SunCoast SpineCare & Chiropractic Neurology

5266 Office Park Blvd. Unit 201 Bradenton, FL 34203
941-365-6400 Fax: 845-507-1153
drschwartz@SunCoastSpineCare.com

PATIENT INFORMATION

Name_____ Preferred Name _____ Sex ____ Age____ DOB_____

Florida Address_____City_____State____ Zip_____

Alternative Address _____*City*_____*State*____ *Zip*_____

Home Tel _____ Cell Phone _____ Email _____

Marital Status_____ Spouse Name _____ Primary Physician _____

Referred by_____ Occupation _____ Employer _____

Work Tel _____ Employer Address _____

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:

( ) 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: _____

_____

_____

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

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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 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 can you not do because of your condition? 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? How long you can stand before the pain starts. 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? These things will improve as you undergo treatment, and you will need to communicate these improvements with us.

How does your condition affect your life currently? _____

INSURANCE INFORMATION

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

Name of Insurance Co: _____ 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 and all my questions have been answered to my satisfaction in language that I can understand. As a result of Covid, we minimize contact with common areas including doorknobs and we keep most doors open. If you have a problem with this policy, please state so on bottom.

Patient Signature: _____Date_____

Cancellation Policy:

SunCoast SpineCare, LLC has a 24-hour cancellation policy. I may be charged a $60 No-Show fee if I do not call and speak with a representative or leave a voice message cancelling my appointment a full 24 hours prior to my appointment time.

Patient Signature: _____Date_____