



Patient Information

First Name:		Middle Name:		Last Name:	
DOB:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		SSN:	
Ethnicity: <input type="checkbox"/> Not Hispanic/Latino		<input type="checkbox"/> Hispanic/Latino			
Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other:					
Primary Language:					
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic					
Address:					
City:		State:		Zip:	
Primary Phone:		Cell Phone:		Home Phone:	
Work Phone:		E-mail:			

Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Unemployed		
Employer:	Occupation:	Employer Phone:
Employer Address:		

Emergency Contact Full Name:		Relationship:
Primary Phone:	Work Phone:	

Is the Patient Financially Responsible? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please complete this section		
Relationship:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:
First Name:	Middle Name:	Last Name:
Address:		
City:	State:	Zip:
Primary Phone:	Cell Phone:	Home Phone:
Employer:	Occupation:	Employer Phone:
Employer Address:		

Is the Reason for Your Visit the Result of an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No?		
If <u>Yes</u> , Please Complete this Section.		
Which Type of Accident? <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Automobile <input type="checkbox"/> Other:		
Date of Accident:	Claim #:	Claim Adjuster:

Insurance Company:		Insured DOB:
Insured/Cardholder's Name:		Relationship:
ID#:	Group #:	Phone:
Secondary Insurance Company:		Insured DOB:
Insured/Cardholder's Name:		Relationship:
ID#:	Group #:	Phone:

Patient Signature: _____

Date: _____



Physician Partners of America

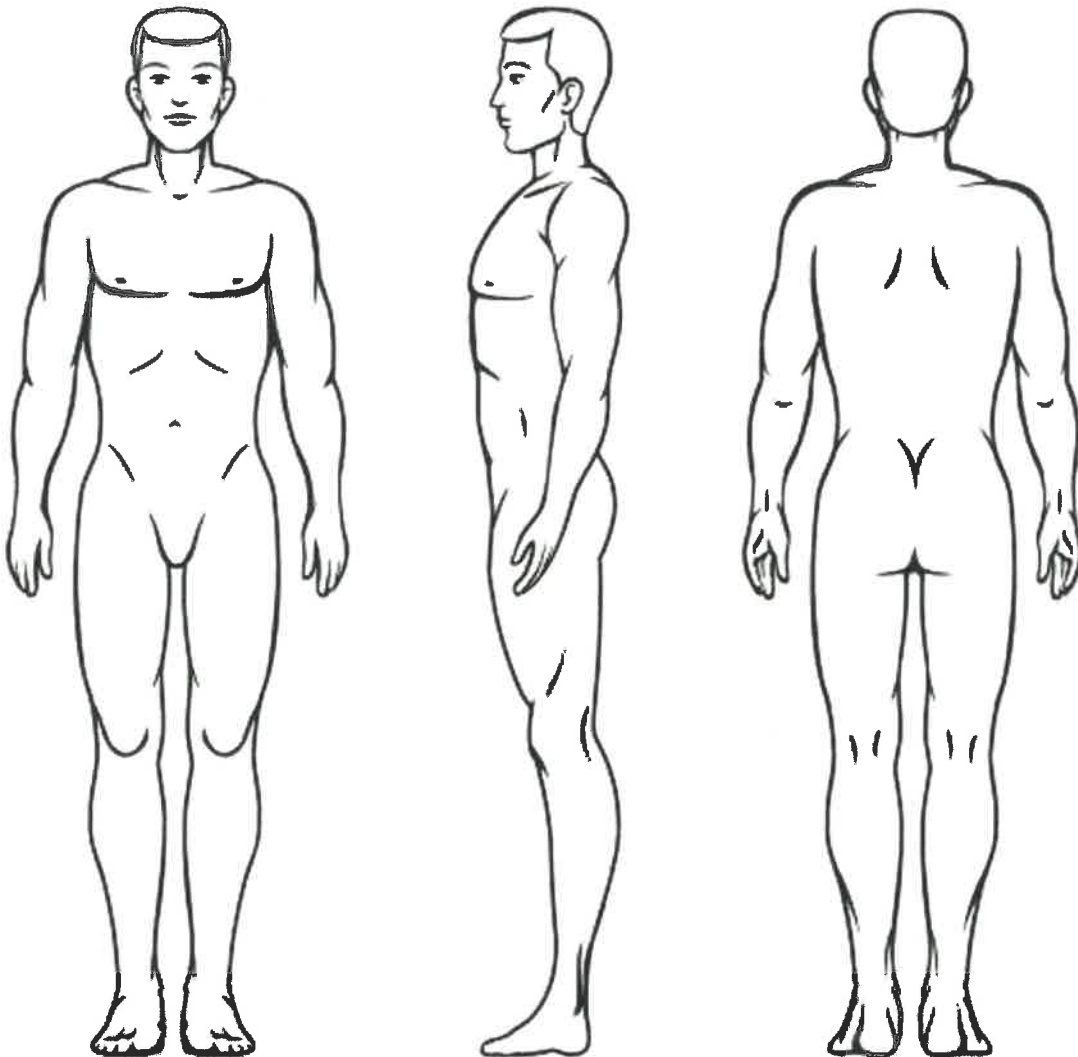
MINIMALLY INVASIVE SPINE GROUP

TELL US ABOUT YOUR MOST SIGNIFICANT PROBLEM

How did you hear about us? Friend Internet Insurance Advertisement Other: _____

Where is your pain located? Please list all that apply

Where is your pain located? Please mark on graphic below



Patient Initials: _____

Date: _____



How long has your pain been occurring?		
Is your pain constant or intermittent?		
Circle all that apply to the type of pain you are feeling? Circle All That Apply:		
Achy	Burning	Dull Sharp Shooting Stabbing Tingling
Circle anything that makes the pain worse? Circle All That Apply:		
Activities	Bending	Stretching Sitting Standing Twisting Walking
Circle any of the following that relieve the pain? Circle All That Apply:		
Heat/ice packs	Laying Down	Pain Medication Rest Standing Sitting Stretching
What is your pain on a scale of 1-10 TODAY?	What is your pain on a scale of 1-10 on your BEST day?	What is your pain on a scale of 1-10 on the WORST day?
_____	_____	_____
Have you had any prior treatment for this condition? Circle All That Apply:		
Physical Therapy	Spine Injection	Anti-inflammatory Medications Pain Medications
Bed Rest	TENS unit	Previous Pain Management Doctor
What recent studies/imaging have you had relating to this condition? Please Circle All That Apply:		
X-Ray	MRI	CT Scan EMG (Needle Testing of Muscles) Nerve Conduction Study Discogram

Do you have a Primary Care provider? If yes please list here:

Any other Healthcare Providers we should know about? Please list here:

PAST MEDICAL, SURGICAL, FAMILY MEDICATION AND SOCIAL HISTORY
Have you had any sports injuries? If yes, when?

Have you ever had any broken bones? If yes, when?
What bone/s?

Have you ever been disabled?

Are you currently disabled? If yes, what type? SSD SSI

Patient Initials: _____

Date: _____

COUNTER

Medication	Dosage	Prescribing Physician	For Which Condition

Review of Symptoms:

Have you recently experienced any of the following? Circle or mark answers below:

<p><u>General/Constitutional</u></p> <input type="checkbox"/> Fever / Chills <input type="checkbox"/> Infection Anywhere <input type="checkbox"/> Sleep Problems	<p><u>Cardiovascular</u></p> <input type="checkbox"/> Chest Pain (any) <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Heart Murmur	<p><u>Respiratory</u></p> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Sleep Apnea / C-PAP / Oxygen
<p><u>Gastrointestinal</u></p> <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Stomach / Abdominal Pain	<p><u>Genitourinary</u></p> <input type="checkbox"/> Kidney Stone Pain <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine	<p><u>Neurological</u></p> <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Incontinence of Bladder
<p><u>Muscle / Bones / Joints</u></p> <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint Pain / Extremity	<p><u>Endocrine</u></p> <input type="checkbox"/> Severe Thirst <input type="checkbox"/> Severe Fatigue <input type="checkbox"/> Decreased Sex Drive	<p><u>Psychiatric</u></p> <input type="checkbox"/> Anxiety / Nervousness <input type="checkbox"/> Feeling Sad / Depressed <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Addiction to Anything
<p><u>Hematological</u></p> <input type="checkbox"/> Easy Bleeding or Bruising <input type="checkbox"/> Bleeding Disorder / Problem <input type="checkbox"/> Lymph Node Enlargement	<p><u>Allergy / Immunology</u></p> <input type="checkbox"/> Shellfish Allergy <input type="checkbox"/> Environmental Allergies <input type="checkbox"/> HIV	<p><u>Cancer</u></p> <input type="checkbox"/> Prostate / Colon <input type="checkbox"/> Breast <input type="checkbox"/> Lung <input type="checkbox"/> Other _____

Patient Initials: _____

Date: _____



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB: ___ / ___ / ___ Phone Number: _____

I authorize the release of my medical records to Physician Partners of America (PPOA) for review and continuation of my medical care. I authorize the following physician offices, clinics, legal offices, diagnostic centers and medical providers to provide copies of my health records to:

Persons/organizations receiving:

(List all facilities, clinics and offices from which information may be requested)

PHYSICIAN OFFICES (please list all physicians you have seen in the past two years)

Physician Name	Address	Phone Number

HOSPITAL / OTHER FACILITIES (surgeries / procedures, radiology reports, laboratory results)

Facility Name	Address	Phone Number

Restrictions: There are NO restrictions to the information that can be released
 The following information CANNOT be released:

DURATION: This Authorization will remain in effect: (please check selection):

- From the date of this Authorization until ___ / ___ / ___
- Until the provider fulfills this Authorization request
- Until the following event occurs:

Date: ___ / ___ / ___ Patient / Guardian Signature _____

Physician Partners of America
Orthopedic Division
 1724 33RD Street
 Suite 200
 Orlando, FL 32839
 Phone: (407) 385-1551
 Fax: (407) 802-4662

Patient Initials: _____

Date: _____



PATIENT PERSONAL HEALTH INFORMATION CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Physician Partners of America originates 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 is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Physician Partners of America's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of the *Notice of Privacy Practices* and acknowledge that I have reviewed the notice prior to signing this consent. I understand that Physician Partners of America reserves the right to change the *Notice of Privacy Practice at any time, and I as a patient have the right to review changes at any time.* I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Physician Partners of America is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Physician Partners of America has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and / or disclosure of my personal health information.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have reviewed Physician Partners of America's *Notice of Privacy Practices* dated July 30, 2015.

I acknowledge that I may request a copy of Physician Partners of America's *Notice of Privacy Practices* dated July 30, 2015 at any time.

Signature of Patient or Legal Representative, _____ Date _____

Print Name of Patient or Legal Representative _____

Witness's Signature _____ Date _____

Witness's Printed Name _____

Patient Initials: _____

Date: _____



Consent to Receive Text Message Appointment Reminders

I _____ authorize Physician Partners of America (PPOA) and its affiliates to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by PPOA or its affiliates under my cell phone plan.

My text/mobile number is: () _____ Patient Initials _____

I know that I am under no obligation to authorize PPOA or its affiliates to send me text messages. I may opt out of receiving these communications at any time by calling the Services desk at

_____.

I understand that text messaging is not a secure form of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date and time of your appointment, name of physician, physician phone number, or other pertinent information.

Signature: _____

By signing below, I authorize my doctor and staff team members to access my prescribed medication list through the pharmacy database, which will help my provider to deliver comprehensive care to me.

Signature: _____

Date: _____ Date of Birth: _____



Name: _____ Date: _____

Have you ever received prior Conservative Care?

Yes / No	Treatment	% of Improvement	When	How long	Area of Body
ie: Y	Chiropractic	5%	25 years ago	Once a month for 2 years	Low back
Ie: Y	Physical Therapy	30%	1 year ago	3 times a week for 6 weeks	Knee
	Acupuncture				
	Aquatic Exercise				
	Back Brace				
	Bed Rest				
	Chiropractic				
	Cool Compresses				
	Steroid Injection				
	Exercise				
	Neck Brace				
	Pain Management				
	Physical Therapy				
	--Physical Therapy continued				
	--Physical Therapy continued				
	--Physical Therapy continued				
	Stretches				
	TENS Unit				
	Warm Compresses				
	Yoga				
	Other				