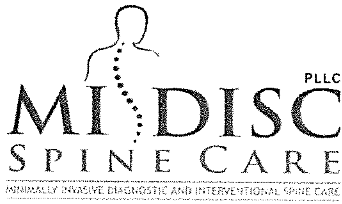


New Patient Form

Robert T. Getter, MD
3067 Tamiami Trail Suite 3
Port Charlotte, Fl 33952
Phone (941) 979-5260 Fax (941) 979-5268

Patient Name: ____________________ Age: ________ Sex: M / F

Address: ____________________ Date of Birth: ________ Race: ________

City, State, Zip: ____________________ Social Security #: ________ Ethnicity: ________

Home Phone #: ____________________ Marital Status: Single Married Other

Cell Phone #: ____________________ Emergency Contact Name: ____________________

Work Phone #: ____________________ Emergency Contact Phone #: ____________________

Primary Insurance: ____________________ If injury was related to an accident, was it an:

Group #: ____________________ Auto Accident ☐ Other ☐

Member ID #: ____________________ Work Related Injury ☐

Subscriber Name: ____________________ Auto Claim #: ____________________

Date of Birth: ____________________ Adjuster Name: ____________________

Relation: ____________________ Adjuster Phone #: ____________________

Secondary Insurance: ____________________ Date of Accident: ________ Case Open?: Y / N

Group #: ____________________ Workers Compensation Adjuster: ____________________

Member ID #: ____________________ Workers Compensation Claim #: ____________________

Reason for visit: ____________________ Adjuster Phone #: ____________________

Referred by: ____________________ Date of Injury: ________ Case Open?: Y / N

Primary Care Physician: ____________________ Attorney Name: ____________________

Cardiologist: ____________________ Attorney Phone #: ____________________

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION AND RECORDS: I hereby authorize MIDISC, PLLC to release and/or obtain any information required in the course of my examination and treatment. This includes sending records by fax machine. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physicians participation with my health plan. I also authorize records to be mailed to me upon my verbal request.

SIGNED (patient or parent, if minor): ____________________ DATE: ____________

AUTHORIZATION TO PAY: I hereby authorize payment directly to MIDISC, PLLC for the surgical and/or medical benefits. If any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered or paid by my insurance in a timely manner.

SIGNED (patient or parent, if minor): ____________________ DATE: ____________

AUTHORIZATION TO TREAT MINOR: I hereby authorize the physician, physician assistants, technicians or other authorized medical personnel of MIDISC, PLLC to treat the above patient.

SIGNED (patient or parent, if minor): ____________________ DATE: ____________

Medications and Allergies

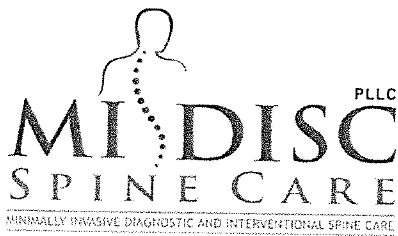
Medications:	Dose:	Directions:	Prescribed by:

Allergies	Reaction

Pharmacy Name ____________________ **Phone #** ____________________

I verify that the listed medications and allergies are accurate to the best of my knowledge. I give permission to verify my medication or narcotic treatment with my primary care doctor and/or other treating physicians.

SIGNED (Patient or Guardian): ______________________________ DATE: ______________



Notice of Privacy Rights

Acknowledgement of Reciept of Notice of Privacy Rights

I, ____, acknowledge that I have received a copy of MIDISC, PLLC's 'Notice of Privacy Practices'. This Notice described how MIDISC, PLLC may use and disclose my protected health information, certain restrictions of the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ ________________

Patient or Legally Authorized Individual Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, MIDISC PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to MIDISC PPLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MIDISC PLLC reserves the right to revise its Notive of Privacy Practices at anytime. A revised Notice of Privacy practes may be obtained by forwarding a written request to MIDISC PLLC Privacy Officer at 3067 Tamiami Trail Suite 3, Port Charlotte, Fl 33952.

With my consent, MIDISC PLLC may call my home or other designated 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 call pertaining to my my clinical care, including laboratory results among others.

With my consent, MIDISC PLLC may mail to my home or other designated 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.

However, 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 MIDISC PLLC's use and disclosure of my protected health information (PHI) to out treatment, payment and healthcare operations (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, MIDISC PLLC may decline to provide treatment to me.

____

Patient or Legally Authorized Individual Signature

____

Patients Printed Name

____ ________________

Legal Guardian Printed Name (If applicable) Date

Patient Authorization to Release Protected Health Information

I, ______________________________, HEREBY AUTHORIZE REPRESENTATIVES OF MIDISC, PLLC TO DISCUSS MY CARE/CONDITION WITH THE FOLLOWING PERSON(S):

Name: ____________________	Name: ____________________
Address: ____________________	Address: ____________________
City/State/Zip: ____________________	City/State/Zip: ____________________
Relationship: ____________________	Relationship: ____________________
Phone #: ____________________	Phone #: ____________________
Name: ____________________	Name: ____________________
Address: ____________________	Address: ____________________
City/State/Zip: ____________________	City/State/Zip: ____________________
Relationship: ____________________	Relationship: ____________________
Phone #: ____________________	Phone #: ____________________

Medical Information discussed / disclosed may include (initial all that apply):

☐ Alcohol and/or Drug Abuse ☐ Sexual Transmitted Disease (STD) ☐ Mental Health

☐ Acquired Immunodeficiency Syndrome (AIDS) ☐ Human Immunodeficiency Virus (HIV) Infection

☐ Only information regarding treatment provided at MIDISC, PLLC ☐ Not applicable

☐ I understand that I have the right to inspect the medical records requested and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by State or Federal Law

PATIENT: ____________________ (Printed Name)

PATIENT: ____________________ (Signature or Legal Guardian)

____________________ DATE

☐ I would like to have a copy of this authorization for my personal files.

MI DISC PLLC
SPINE CARE
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

PATIENT MEDICAL HISTORY

Name: ______________________________ Date: __________

Hand Dominance: ☐ Left ☐ Right

Past Medical History: (Please Check any of the following that you have experienced.)

☐ AIDS	☐ DEPRESSION	☐ HIGH CHOLESTEROL	☐ POLIO
☐ A-FIB	☐ DIABETES	☐ HIGH BLOOD PRESSURE	☐ PSYCHOLOGICAL PROBLEMS
☐ ANEMIA	☐ DIVERTICULOSIS	☐ HIV	☐ RHEUMATIC FEVER
☐ ANXIETY	☐ EAR TROUBLE	☐ IRREGULAR HEART BEAT	☐ SCOLIOSIS
☐ ARTHRITIS	☐ ENLARGED PROSTATE	☐ IRRITABLE BOWEL SYNDROME	☐ SEIZURES
☐ ASTHMA	☐ FIBROMYALGIA	☐ JAUNDICE	☐ SEXUALLY TRANSMITTED DISEASE
☐ BIPOLAR DISORDER	☐ GASTRITIS	☐ KIDNEY DISEASE	☐ STROKE
☐ CANCER:__________	☐ GERD (ACID REFLUX)	☐ KIDNEY STONES	☐ THYROID DISEASE
☐ COLON POLYP	☐ GLAUCOMA	☐ LIVER DISEASE	☐ TUBERCULOSIS
☐ CONGESTIVE HEART FAILURE	☐ GOUT	☐ LUPUS	☐ ULCERS
☐ COPD/Emphysema	☐ HEAD INJURY	☐ OSTEOPOROSIS	
☐ CORONARY ARTERY DISEASE	☐ HEART ATTACK/ANGINA	☐ PARKINSONS DISEASE	
☐ DEEP VENOUS THROMBOSIS	☐ HEPATITIS C	☐ PERIPHERAL VASCULAR DISEASE	

☐ OTHER MEDICAL PROBLEMS: ______________________________

____

____

____

Past Surgical History:

Type of Surgery	Year	Physician	Type of Surgery	Year	Physician

MI DISC PLLC
SPINE CARE
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

Social History / Family History

Name: ______________________ Date: __________

Social History

Do you smoke now?	☐ Yes	☐ No	______ packs/day	______ # of yrs.
Previous history of smoking in the past?	☐ Yes	☐ No	______ packs/day	______ # of yrs.
Do you drink alcohol?	☐ Yes	☐ No	______ number of drinks/wk.	
Do you have a history of alcohol abuse?	☐ Yes	☐ No		
Do you have a history of drug abuse?	☐ Yes	☐ No		

Highest level of education completed: ☐ Grade School ☐ High School ☐ Associate Degree ☐ Bachelor Degree ☐ Graduate School

Employment Status? ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Disabled

Occupation: ______________________

Does your job require you to: ☐ Lift or carry greater than 15 lbs. ☐ Work overhead ☐ Bend or twist repetitively ☐ Repetitive motion of arms or legs

Marital Status? ☐ Single ☐ Engaged ☐ Married ☐ Seperated ☐ Divorced ☐ Widowed

Family History (Please Check all that apply)

Relative / Family Member (i.e., Mom, Grandfather)

______________________ ☐ Arthritis
______________________ ☐ Back or Neck Surgery
______________________ ☐ Back Pain / Sciatica
______________________ ☐ Cancer
______________________ ☐ Diabetes
______________________ ☐ Heart Attack/Disease
______________________ ☐ High Blood Pressure
______________________ ☐ Mental Illness
______________________ ☐ Muscle Disease
______________________ ☐ Neck Pain
______________________ ☐ Nerve Disease
______________________ ☐ Stroke

MI DISC PLLC
SPINE CARE
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

Family History (Continued)

Name: ______________________ Date: ________

Family History (Continued)

Relation				If deceased, cause of death
Father	☐ Alive	☐ Deceased	Age ______	______________
Mother	☐ Alive	☐ Deceased	Age ______	______________

History of Present Illness

Date Problem/Symptoms Started: ________

Location of symptoms/pain: (Please check all that apply)

☐ Neck Pain	☐ Left Shoulder Pain	☐ Left Arm Pain	☐ Left Hand Pain
	☐ Right Shoulder Pain	☐ Right Arm Pain	☐ Right Hand Pain
☐ Lower Back Pain	☐ Left Buttock Pain	☐ Left Hip Pain	☐ Left Leg Pain
	☐ Right Buttock Pain	☐ Right Hip Pain	☐ Right Leg Pain
☐ Mid Back Pain	☐ Left Foot Pain	☐ Right Foot Pain	

If you have numbness or tingling please specify where: ______________

____

How did the problem start?

☐ Home/Leisure ☐ At Work ☐ Motor Vehicle Accident ☐ Fall

☐ Other: ______________________________

____

Frequency of symptoms/pain: (Please check one)

☐ Constant ☐ Intermittent ☐ Rare

Since the onset of symptoms, has the problem: (Please check one)

☐ Improved ☐ Worsened ☐ Stayed the Same

Does coughing or sneezing cause any pain? ☐ Yes ☐ No

If yes, where? ______________________________

Which activities make your symptoms worse? (Please check all that apply)

☐ Walking	☐ Lying	☐ Bending/Twisting	☐ Working Overhead
☐ Sitting	☐ Kneeling	☐ Lifting/Carrying	☐ Other: ________
☐ Standing	☐ Typing	☐ Pushing/Pulling	________

MI DISC PLLC
SPINE CARE
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

History of Present Illness

Name: ______________________ Date: __________

List any activities, positions or treatments that makes the pain better: ______________________

____

Do you have weakness? (Please check all that apply)

☐ Left Leg ☐ Right Leg ☐ Left Arm ☐ Right Arm ☐ Muscle

☐ Other: ______________________

Do you a have problems with any of the following after new onset of Neck/Back Pain?:

Control of Urination	☐ Yes	☐ No
Bowel Movements	☐ Yes	☐ No

Have you experienced recent weight loss or fevers? ☐ Yes ☐ No

Diagnostic History (Please Check All That Apply)

				Date	Location
☐ X-RAY	☐ Cervical	☐ Lumbar	☐ Thoracic		
☐ MRI	☐ Cervical	☐ Lumbar	☐ Thoracic		
☐ CT Scan	☐ Cervical	☐ Lumbar	☐ Thoracic		
☐ Whole Body Bone Scan					
☐ EMG					
☐ Other: ______					

History of Treatment (Medications)

				Did this help?
Anti-Inflammatories Cox-2 Inhibitors	☐ Aleve ☐ Advil	☐ Voltaren ☐ Celebrex		☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
Muscle Relaxers	☐ Skelaxin ☐ Zanaflex	☐ Flexeril ☐ Valium	☐ Soma	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
Pain Medication	☐ Dilaudid ☐ Oxycodone	☐ Morphine ☐ Other: ______	☐ Hydrocodone	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief

MI DISC SPINE CARE PLLC
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

History of Treatment

Name: ______________________ Date: __________

History of Treatment (Medications Continued)

			Did this help?
Oral Steroids	☐ Prednisone	☐ Medrol Dose Pak	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
Other: ______________________			
Other Medications	☐ Neurontin	☐ Pamelor	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
☐ Paxil	☐ Zonegram	☐ Elavil	
☐ Amitriptyline	☐ Nortriptyline	☐ Prozac	

History of Treatment (Non-Operative Care)

			Did this help?
Conservative Care	☐ No Recent Therapy	☐ Exercise	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
	☐ Physical Therapy	☐ Braces/Corsets	
	☐ Chiropractic Care		
Injections	☐ Epidural Steroid Injections		☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
	☐ Injections in Muscle		
Physician(s) who did injections ______________________			

Previous Evaluation

Prior to the onset of your current problem, did you ever visit a healthcare provider for problems related to your spine? (If yes, please list physician) ☐ Yes ☐ No

Physician: ______________________ Date: __________

By signing you attest that all information provided is accurate and true to the best of your knowledge.

PATIENT: ______________________ (Printed Name)

PATIENT: ______________________ (Signature or Legal Guardian)

__________ DATE