this account.

Signature: ___________________________________________ Signature of Parent or Legal Guardian, If patient is a minor.

Printed name: ______________________________________ Date: __________________________
CONSENT TO REQUEST/OBTAIN MEDICAL INFORMATION

FACILITY/PERSON

STREET ADDRESS

CITY STATE ZIP

FAX

RE: PATIENT NAME (PRINT) CHART #

I hereby give consent to Florida SpineCare Center and all health care providers furnishing care within Florida SpineCare Center to obtain my protected health information for the purposes of treatment, payment, and health care options.

and/or

Please release all medical, drug, and/or alcohol abuse, diagnostic test results, HIV antibody test results and/or AIDS diagnosis, and/or x-rays to: Florida SpineCare Center, PO BOX 568008, Orlando, FL 32856-8008.

Alcohol, drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal regulation (42CFR part II) prohibits making any further disclosure of it without specific written consent of the undersigned, or as otherwise permitted by such regulations.

*** I understand that this release will remain in effect until revoked by me in writing.

PATIENT SIGNATURE DATE

DATE OF BIRTH SSN

PERSONS ALLOWED TO RECEIVE INFORMATION PER PATIENT

WITNESS