



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

Pt. Name: _____

Pt. DOB: _____

ATTENTION

All New Patients and IME Patients

You **MUST** bring with you to your appointment ALL prior X-rays, MRI's, CT Scans, Myelograms and any other films pertaining to your injury.

WITHOUT these films the surgeons cannot do a complete evaluation and you will **NOT** be seen.

The surgeons at **The B.A.C.K. Center** proudly serve on the hospital trauma teams throughout Brevard County. These units were established to respond to severe medical emergencies and when these emergencies present, the physicians and surgeons who are a part of these units must respond.

During these rare cases when we are called upon to assist, we ask your patience and understanding for the inconvenience of having your appointment rescheduled.

We thank you in advance for your understanding and cooperation.

Warmest Regards,

Richard A. Hynes, MD, FACS

Devin K. Datta, MD



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 X-Ray Department**

***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.

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; and your appointment may be rescheduled.

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: _____@
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

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Patient Advocate

Because we are committed to providing you with clinically superior, patient centric care,

Brevard Orthopaedic Spine & Pain Clinic, Inc. (The B.A.C.K. Center) has a Patient Advocate on staff that is dedicated to ensuring that your care experience is always a positive one.

Should you have a complaint, problem or concern or require assistance in resolving any issue; or if you are simply interested in learning more about your patient rights and responsibilities, our Patient Advocate stands ready to serve you and your family in a safe, confidential setting.

Our Patient Advocate is:

Patricia Vargas

Phone: (321) 501-3732

Email: helpme@thebackcenter.net

Hours: Monday – Friday, 8:00am to 5:00pm

****Please keep this page for your reference****



Pt. Name: _____

Pt. DOB: _____

No Show Policy

Effective January 1, 2018

APPOINTMENT NO SHOW: Effective January 1, 2017 we implemented a **no show policy**. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit if necessary. We ask that if you must change an appointment, please give us at least 1 business days' notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

In the event that you "no show" or cancel with less than 1 business days' notice for a scheduled appointment, the following fees will be applied:

Office Visit No Show Fee- \$35.00

Procedure Visit No Show Fee- \$75.00

THIS FEE IS NOT COVERED BY YOUR INSURANCE & MUST BE PAID PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT.

For your convenience, payments for these fees can be made in person at our office or by phone where we accept cash, checks (in office) and all major credit cards. After 3 no-shows, it will be at the physician's discretion to refer you to an outside provider.

By signing this statement, I am acknowledging I have been informed/provided the No Show Policy information.

Patient Signature: _____ Date: _____



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 result 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

*To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Initial: _____

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 Demographic Information

Patient Last Name Patient First Name Patient Middle Initial
Male Female
Patient DOB Gender Social Security #

Race Ethnicity Preferred Language Martial Status

Gender Identity: _____ or Choose not to disclose

Assigned sex at Birth: _____ or Choose not to disclose

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: _____



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

Musculoskeletal

- You Family
Osteoarthritis
Rheum. Arthritis
Osteoporosis
Gout

Respiratory

- You Family
Emphysema
Asthma
Sleep Apnea
COPD

Psychiatric

- You Family
Anxiety
Depression
Schizophrenia

Endocrine

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

Neurological

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

Gastrointestinal

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

Renal

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

Infectious Disease

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

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: _____



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) _____	_____	_____	____/____/____

Allergy/Reaction

Please list ALL Types of Allergies and Reactions including: Medication, Dye or Contrast, Environmental and Other
(ie: Latex)

- | | | |
|----------|----------|----------|
| 1 _____ | 2 _____ | 3 _____ |
| 4 _____ | 5 _____ | 6 _____ |
| 7 _____ | 8 _____ | 9 _____ |
| 10 _____ | 11 _____ | 12 _____ |



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Pt. Name: _____

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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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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



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Pt. Name: _____

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Complete this form ONLY for BACK and/or LEG PAIN

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	_____	_____	_____



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Pt. Name: _____

Pt. DOB: _____

Complete this form ONLY for NECK and/or ARM Pain 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: _____

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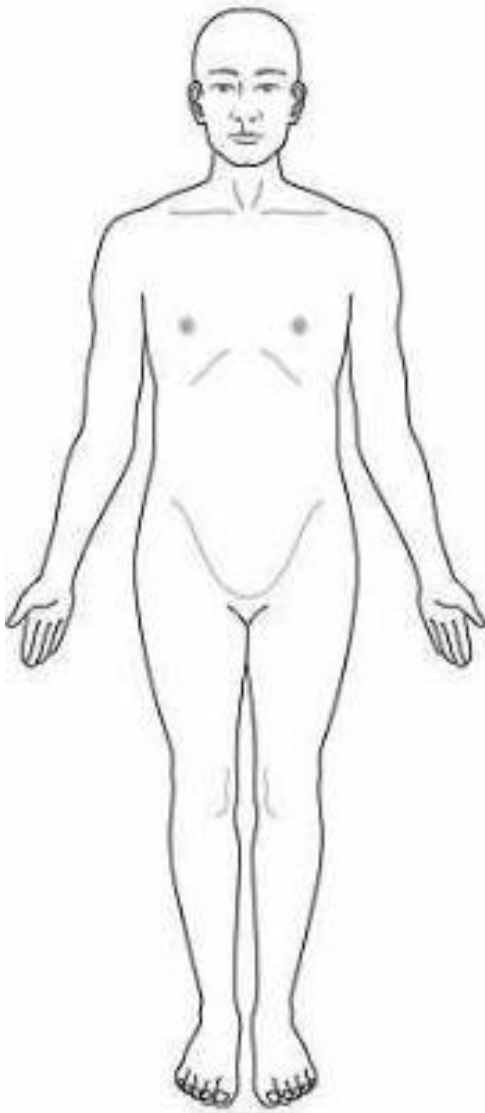
Please indicate areas of pain on the model below:

Mark areas with the following

Tingling (0000)

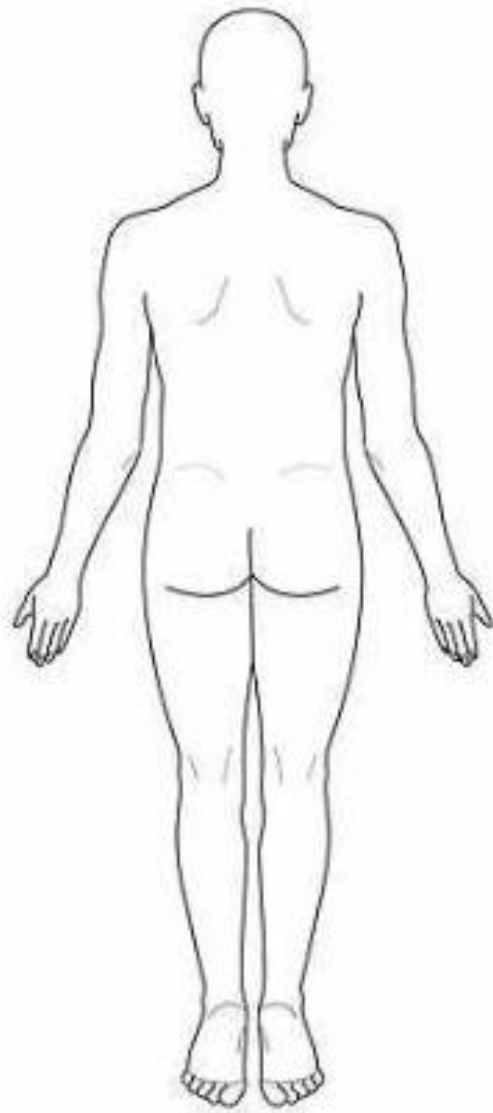
Pain (xxxx)

Numbness (III)



Right

Left



Left

Right



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 Imaging

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