MIDISC PLLC
SPINE CARE
MINIMALLY INVASIVE DIAGNOSTIC AND INTERVENTIONAL SPINE CARE

New Patient Form

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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 #: _____

Email Address: _____ I give permission to contact through email: Y / N

Primary Insurance: _____

Group #: _____

Member ID #: _____

Subscriber Name: _____

Date of Birth: _____

Relation: _____

Secondary Insurance: _____

Group #: _____

Member ID #: _____

Reason for visit: _____

Referred by: _____

Primary Care Physician: _____

If injury was related to an accident, was it an:

Auto Accident ☐ Other ☐

Work Related Injury ☐

Auto Claim #: _____

Adjuster Name: _____

Adjuster Phone #: _____

Date of Accident: _____ Case Open?: Y / N

Attorney Name: _____

Attorney Phone #: _____

Cardiologist: _____

Pulmonologist: _____

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: _____

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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: _____

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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

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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: _____ PATIENT: _____ _____
(Printed Name) (Signature or Legal Guardian) DATE

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

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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

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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

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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	_____

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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	☐ Voltaren		☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
	☐ Advil	☐ Celebrex		
Muscle Relaxers	☐ Skelaxin	☐ Flexeril	☐ Soma	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
	☐ Zanaflex	☐ Valium		
Pain Medication	☐ Dilaudid	☐ Morphine	☐ Hydrocodone	☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Good Relief ☐ Complete Relief
	☐ Oxycodone	☐ Other: _____		

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History of Treatment

Name: _____ Date: _____

History of Treatment (Medications Continued)

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

History of Treatment (Non-Operative Care)

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

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: _____ PATIENT: _____ _____

(Printed Name) (Signature or Legal Guardian) DATE