SunCoast SpineCare

5266 Office Park Blvd. Bradenton, FL 34203
941-365-6400 Fax: 845-507-1153
drschwartz@SunCoastSpineCare.com

PATIENT INFORMATION

Name:________________________________Sex: ____ SS #:_____________Marital Status____Age____

Address):____City_____________________State___Zip_________

DOB________ Home Tel:___________ Work Tel:_________________Cell Phone:____________________

Email Address:________________________ Occupation:________________Primary Physician:______________

Spouse Name:________________ Referred by____________________________

Employer___________________ EmployerAddress____

MEDICAL HISTORY

What is your major complaint?____

On a scale of 0-10 (with 0 being none), how severe is your pain?_____How frequent?________________

When did it start?___________How did it start?____

What types of treatment have you tried and which doctors have you seen?_________________________

What makes your condition worse?____

What makes it better?____

Check symptoms you have experienced since the accident:

( ) Headache	( ) Dizziness	( ) Depression	( ) Fatigue
( ) Stomach Upset	( ) Light sensitive	( ) Buzzing in ears	( ) Diarrhea
( ) Neck Pain	( ) Head seems heavy	( ) Loss of memory	( ) Feet cold
( ) Neck stiff	( ) Pins & needles in arms	( ) Ringing in ears	( ) Hands cold
( ) Fainting	( ) Sleeping Problems	( ) Loss of Balance	( ) Back Pain
( ) Face Flushed	( ) Pins & needles in legs	( ) Constipation	( ) Tension
( ) Nervousness	( ) Numbness in Fingers	( ) Loss of smell	( ) Fever
( ) Irritability	( ) Numbness in toes	( ) Loss of taste	( ) Chest Pain
( ) Cold Sweats	( ) Shortness of Breath	( ) Pain in Arms	( ) Pain in Legs

List any surgical procedures you have had and when:____
____

List any Medications that you are currently taking and for conditions:____________________________________
____

Have you had a CT scan? Yes No MRI? Yes No EMG? Yes No Other:______ Are you diabetic?_____

For Females: Are you pregnant or is there a chance you are pregnant? Yes No

Your Past History: Please list heart, lung, kidney, asthma, allergies, hypertension, thyroid problems, anything you take medication for:____

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Family History:	Condition	Age	
Mother			Living or Deceased
Father			Living or Deceased
Brother			Living or Deceased
Sister			Living or Deceased
Grandmother			Living or Deceased
Grandfather			Living or Deceased

This next section is very important. These days insurance companies are more concerned about how your condition is affecting your lifestyle rather than how much pain it causes you. Therefore in addition to asking about your pain level, we will be asking you to explain how it affects your life. What types of things you cannot do because of your condition. In other words, how does it affect your ability to sit and for what length of time? How does it affect your walking? How many yards or blocks can you walk before you experience the pain? These things will improve as you undergo treatment and you need to communicate these improvements with us. Don't just say you can't stand. Tell us how long you can stand before the pain starts. If you can't lift, how much can you lift before experiencing your symptoms. Can you sit at a computer? How long? Can you brush your hair? Brush your teeth? Can you sit on a toilet? Can you wash dishes?
Please explain:
How does your condition affect your life? ____

____

INSURANCE INFORMATION

Is your Condition due to a reported On-The-Job injury? ___ Due to an Auto Accident?___

Name of Insurance Company:__________________ Your ID#_______________________________________
Insured's Name____________________________ Patient's Relationship to Insured_____________________
Insured's Employer_________________________Employer's Address_______________________________
Insured's Sex____Insured's DOB___________Insured's ID #_____________Group #_____________

Authorization and Assignment:
I hereby authorize that payment from the insurance company(s) direct benefits for services go directly to:
Dr. Jay H. Schwartz/SunCoast SpineCare, LLC
This is a direct assignment of my rights and benefits under my policy.
I understand that this office will prepare any necessary reports or forms to assist me in making collection from the insurance company; thereof, I also authorize the release of any information pertinent to the processing of this claim to the above mentioned insurance company(s) and or attorney(s) involved in my case. This agreement also applies to any insurance company or plan that I switch to in the future.

Patient Signature___________________________________Date______________

Notice of Receipt of Privacy Notice:

By signing below, I acknowledge that I have received and reviewed the privacy notice of SunCoast SpineCare, LLC in and all of my questions have been answered to my satisfaction in language that I can understand.

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Patient Signature:____Date____________________________________