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: 321-541-1570
We look forward to seeing you and participating in your care

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

Pt. Name: _____ Pt. DOB: _____

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

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

Pt. Name: _____ Pt. DOB: _____

Worker Compensation Information

Please complete entire form

Date of Workers Comp Report: _____/_____/_____

_____

Employer name | Employer Address | City/State/Zip code

_____

Employer Phone # | Injury Verified By | Contact Info

_____

Name of Worker Compensation Carrier | Address | City/State/Zip code

_____

Adjuster Name | Phone #

Injury Information

_____AM/PM_____

Date of Injury | Time: | Place of Injury

_____

Accident reported: employer name | Name of person reported to

Please give a full description of how the accident happened:

_____

_____

_____

Have you lost time from work: Yes / No How Much time? _____

Are you seeing other doctors for this injury? Yes / No Doctor(s) Name: _____

Diagnosis: _____

X-Rays? Yes / No If Yes, Where: _____

Other Tests? Yes / No If Yes, Please tell us where, by whom and the results

_____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that the claims for Worker Compensation benefits are denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges

_____ _____ _____

Printed Name | Signature | Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered.** This means that those services have **already been provided.**

   _____

   _____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

Licensed Medical Professional Rendering Treatment *(Signature by his or her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

REQUEST FOR RESIDUAL PIP BENEFITS

VIA FACSIMILE TO: _____ DATE: _____

TO: _____

Address: _____

ATTN: _____

I, the undersigned patient, am receiving medical care and treatment from The B.A.C.K. Center, 2222 S. Harbor City Blvd. Ste. 610, Melbourne, FL 32901 EIN: 59-3297304

I authorize you to furnish and fax immediately to the above named provider any all of the following information, which may be requested.

a. PIP payout log on my Personal Injury Protection Claim
b. Amount of PIP and Medical Payments coverage
c. The amount of unexhausted benefits

CLAIM NUMBER: _____

Date of Automobile _____ Accident:

Policy Number _____

Date _____ _____
Month/Day/Year Signature of Patient

_____
Printed Name

CONFIDENTIALITY NOTE: The information contained in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity names above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this telecopy is strictly prohibited. If you have received this telecopy in error, please immediately notify the sender above and return the original message to us at the address above by the United States Postal Service.

2222 S. Harbor City Blvd., Suite 610, Melbourne, FL 32901
Phone 321-723-7716 Fax 321-723-0604

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

Pt. Name: _____ Pt. DOB: _____

Auto Information

Date of Accident: _____/_____/_____

Name of Auto Insurance: _____

Auto Policy ID #: _____

Auto Claim #: _____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that my claims for my Auto Benefits are denied. I understand that filing for Auto benefits does not relieve me from my responsibility for the payment of all charges.

*******Please bring your auto insurance card with you to your first visit*******

_____ _____

Printed Name Signature Patient/Guarantor Date

You have stated that you have an injury as a result of an automobile accident and that you have Auto Insurance. Please provide us with this information at the time of service. In addition, you will also be required to provide your health insurance, as we will file services to your health insurance should your auto insurance become exhausted. If this is the case, you may receive requests from your health carrier relating to your accident. Please ensure that you respond promptly in order to prevent processing delays. Should your health insurance require an authorization for treatment, you will be responsible for obtaining authorization and providing this information to our office prior to your visits.

If you are working with an attorney, please provide us with this information below:

Attorney Name:_____Case #:_____

Address:_____

Phone/Fax #:_____

Please note that you will also be required to sign a Personal Injury Protection Disclosure and Acknowledgement Form, as attached, for each initial office visit per provider.

Should you have any questions pertaining to services rendered please do not hesitate to contact our patient financial services office at (321) 725-5050.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

_____ _____ _____

Name (PRINT or TYPE) Signature Date

2222 S. Harbor City Boulevard * Melbourne, FL * 32901 * 321-725-5050

PIP PATIENT LOG

Patient______________________________ **Claim No.**____________________

_____ Office Visit
_____ Manual Therapy
_____ Therapeutic Exercises
_____ Therapeutic Ultrasound
_____ Massage Therapy
Date_________________

_____ Hot/Cold Pack
_____ Whirlpool
_____ Electrical Stimulation
_____ Cervical Traction
_____ X-Rays
Patient Signature____________________________________

_____ Gait Training
_____ Functional Activities
_____ Other________________
_____ ______________________
_____ ______________________

_____ Office Visit
_____ Manual Therapy
_____ Therapeutic Exercises
_____ Therapeutic Ultrasound
_____ Massage Therapy
Date_________________

_____ Hot/Cold Pack
_____ Whirlpool
_____ Electrical Stimulation
_____ Cervical Traction
_____ X-Rays
Patient Signature____________________________________

_____ Gait Training
_____ Functional Activities
_____ Other________________
_____ ______________________
_____ ______________________

_____ Office Visit
_____ Manual Therapy
_____ Therapeutic Exercises
_____ Therapeutic Ultrasound
_____ Massage Therapy
Date_________________

_____ Hot/Cold Pack
_____ Whirlpool
_____ Electrical Stimulation
_____ Cervical Traction
_____ X-Rays
Patient Signature____________________________________

_____ Gait Training
_____ Functional Activities
_____ Other________________
_____ ______________________
_____ ______________________

_____ Office Visit
_____ Manual Therapy
_____ Therapeutic Exercises
_____ Therapeutic Ultrasound
_____ Massage Therapy
Date_________________

_____ Hot/Cold Pack
_____ Whirlpool
_____ Electrical Stimulation
_____ Cervical Traction
_____ X-Rays
Patient Signature____________________________________

_____ Gait Training
_____ Functional Activities
_____ Other________________
_____ ______________________
_____ ______________________

_____ Office Visit
_____ Manual Therapy
_____ Therapeutic Exercises
_____ Therapeutic Ultrasound
_____ Massage Therapy
Date_________________

_____ Hot/Cold Pack
_____ Whirlpool
_____ Electrical Stimulation
_____ Cervical Traction
_____ X-Rays
Patient Signature____________________________________

_____ Gait Training
_____ Functional Activities
_____ Other________________
_____ ______________________
_____ ______________________

My signature on this document attests to the fact that the services set forth herein were actually rendered. The person rendering the medical services for which a claim will be submitted has explained the services to me in detail.

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

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: _____

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

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: _____

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_____

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

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

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

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: _____

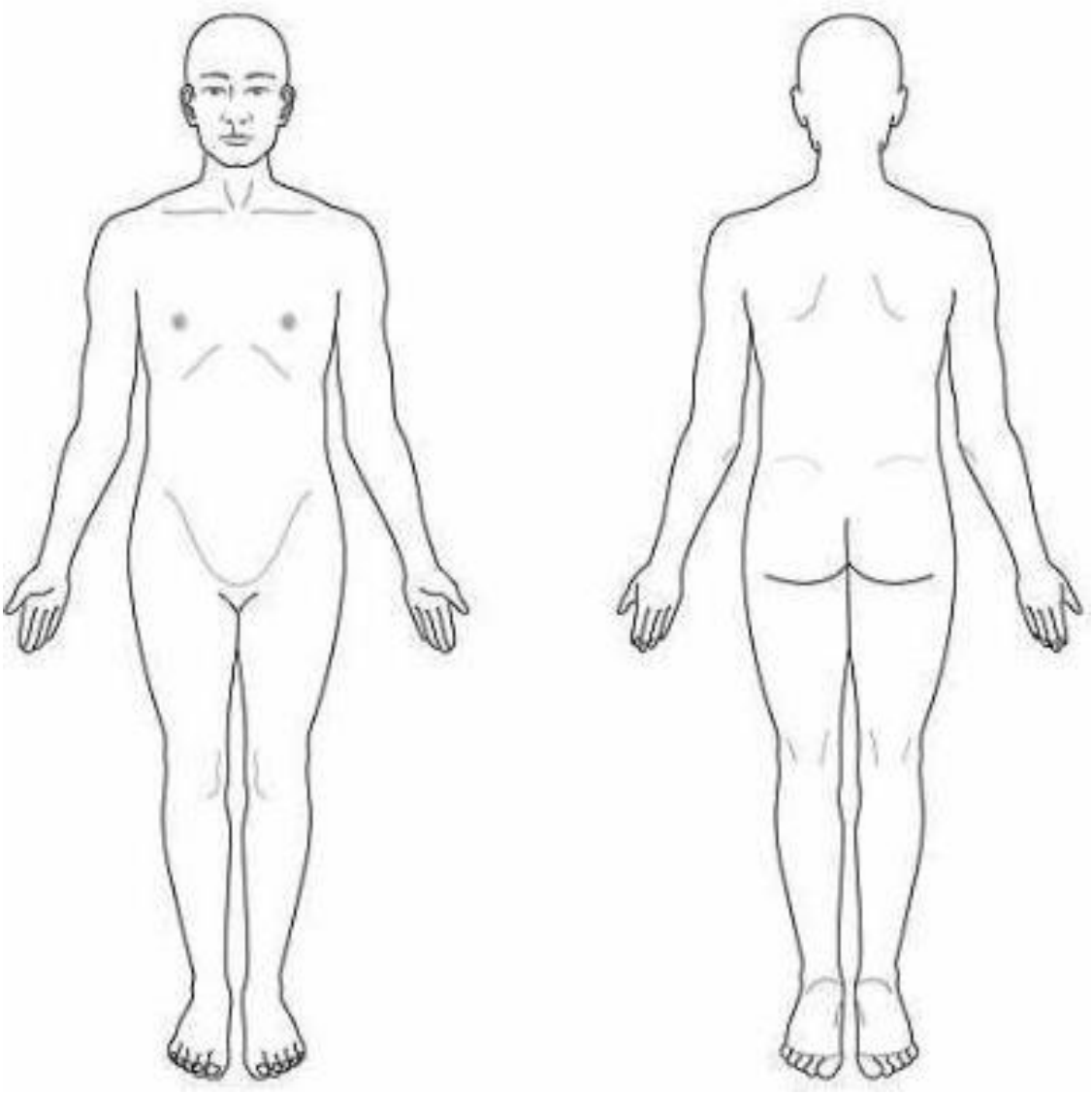
Please indicate areas of pain on the model below:

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: _____

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