Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

Dear _____ Date: _____

**Welcome to THE B.A.C.K. CENTER**
**We have received your paperwork and are happy you chose us for your orthopedic needs**

Appointment Date: _____ Time: _____ with _____

X-Rays Appointment Date: _____ Time: _____ Located 5th Floor in the Crane Creek Medical Building

***Please note –x- ray appointments may be added to schedule at a later time***
***You will be notified of this change via telephone***

2222 S. Harbor City Blvd
6th Floor, Suite 610
Melbourne, FL 32901

650 S Courtenay
Parkway Suite 100
Merritt Island, FL 32952

Enclosed you will find your NEW PATIENT PAPERWORK. It is important that you complete this paperwork in its entirety and bring it with you for your appointment, you may go online and print this form out at **http://www.thebackcenter.net/pdf/new-patient-information.pdf.**

Your primary care physician or the physician that referred you should have faxed your medical records to our office. If they have not, you will need to contact them to do so.

**If your insurance plan requires authorization or referral from your primary care physician** to be seen by a specialist. **IT IS NECESSARY** that **you contact your PCP for the authorization**. Our office must receive authorization before you are seen for your appointment.

**YOU MUST BRING any previous x-rays, MRI's, CT/Myelograms or other films with you to your appointment**. It is necessary to hand carry the actual films themselves or discs with film on them and **not just the reports**. We are unable to see you without them, **your appointment WILL be rescheduled without these**.

**If you have had any previous testing such as bone density studies, NCV/EMG or bone scans; please bring the reports only to the visit. We will also need a current list of medications (including dosage and directions), allergies to medications and past surgical and medical history.**

**THIS IS A FRAGRANCE FREE OFFICE** Please help us to accommodate our patients who are chemically sensitive to fragrances and other scented products.

Thank you for not wearing perfume, aftershave, scented hand lotion, fragranced hair products and/or similar products.

If you have any questions, please feel free to contact our office at:
321-723-7716 ext. _____ We look forward to seeing you and participating in your care

**Thank you again for choosing THE B.A.C.K. Center.**

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

## Authorization for treatment and Assignment of Benefits
## Health Information Release and Privacy Practice Notice

I, _____ herby authorize THE B.A.C.K. Center or any of its physicians/providers
(Patient/Guarantor Name)
to evaluate and treat me for conditions requiring medical, surgical and pain management treatment. I authorize THE B.A.C.K. Center to furnish my insurance company(ies) or representative with any and all information that may be contained in my medical records. I also acknowledge that I have the right to restrict health information shared with my health insurance company(ies) if I pay cash or out of pocket in full for my visit.

It is my responsibility to notify THE B.A.C.K. Center and sign an Assignment of Benefits form for each visit that I do not want billed to my insurance company(ies). I further acknowledge that my health insurance company(ies) may not pay for future visits, procedures, or surgeries as a results without release of previous PHI in where my insurance company was not billed.

I further authorize payments to THE B.A.C.K. Center for provider benefits otherwise payable to me, but not to exceed the regular charges for this period of treatment. I understand that I am financially responsible to THE B.A.C.K. Center for charges/benefits not covered by this assignment. I also understand THE B.A.C.K. Center is not responsible for the terms of the contract(s) which I have with my insurance company(ies) and that in certain circumstances my insurance company(ies) may determine to pay all, some, or none of the charges resulting from my medical care provided by THE B.A.C.K. Center.

I authorize the person(s) listed below to have access to any and all of my health information including HIV, drug and alcohol abuse, and psychiatric records. THE B.A.C.K. Center is permitted to share any medical information with them, including but not limited to test results and information disclosed during office visits.

Authorized Person(s) Full Name: _____

You may notify me of test results, appointment reminders and other information regarding my health information as follows, please initial what applies below

_____ Detailed Message via - Please Circle which below:
Email Cell Home Work
_____ Okay to send Text for appointment reminders

_____ I do NOT wish to have any detailed messages left on any machine regarding health information

By signing this document, I acknowledge, understand, and direct that this authorization will remain in effect until revoked by me in writing.

I, _____ acknowledge that I have received and understand THE B.A.C.K. Center Notice of Privacy Practices.

_____ _____ _____
Printed Name Signature Patient/Guarantor Date

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

# New Patient Information

## Patient Demographic Information

_____,_____

Patient Last Name | Patient First Name | Patient Middle Initial

_____ Male _____ Female _____ _____-_____-_____

Patient DOB | Gender | Social Security #

_____

Race | Ethnicity | Preferred Language

_____

Patient Address | City/State/Zip Code | Cell # | Home #

_____

Patient Email Address | Emergency Contact Name | Cell Number | Other # | Relationship

## Patient Insurance Information

**Insurance # 1** (other than auto)

Name of Insurance Carrier: _____ Policy/ID #: _____

Phone # on Card: _____ Group #:_____

**Insurance # 2** (if applicable)

Name of Insurance Carrier: _____ Policy/ID #: _____

Phone # on Card: _____ Group #:_____

I Certify the Above Information is Correct (circle) Yes No

Patient or Guarantor Signature _____ Print Name: _____

## Who May We Thank for Your Referral to Our Office?

Name: _____ Phone # / Relationship: _____/_____

## Please tell us why you are here

Chief Complaint(s): _____

_____

Is this a work related injury? Yes _____ No_____ **If Yes, Please fill out Worker Compensation Section**

Is this an Auto Related injury? Yes _____ No_____ **If Yes, Please fill out Auto Section**

Is there litigation or a legal issue pending? Yes _____ No_____

If none of the above, please indicate type of injury: (please circle) Slip & Fall Lifting Accident

Other: _____

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Pt. Name: _____ Pt. DOB: _____

## Medical History

**Check all conditions that apply to you or immediate family**

**Cardiovascular**

| You | Family | |
|---|---|---|
| _____ | _____ | Peripheral Vascular Disease |
| _____ | _____ | Heart Attack |
| _____ | _____ | Hypertension |
| _____ | _____ | Stroke |
| _____ | _____ | Atrial Fib |
| _____ | _____ | Coronary Artery Disease |
| _____ | _____ | Congestive Heart Failure |
| _____ | _____ | High Cholesterol |
| _____ | _____ | Valvular Disorders |

**Hematologic**

| You | Family | |
|---|---|---|
| _____ | _____ | Anemia |
| _____ | _____ | Blood Clots |
| _____ | _____ | Bleeding disorders |

**Respiratory**

| You | Family | |
|---|---|---|
| _____ | _____ | Emphysema |
| _____ | _____ | Asthma |
| _____ | _____ | Sleep Apnea |
| _____ | _____ | COPD |

**Musculoskeletal**

| You | Family | |
|---|---|---|
| _____ | _____ | Osteoarthritis |
| _____ | _____ | Rheum. Arthritis |
| _____ | _____ | Osteoporosis |
| _____ | _____ | Gout |

**Psychiatric**

| You | Family | |
|---|---|---|
| _____ | _____ | Anxiety |
| _____ | _____ | Depression |
| _____ | _____ | Schizophrenia |

**Endocrine**

| You | Family | |
|---|---|---|
| _____ | _____ | Diabetes |
| _____ | _____ | Thyroid Disease Hypo / Hyper |
| _____ | _____ | Extreme Wgt. Gain |
| _____ | _____ | Extreme Wgt. Loss |

**Gastrointestinal**

| You | Family | |
|---|---|---|
| _____ | _____ | Colitis |
| _____ | _____ | Gallstones |
| _____ | _____ | Crohns Disease |
| _____ | _____ | Gastric Reflux |
| _____ | _____ | Gastric Bypass Surgery |

**Neurological**

| You | Family | |
|---|---|---|
| _____ | _____ | Migraines |
| _____ | _____ | Seizures |
| _____ | _____ | Multiple Sclerosis |
| _____ | _____ | Peripheral Neuropathy |
| _____ | _____ | Transient Ischemic Attack |
| _____ | _____ | Fibromyalgia |
| _____ | _____ | Alzheimer's |
| _____ | _____ | Parkinson's |
| _____ | _____ | Dementia |
| _____ | _____ | Head Injury |

**Infectious Disease**

| You | Family | |
|---|---|---|
| _____ | _____ | Aids/HIV |
| _____ | _____ | Hep A, B, C (specify) _____ |
| _____ | _____ | Tuberculosis |
| _____ | _____ | MRSA/Post-Operative Infection |

**Renal**

| You | Family | |
|---|---|---|
| _____ | _____ | Kidney Stones |
| _____ | _____ | Chronic Kidney Disease |
| _____ | _____ | Frequent Urinary Tract Infections |

**Cancer** – Type_____ Year Diagnosed_____with Chemotherapy_____Radiation_____

**Cancer** – Type_____ Year Diagnosed_____with Chemotherapy_____Radiation_____

**FEMALES**

Are you pregnant: Yes No Last Menstrual Period Date: _____ If applicable, Age at Menopause: _____

Birth control method: _____ Bilateral Tubal Ligation: Yes No If Yes, Date: _____

Hysterectomy: Yes No If Yes, (circle) Partial or Full Date: _____

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

## Medications

**To better serve you before your visit,**
**Please list ALL current Medications/Vitamins/Herbal Supplements with dosages, frequency taken and start date**
**It's very important to complete ALL fields. Bring your medication with you to your appointment**

| | **Name** | **Dose: (ex.: 1 application or 125 mcg)** mg/mcg/units/ topical application | **Frequency** (QD, BID, 1x) | **Start Date** |
|---|---|---|---|---|
| 1) | _____ | _____ | _____ | ____/____/____ |
| 2) | _____ | _____ | _____ | ____/____/____ |
| 3) | _____ | _____ | _____ | ____/____/____ |
| 4) | _____ | _____ | _____ | ____/____/____ |
| 5) | _____ | _____ | _____ | ____/____/____ |
| 6) | _____ | _____ | _____ | ____/____/____ |
| 7) | _____ | _____ | _____ | ____/____/____ |
| 8) | _____ | _____ | _____ | ____/____/____ |
| 9) | _____ | _____ | _____ | ____/____/____ |
| 10) | _____ | _____ | _____ | ____/____/____ |
| 11) | _____ | _____ | _____ | ____/____/____ |
| 12) | _____ | _____ | _____ | ____/____/____ |
| 13) | _____ | _____ | _____ | ____/____/____ |
| 14) | _____ | _____ | _____ | ____/____/____ |
| 15) | _____ | _____ | _____ | ____/____/____ |
| 16) | _____ | _____ | _____ | ____/____/____ |
| 17) | _____ | _____ | _____ | ____/____/____ |

**Medication Allergies:** Yes No If Yes, list medications and type of reaction

_____

_____

Brevard Orthopaedic Spine and Pain Clinic, Inc.
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Pt. Name: _____ Pt. DOB: _____

**Prior Surgeries and date(s):**

_____

_____

## Social History

Do you use tobacco products? Yes _____ No_____ If Yes, No. of cigarettes per day: _____ No. of years: _____

Do you drink Alcohol? Yes _____ No_____ Liquor / Beer / Wine/Other_____ (circle which pertain to you)

How often? Daily, No. of drinks _____ Weekly, No. of drinks _____ Monthly, No. of drinks _____
Socially, No. of drinks/frequency _____/_____

Do you participate in recreational or IV Drug use? Yes _____ No_____

Do you smoke marijuana? Yes _____ No_____ Rarely _____

Do you consume caffeine? Yes _____ No_____ If Yes, How frequently _____ (1X day, 2x day, 3x day)

What is your dominant hand? Right ____ Left ____ Both ____

What is your primary language? _____

What country were you born in? _____

Are you employed? Yes _____ No_____

Have you ever been in the military? Yes _____ No_____If Yes, what Branch? _____

Do you have children? Yes _____ No_____

Do you have animals in your home? Yes _____ No_____If yes, what kinds? _____

Do you wear your seatbelt in the car? Yes _____ No_____

Do you agree to a blood transfusion if necessary? Yes _____ No_____

Do you have a living will? Yes _____ No_____

Do you have a Do Not Resuscitate in order? Yes _____ No_____

Do you have a Do Not place on life support in order? Yes _____ No_____

Do you have a Power of Attorney? Yes _____ No _____ If Yes who, _____

Do you have a Health Care Proxy? Yes _____ No _____ If Yes who, _____

**I certify the above information is correct Yes _____ No_____**

_____ _____ _____

**Printed Name** **Signature Patient/Guarantor/Legal Authorized Rep** **Date**

Pt. Name: _____ Pt. DOB: _____

## Review of Systems

**Do You CURRENTLY experience any of the below? If yes, please check off what pertains to you**

General
____ Major weakness
____ Fever
____ Increased Weight Gain
____ Decreased Weight Loss

Skin
____ Nail Changes
____ New Lesions
____ Rash
____ Skin Color Changes

HEENT
____ Blurred Vision
____ Decreased Hearing
____ Dry Mouth
____ Ear Ringing
____ Nose Bleeds
____ Oral Ulcers
____ Sore Throat
____ Swollen Glands
____ Head Injury

Respiratory
____ Coughing up blood
____ Wheezing
____ Chronic Cough

Cardiovascular
____ Chest Pain
____ Shortness of Breath
____ Leg Swelling
____ Palpitations

Urogenital
____ Painful Urination
____ Menstrual Irregularities
____ Increased Urination
____ Nighttime Urination
____ Blood in Urine
____ Testicular mass
____ Testicular Pain
____ Impotence

Musculoskeletal
____ Joint Pain
____ Joint Redness
____ Joint Swelling
____ Joint Stiffness
____ Muscle Weakness
____ Muscle Aches/Pains

Gastrointestinal
____ Abdominal Pain
____ Change in Bowel Habits
____ Constipation
____ Diarrhea
____ Nausea
____ Vomiting
____ Rectal Bleeding
____ Trouble Swallowing

Hematology
____ Easy Bruising
____ Enlarged Lymph Nodes
____ Prolonged Bleeding

Neurological
____ Loss of Bowel Control
____ Dizziness
____ Headaches
____ Tingling/Numbness in arms or legs
____ Passing out
____ Seizures
____ Tremors

Psychiatric
____ Anxiety
____ Change in Sleep Pattern
____ Depression
____ Hallucinations
____ Suicidal Thoughts

Endocrine
____ Appetite increase/decrease
____ Cold Intolerance
____ Increased Thirst
____ Hair Changes/Loss
____ Sexual Dysfunction

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Pt. Name: _____ Pt. DOB: _____

## OSTEOPOROSIS RISK FACTOR SURVEY

Please circle below:

Race: Asian Caucasian African American Hispanic Native American Other

Have you ever broken any bones? Yes _____ No _____

If yes, which ones? ____ Wrist ____ Elbow ____ Shoulder ____ Hip ____ Compression Fracture Back

____ Other _____

Are you postmenopausal? Yes _____ No _____ If yes, when did you start menopause? _____

Have you ever had a Dexa Bone Density Scan? Yes _____ No _____

If yes, when? _____ results _____ Normal _____ Osteoporosis _____ Osteopenia

Have you ever taken any of the following medications for MORE THAN ONE MONTH?

| | | |
|---|---|---|
| Thyroid replacement medicine | Yes _____ | No _____ |
| Steroids including inhalers for asthma | Yes _____ | No _____ |
| Estrogen/Testosterone replacement | Yes _____ | No _____ |
| Bisphosphonates (Fosamax, Actonel) | Yes _____ | No _____ |
| Anticonvulsants (Neurontin, Topamax, Dilantin, etc.) | Yes _____ | No_____ |
| Heparin | Yes _____ | No _____ |
| Chemotherapy | Yes _____ | No _____ |
| Lithium | Yes _____ | No _____ |
| Methotrexate | Yes_____ | No _____ |
| Antacids (Maalox, Gaviscon, Mylanta) | Yes _____ | No _____ |
| Cholestyramine (Questran) | Yes _____ | No _____ |

**I certify the above information is correct Yes _____ No _____**

**Printed Name** **Signature Patient/Guarantor** **Date**

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

**Complete this form <u>ONLY for BACK and/or LEG PAIN</u>** **Not applicable ____**

Have you been treated in this office before? Yes ____ No ____
If Yes, when/by whom? _____/_____

Have you had a treatment for this problem prior to this accident/injury? Yes ____ No ____
If Yes, when and by what provider? _____/_____

How long have you had this problem? _____

I feel my pain is (circle all that apply)

Sharp Burning Tingling Tearing Dull Cramping Weakness Aching

Mild Stiff Discomfort Tightness Severe Numbness Other _____

**Over the last few days, my average pain is:**

**Use the scales below:**

**1)** **(Please Circle Number)**

**0 1 2 3 4 5 6 7 8 9 10**

**No Pain - - - - - - - - - - - - - - - - - - - Moderate Pain- - - - - - - - - - - - - - - - Worst Pain Possible**

**2)**

| **My Pain is:** | **Better** | **Worse** | **No Change** |
|---|---|---|---|
| In the Morning | _____ | _____ | _____ |
| Bending Forward | _____ | _____ | _____ |
| Sitting in the car | _____ | _____ | _____ |
| Night time Pain | _____ | _____ | _____ |
| Lying on my stomach | _____ | _____ | _____ |
| Coughing/Sneezing | _____ | _____ | _____ |
| Prolonged sitting | _____ | _____ | _____ |
| Prolonged standing | _____ | _____ | _____ |
| Prolonged walking | _____ | _____ | _____ |
| Riding Bike | _____ | _____ | _____ |
| Exercise | _____ | _____ | _____ |

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

**Complete this form <u>ONLY for NECK and/or ARM Pain</u> Not applicable ____**

Have you been treated in this office before? Yes ____ No ____

If Yes, when/by whom? _____/_____

Have you had a treatment for this problem prior to this accident/injury? Yes ____ No ____

If Yes, when and by what provider? _____/_____

How long have you had this problem? _____

I feel my pain is (circle all that apply)

Sharp Burning Tingling Tearing Dull Cramping Weakness Aching

Mild Stiff Discomfort Tightness Severe Numbness Other _____

**Over the last few days, my average pain is:**

**Use the below scales:**

**1)** **(Please Circle Number)**

**0 1 2 3 4 5 6 7 8 9 10**

**No Pain - - - - - - - - - - - - - - - - - - - - Moderate Pain- - - - - - - - - - - - - - - - - Worst Pain Possible**

**2)**

| **My Pain is:** | **Better** | **Worse** | **No Change** |
|---|---|---|---|
| In the Morning | _____ | _____ | _____ |
| Bending Forward | _____ | _____ | _____ |
| Sitting in the car | _____ | _____ | _____ |
| Night time Pain | _____ | _____ | _____ |
| Lying on my stomach | _____ | _____ | _____ |
| Coughing/Sneezing | _____ | _____ | _____ |
| Prolonged sitting | _____ | _____ | _____ |
| Prolonged standing | _____ | _____ | _____ |
| Prolonged walking | _____ | _____ | _____ |
| Riding Bike | _____ | _____ | _____ |
| Exercise | _____ | _____ | _____ |

Pt. Name: _____ Pt. DOB: _____

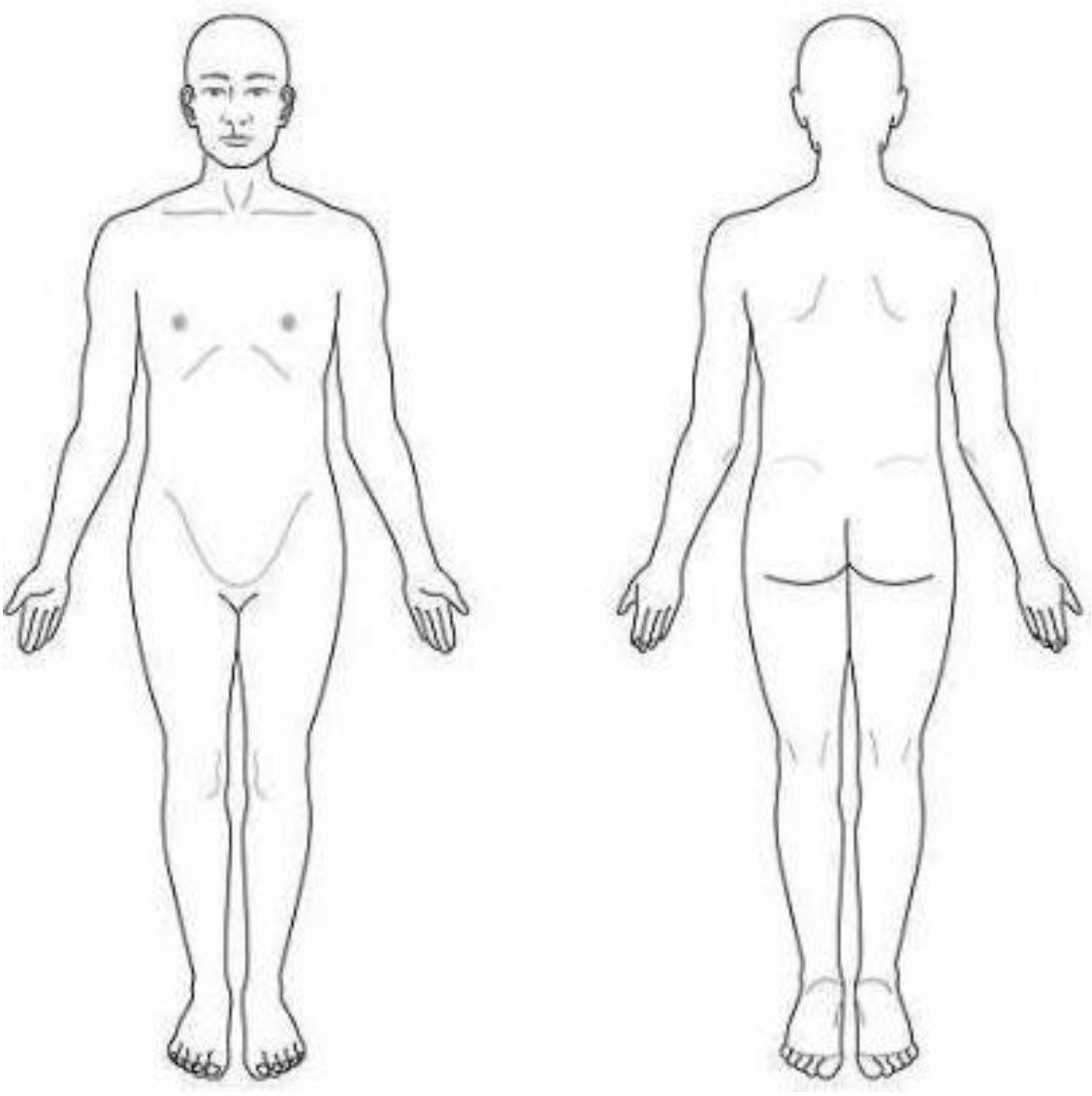
Please indicate areas of pain on the model below:

Mark areas with the following

Tingling (0000)

Pain (xxxx)

Numbness (IIII)



Right Left Left Right

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

## Patient Medical Record Release

Date of Request: _____/_____/_____

Patient's Phone #: (____)_____

Please indicate the records you are requesting

_____ Dictation date from _____ to _____ Provider _____

_____ Labs date from _____ to _____Specify Lab/Facility_____

_____ Diagnostic test(s): All or specific test(s)_____

_____ Billing Record(s): All or specific date(s) of service_____

**THIS IS FOR PAPER REPORTS ONLY, NOT FILMS**
**IF YOU NEED THE ACTUAL FILMS, PLEASE CONTACT THE X-RAY DEPARTMENT**

_____ Operative Reports(s): All or specific reports_____

_____

_____ Entire Chart (Not including external medical records)

**I understand that if I request duplication of records within one year time period, I will be charged a fee of up to $1.00 per page for each page copied. Please make a copy of your records for future use**

____ Patient will pick up

____Records to be mailed to the below address

_____
Name

_____
Address

_____,_____
City State Zip Code

_____ _____ _____
Printed Name Signature Patient/Guarantor Date

REASON for Request:

_____

_____

---

Proof of ID: _____ Yes _____ No

_____ _____
Witness Name Signature Date Copied

Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

## Authorization to Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. _____ Patient Acct. # _____

I hereby authorize the B.A.C.K. Center to obtain Protected Health Information of the above-named patient from:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Information authorized to release: ☐ Medical Records ☐ Billing Records

Information authorized to release for services rendered during the period from _____ to _____, to include any Federal and State protected information under the Florida Statue 394.459 (9) Psychiatric information, Florida Statue 397.053 and Florida statue 396.112, Drug and/or Alcohol Abuse information and Florida Statue 381.609 (2) Human Immunodeficiency Virus test results (AIDS and related conditions). I understand that authorizing the disclosure of this protected health information is voluntary.

I understand and direct that this authorization remain in effect for six (6) months or until I revoke it in writing. I hereby release your office or facility and its employees from any and all liability that may arise from the release of this information as I have directed.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient. Signature of Witness

Please send the above information to:

The B.A.C.K. Center
2222 S. Harbor City Blvd, Ste 610
Melbourne, Fl. 32901
(321) 723-7716

Attention: B.A.C.K. Center Physician: _____

B.A.C.K.™ Back Authority for Contemporary Knowledge