Patient Information Sheet

DATE_____/_____/_____ ACCT#________________

WHO SENT YOU TO THIS OFFICE? ______________________________

Date of first symptom_____/_____/_____

Attorney assisting you with this problem: (circle) YES/ NO If yes whom: ____________________

Problem related to: (circle) Employment Auto Other (please list) ____________________

Patient's full name: (LAST) ______________ (FIRST) ______________ (MIDDLE) __________

Social Security Number: _____-_____-_____ Patient's date of birth: ___/___/___ Age: ___Sex:____

Patient's Telephone Number: HOME: ____________WORK:____________CELL:____________

Seasonal Address________________________City__________ST________Zip________

Permanent Address: ________________________City__________ST________Zip________

Employer: ____________________________ Employer Phone Number: ( ) ____________

Marital Status: ☐ S ☐ M ☐ Other

Spouse's full name (parent's name if minor):________________________Date of Birth________

Primary Care Physician Name: ____________________________________

********INFORMATION TO BE FILLED OUT BY OFFICE********

Problem to be treated: ________________________Ref.Physician:____________________

☐ Left ☐ Right ☐ Bilateral ☐ Acute ☐ Chronic ☐ Multiple body parts list: ____________

Name____DOB:________________

Home Phone #:____________________________Work/Cell #__________________________

Previous Treatment____

Referring to send: MRI CT X-RAY From Where? __________________________

Called For? ☐Yes ☐No Patient to bring? ☐Yes ☐No

Insurance Information: ____

Referral Needed? ☐Yes ☐No From Where? __________________________

Completed By: ____________________________________

APPT. DATE: ________________ TIME:________________

PATIENT NAME__________________ DATE: ______________

Chief Complaint of Reason for Visit (Please circle all that apply)

Low back pain   Neck pain

Symptoms:
Can you describe your pain as?
Constant   Burning   Sharp   Comes and goes   Ache   Dull

How long have you had your pain? ____________
How is your pain compared to when it first started? Better   Worse   Same

Please rate your pain on a scale from 1-10 (10 being most severe) _______
Pain worsens with: Walking   Standing   Sitting   Lying down   Bending
Pain improves with: Walking   Standing   Sitting   Lying down   Bending forward

Does the pain radiate down your: Left/Right arm   Left/Right leg   Buttock   Other: __________

Do you have numbness and/or tingling? YES   NO   Where? ____________________

Does your pain affect any of the following activities? (Circle those that apply)
Walking   Sitting   Housecleaning   Running   Stairs   Driving   Sleeping   Dressing
Sports   Standing

Have you tried any of the following? (Circle those that apply)
Heat   Ice   Tylenol   Advil   Muscle relaxants   Pain medication   Physical therapy   Cane
or Walker   Exercise   Chiropractor   Cortisone

Have you had surgery for this condition? YES   NO

DIAGNOSTIC TESTS: Please indicate which tests you have had in evaluation of your main complaint:

TEST	DATE	TEST	DATE
Plain x-rays		Myelogram	
MRI		EMG/Nerve conduction	
CT scan		Other:	
Bone Scan			

Like other Orthopedic Surgeons in this area Dr. Lonstein has elected not to carry Mal Practice Insurance "Under Florida Law, Physicians are generally required to carry medical malpractice insurance otherwise demonstrate financial responsibility to cover potential claims for medical malpractice! YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

THIS NOTICE IS PROVIDIED PURSUANT TO THE FLORIDA LAW

Patient or Guardian Signature_________________________________ Date: ______________

1. CONSTITUTIONAL:	YES	NO
Fever	☐	☐
Weight Loss	☐	☐
Ill Feeling	☐	☐
2. EYES:		
Excessive tearing	☐	☐
Blurred vision	☐	☐
Dryness	☐	☐
3. CARDIOVASCULAR:		
Ankle Swelling	☐	☐
Chest Pain	☐	☐
Irregular Heart Beats	☐	☐
4. ENT:		
Feeling of Dizziness	☐	☐
Ringing in Ears	☐	☐
Recent Hearing Loss	☐	☐
5. RESPIRATORY:		
Wheezing	☐	☐
Shortness of Breath	☐	☐
Cough	☐	☐
6. GI:		
Rectal Bleeding	☐	☐
Abdominal Pain	☐	☐
Black-Tar like stools	☐	☐
7. URINARY:		
Pain with Urination	☐	☐
Involuntary Urination	☐	☐
Decreased Urinary Flow	☐	☐
8. MUSCULOSKELTAL		
Motion Loss	☐	☐
Swelling in Joints	☐	☐
Morning Stiffness	☐	☐
9. INTEGUMENTARY:		
Skin Rash	☐	☐
Skin Lumps	☐	☐
Abrasions	☐	☐
10. NEUROLOGICAL:		
Burning Sensation	☐	☐
Tingling	☐	☐
Sensation Loss	☐	☐
11. PSYCHIATRIC:		
Depressed Feeling	☐	☐
Suicide Attempts	☐	☐
Hallucinations	☐	☐
12. ENDOCRINE:		
Excessive Thirst	☐	☐
Changes in Hair	☐	☐
Decreased Energy	☐	☐
13. HEMATOLOGIC:		
Bleed Easily	☐	☐
Fatigue Easily	☐	☐
Bruise Easily	☐	☐
14. IMMUNOLOGIC:		
Skin Reactions	☐	☐
Eczema	☐	☐
Severe Allergic Reactions	☐	☐

15. ILLNESSES	YES	NO
Anemia	___	___
Arthritis (type)________	___	___
Asthma or Bronchitis	___	___
Bladder Infection	___	___
Blood Clots	___	___
Blood Disorders	___	___
BP Over 130/90	___	___
Cancer (type)________	___	___
Diabetes	___	___
Emphysema	___	___
GI Bleeding/Gastritis/Reflux	___	___
Gout	___	___
Heart Attack/ Heart Disease	___	___
HIV/AIDS	___	___
Kidney Stones	___	___
Liver Disease/ Hepatitis	___	___
Lung Disease	___	___
Lyme Disease	___	___
Neurological Disease	___	___
Osteoporosis	___	___
Pacemaker	___	___
Phlebitis	___	___
Parkinsonism	___	___
Prostate Enlargement	___	___
Pulmonary Embolus	___	___
Stroke/ Seizures	___	___
Thyroid Disease	___	___
Ulcers	___	___

Other:____________________

____

____

____

16. CURRENT MEDICATIONS:

NONE: ☐

Name	Frequency
________	________
________	________
________	________
________	________
________	________
________	________
________	________
________	________

17. ALLERGIES TO MEDICATION:

NONE: ☐

Medication	Reactions
________	________
________	________
________	________

Height:__________

Weight:__________

18. PAST SURGERIES:	YES	NO	YR
Appendix	___	___	___
Arthroscopy	___	___	___
Spine	___	___	___
Breast Biopsy	___	___	___
Cancer (type)________	___	___	___
Coronary Artery Bypass	___	___	___
Gallbladder	___	___	___
Hysterectomy	___	___	___
Joint Replacement	___	___	___
Prostate	___	___	___
Tonsils	___	___	___
Wisdom Teeth	___	___	___

19. OTHER HOSPITALIZATIONS:

____

____

____

____

20. FRACTURES:

____

____

____

21. SOCIAL HISTORY:	YES	NO
Married	___	___
Single	___	___
Divorced	___	___
Widowed	___	___
Presently Living Alone	___	___

Number of Living Children _____

22. PAST SMOKING: Never Smoked ☐

Total Years__________

Packs Per Day__________

Date Stopped__________

23. ALCOHOL USE: Never Drank ☐

Total Years__________

Drinks per Day__________

Date Stopped__________

24. ILLICIT DRUG USE: Never Used ☐

Type__________

Total Years__________

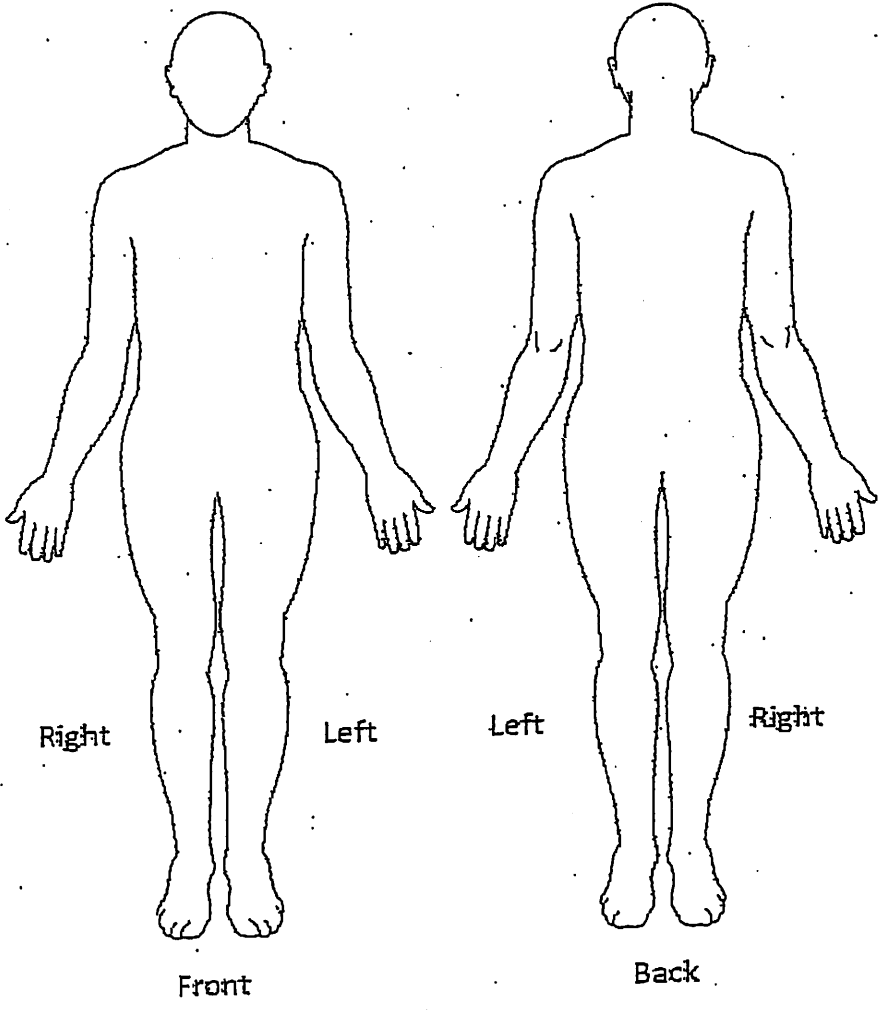
Date Stopped__________

25. FAMILY HISTORY:	YES	NO
AIDS	___	___
Bleeding Disorders	___	___
Cancer	___	___
Heart Disease	___	___
Mental Illness	___	___
Alcoholism	___	___

PATIENT NAME (PRINT):______________________________ DATE:__________

PATIENT SIGNATURE:______________________________

Aching	Numbness	Pins and Needles	Burning	Stabbing
△ △ △	= = =	O O O	X X X	/ / /



Insurance Information

Please provide all current insurance cards so that they may be copied for you office file.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier, attorney and/or other parties to Mark B. Lonstein, M.D. with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. If Mark B. Lonstein, M.D. is required to retain the services of an attorney or other collection agency to collect the sums which I owe, I will be required to pay for all legal fees and costs incurred by Mark B. Lonstein, M.D.

I authorize Mark B. Lonstein, M.D. to furnish me and/or my insurance company, and physicians or health care providers with my medical records or information requested regarding my past or present condition(s) or treatment(s).

Patient or Guardian Signature____

Date______________________________

MEDICATION RENEWAL POLICY

Prescription renewals are always called in at 5 pm, once we complete office hours.

Renewing prescriptions must be done during regular office hours. To expedite renewal of your prescription medication, call your pharmacist first, they will place a call to our office, which will expedite renewal of your prescription.

We realize that emergencies arise that cannot be anticipated. However, WE MUST INSIST OUR PATIENTS ANTICIPATE ROUTINE MEDICATION RENEWALS AND ACCOMPLISH THIS DURING OFFICE HOURS MONDAY THROUGH FRIDAY, 8:00 AM TO 4:00 PM. MEDICATION REFILLS ARE DONE AT THE END OF EVERY WORK DAY. Renewals called in to our office after 4 pm will be handled the next business day.

______________________________ ____________________

Patient/Guarantor Signature Date Signed

OUR FINANCIAL POLICY

Considerable care has been taken in setting our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other Orthopedic Physicians in this area.

INSURANCE "USUAL AND CUSTOMARY": Our fees are generally considered to fall within the acceptable range of usual and customary by most companies, and therefore are normally covered up to the maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

OUR POLICY: Our policy requires payment at the time of service. All charges are your responsibility form the date services are rendered. We will assist you in filing your own insurance claim; we provide you with an itemized charge ticket that you can simply send to your insurance carrier to expedite your reimbursement. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

HMO & PPO MEMBERS: If you are a member of an HMO or PPO in which we participate, your deductible or co-payment is required at the time of service. You are also responsible to see that we have a current referral/authorization for each visit, if your insurance carrier requires one. If you come to the office for an appointment without a valid authorization, you will not be seen.

PRIVATE INSURANCE: Our office files insurance claims to all insurance carriers who we participate with. Please check with our office personnel to be sure that your insurance is one that we file. But, all services we submit on your behalf are still your responsibility. We expect monthly payments on all services 30 days and older.

MEDICARE: We are participating with Medicare. Our office submits all charges to Medicare. We also, as a courtesy, file to your supplementary insurance in most cases.

I have read and understand my financial responsibilities under this policy.

______________________________ ____________________

Patient/Responsible Party Signature Date Signed

CONSENT AGREEMENT

Consent to Use and Disclosure of Health Information for Treatment, Payment, or Health Operations.

I, ______________________________ (patient name), understand that as part of my healthcare this practice originated and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information practices* that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my information may be used or disclosed to carry out the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

______________________________________ ____________________

Signature of patient or legal representative Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

SARASOTA SPINE SPECIALISTS, PA
MARK B. LONSTEIN, M.D., F.A.A.O.S.

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

____
(Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a yearly appointment reminder and/or test results to your home? Y____N____

Call you at home? Y____N____

Call you at work? Y____N____

Leave Messages on your home phone? Y____N____

Leave Messages on your work phone? Y____N____

Leave medical information on your answering machine?

At home? Y____N____

At work? Y____N____

Share your medical and/or appointment information with another person? Y____N____

Share your medical information with another person during a hospitalization? Y____N____

Share your billing information with another person? Y____N____

Name of Person______________________________

Relationship______________________________

______________________________ ______________________
Signature of Patient Date