

# SOUTH PALM ORTHOSPINE INSTITUTE

## PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_

<b>Patient Information</b>		
PATIENT'S NAME: (Last)	First	M.Init.
LOCAL ADDRESS....Street		
		Unit/Apt. #
City	State	Zip Code
HOME PHONE: (LOCAL #) ( )	CELL PHONE: ( )	
SEX... <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
DATE OF BIRTH: AGE:		
SOCIAL SECURITY #:		
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOW (ER)		
PERMANENT ADDRESS: <i>(if different from local above)</i> Unit/Apt #		
City	State	Zip Code
PHONE NUMBER: (Permanent Location) ( )		
EMERGENCY CONTACT #: ( )		
NAME:		RELATION:
FAMILY PHYSICIAN:		PHONE NUMBER: ( )
CARDIOLOGIST:		( )
REFERRED BY?		

<b>Complete if <u>AUTO OR WORK</u> Injury</b>	
THE <u>STATE</u> IN WHICH ACCIDENT OCCURRED:	
DATE OF INJURY:	<input type="checkbox"/> <b>AUTO ACCIDENT</b> <input type="checkbox"/> <b>AT WORK</b> <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> PEDESTRIAN
WILL YOU BE CLAIMING THIS INJURY UNDER YOUR EMPLOYER'S WORKERS COMPENSATION INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THIS A LIABILITY CASE? (ARE YOU SUING ANOTHER PARTY?) <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="background-color: black; color: white; padding: 2px;">If yes, complete Attorney Info.</span>	
DESCRIBE HOW THE INJURY OCCURRED...	

<b>Primary Insurance (copy on file)</b>	
INSURANCE THROUGH EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
INSURED'S NAME: _____	
Relationship to patient?	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Date of Birth _____

<b>Employer Information</b>	
EMPLOYER: _____	
OCCUPATION: _____	Retired: Y N
WORK PHONE: ( )	Ext. _____
EMPLOYER'S Address...Street	
Suite/Unit	
City	State
Zip Code	

<b>Attorney Information (Liability Case <u>ONLY</u>)</b>	
FIRM & ATTORNEY'S NAME: _____	
ATTORNEY'S Address...Street	
Suite/Unit	
City	State
Zip Code	
ATTORNEY'S PHONE: _____	
( )	
FILE/CASE #	

<b>Authorization for Treatment:</b>	
I hereby give my permission to <b><u>South Palm OrthoSpine Institute</u></b> to evaluate and treat as deemed medically necessary.	
SIGNED: _____	

**PATIENT'S NAME:** \_\_\_\_\_

**WHICH PART OF THE BODY IS HURTING** (Why are you here to see the doctor today?)

\_\_BACK      \_\_HIP (R/L)                      \_\_HEAD    \_\_SHOULDER (R/L)      \_\_OTHER: \_\_\_\_\_  
\_\_LEG (R/L)    \_\_KNEE (R/L)                      \_\_NECK    \_\_ARM (R/L)

**CIRCLE EACH THAT APPLIES:**

**TYPE OF PAIN:** NONE, INTERMITTENT, CONSTANT, STABBING, ACHE, THROBBING, HEADACHES

**ONSET** (Date condition began): \_\_\_\_\_ **INTENSITY (1-10):** \_\_\_\_/10

**SYMPTOMS** (Describe): TINGLING, BURNING, NUMBNESS, PINS & NEEDLES, THROBBING, PRESSURE, WEAKNESS

**USE OF ASSISTED DEVICES:** CANE, WALKER, WHEELCHAIR, NONE

**CONTRIBUTING FACTORS:** ADL'S; WALKING; SITTING; STANDING; RESTING; DRIVING; OTHER: \_\_\_\_\_

**CURRENT UTILIZED TREATMENT FOR PAIN:** NONE / PHYSICAL THERAPY: YES / NO: LAST THERAPY \_\_\_\_\_

**PAIN MANAGEMENT (INJECTION):** YES / NO: WHERE: \_\_\_\_\_ LAST TREATED: \_\_\_\_\_ RELIEF: Y / N

**MEDICATION FOR PAIN:** \_\_\_\_\_ **RX BY DOCTOR:** \_\_\_\_\_

Mark the areas on this body drawing where you feel the described sensations.  
Use the appropriate symbols. **Mark areas of radiation, include all affected areas.**

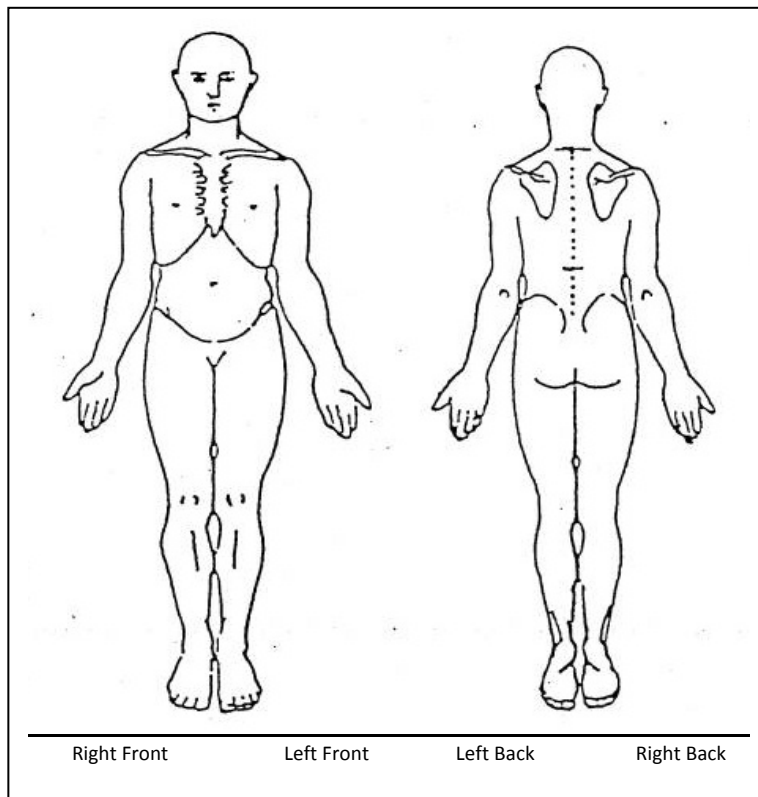
NUMBNESS                      PINS & NEEDLES

-----                      000000  
BURNING    ACHING    STABBING  
xxxxxx                      // // // //

**LOCATION AND INTENSITY OF PAIN**

ON A SCALE OF 1-10, INDICATE YOUR CURRENT LEVEL OF PAIN:

- 0 - Normal
- 1                       BACK
- 2
- 3 - Low Pain                       RIGHT LEG
- 4
- 5 - Moderate Pain                       LEFT LEG
- 6
- 7                       NECK
- 8 - Intense Pain
- 9
- 10 - Emergency



PATIENT'S NAME: \_\_\_\_\_

## Current Medical History

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  RIGHT HANDED  LEFT HANDED

ALLERGIES TO MEDICATION (List): \_\_\_\_\_  NONE KNOWN

\_\_DIABETIC (  INSULIN  TYPE II ) \_\_\_\_\_BLOOD THINNERS \_\_\_\_\_MORPHINE PUMP  
\_\_HEART (  PACEMAKER,  DEFIBRILLATOR,  STENTS )

PAST SURGICAL HISTORY: All Types...  NONE

<u>TYPE</u>	<u>APPROX DATE</u>	<u>DOCTOR</u>	<u>FACILITY PERFORMED</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Mother Father Sister(s) brother(s)

AGE: \_\_\_\_\_

HEALTH: \_\_\_\_\_

LIVING: \_\_\_\_\_

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:** (COMPLETE FORM, IF IT **DOES NOT APPLY**, WRITE **DNA**) Have you / or are you being treated for the following:

- |  |                             |  |                             |
|--|-----------------------------|--|-----------------------------|
| <b>1. <u>ENDOCRINE:</u></b>                                    | <b><u>Include dates</u></b> | <b>7. <u>BREASTS:</u></b>                                  | <b><u>Include dates</u></b> |
| <input type="checkbox"/> Diabetes                              |                             | <input type="checkbox"/> Masses                            |                             |
| <input type="checkbox"/> Thyroid disorders                     |                             | <input type="checkbox"/> Cystic Condition                  |                             |
| <input type="checkbox"/> Fever                                 |                             | <input type="checkbox"/> Past Biopsy or surgery            |                             |
| <input type="checkbox"/> Weakness                              |                             |  |                             |
| <input type="checkbox"/> Chills                                |                             | <b>8. <u>RESPIRATORY:</u></b>                              | <b><u>Include dates</u></b> |
| <input type="checkbox"/> Night sweats                          |                             | <input type="checkbox"/> Cough                             |                             |
| <input type="checkbox"/> Recent change in weight or appetite   |                             | <input type="checkbox"/> Asthma                            |                             |
|  |                             | <input type="checkbox"/> Bronchitis                        |                             |
| <b>2. <u>SKIN AND HEMATOLOGIC:</u></b>                         | <b><u>Include dates</u></b> | <input type="checkbox"/> Emphysema                         |                             |
| <input type="checkbox"/> Skin color                            |                             | <input type="checkbox"/> Pneumonia                         |                             |
| <input type="checkbox"/> Texture                               |                             | <input type="checkbox"/> Tuberculosis                      |                             |
| <input type="checkbox"/> Frequent infections                   |                             | <input type="checkbox"/> Congestive failure                |                             |
| <input type="checkbox"/> Varicosities                          |                             |  |                             |
| <input type="checkbox"/> Coagulation disorders                 |                             | <b>9. <u>CARDIOVASCULAR:</u></b>                           | <b><u>Include dates</u></b> |
| <input type="checkbox"/> Anemia                                |                             | <input type="checkbox"/> Angina chest pain                 |                             |
|  |                             | <input type="checkbox"/> Heart Attack                      |                             |
| <b>3. <u>CNS:</u></b>  | <b><u>Include dates</u></b> | <input type="checkbox"/> Murmurs                           |                             |
| <input type="checkbox"/> Unusual headaches/ Migraines          |                             | <input type="checkbox"/> Hypertension                      |                             |
| <input type="checkbox"/> Loss of consciousness                 |                             | <input type="checkbox"/> Stroke                            |                             |
| <input type="checkbox"/> Epilepsy                              |                             | <input type="checkbox"/> Stroke                            |                             |
| <input type="checkbox"/> Head trauma                           |                             | <input type="checkbox"/> Palpitations                      |                             |
| <input type="checkbox"/> Seizure disorders                     |                             | <input type="checkbox"/> Peripheral edema                  |                             |
| <input type="checkbox"/> Stroke                                |                             | <input type="checkbox"/> Claudication                      |                             |
| <input type="checkbox"/> Loss of memory                        |                             | <input type="checkbox"/> Poor circulation                  |                             |
| <input type="checkbox"/> Vertigo                               |                             | <input type="checkbox"/> Congestive heart failure          |                             |
| <input type="checkbox"/> Syncope                               |                             | <input type="checkbox"/> Phlebitis                         |                             |
| <input type="checkbox"/> Paralysis                             |                             | <input type="checkbox"/> Cramping of legs when walking     |                             |
| <input type="checkbox"/> Numbness/tingling in extremities      |                             |  |                             |
|  |                             | <b>10. <u>GASTROINTESTINAL:</u></b>                        | <b><u>Include dates</u></b> |
| <b>4. <u>EYES:</u></b>   | <b><u>Include dates</u></b> | <input type="checkbox"/> Constipation                      |                             |
| <input type="checkbox"/> Glaucoma                              |                             | <input type="checkbox"/> Enteritis                         |                             |
| <input type="checkbox"/> Cataracts                             |                             | <input type="checkbox"/> Vomiting blood                    |                             |
| <input type="checkbox"/> Change in vision                      |                             | <input type="checkbox"/> Melena                            |                             |
| <input type="checkbox"/> Use of glasses for reading            |                             | <input type="checkbox"/> Bright red blood per rectum       |                             |
|  |                             | <input type="checkbox"/> Jaundice                          |                             |
| <b>5. <u>EARS:</u></b>   | <b><u>Include dates</u></b> | <input type="checkbox"/> Hepatitis                         |                             |
| <input type="checkbox"/> Buzzing or ringing in ears (tinnitus) |                             | <input type="checkbox"/> Diverticulitis                    |                             |
| <input type="checkbox"/> Change in hearing                     |                             | <input type="checkbox"/> Gallbladder disease               |                             |
| <input type="checkbox"/> Use of hearing aid                    |                             | <input type="checkbox"/> Peptic or duodenal ulcer disease. |                             |
| <input type="checkbox"/> Earache                               |                             |  |                             |
| <input type="checkbox"/> Discharge from ears                   |                             | <b>11. <u>UROLOGY:</u></b>                                 | <b><u>Include dates</u></b> |
|  |                             | <input type="checkbox"/> Pain on urination                 |                             |
| <b>6. <u>NOSE AND MOUTH:</u></b>                               | <b><u>Include dates</u></b> | <input type="checkbox"/> Frequency                         |                             |
| <input type="checkbox"/> Difficulty Speaking                   |                             | <input type="checkbox"/> Urgency                           |                             |
| <input type="checkbox"/> Sinus problems                        |                             | <input type="checkbox"/> Decreased stream                  |                             |
| <input type="checkbox"/> Unusual bleeding                      |                             | <input type="checkbox"/> Kidney stones                     |                             |
| <input type="checkbox"/> Dentures                              |                             | <input type="checkbox"/> Incontinence                      |                             |
|  |                             | <input type="checkbox"/> Bladder infections                |                             |
|  |                             | <input type="checkbox"/> Blood in urine                    |                             |
|  |                             | <input type="checkbox"/> Syphilis                          |                             |
|  |                             | <input type="checkbox"/> Gonorrhea                         |                             |

# *Patient consent form*

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## 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 **Stewart G. Eidelson, M.D., 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.

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

# SOUTH PALM ORTHOSPINE INSTITUTE

**Stewart G. Eidelson, M.D.**

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.

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Signature

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Date