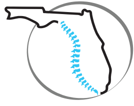

Florida Surgery Consultants
Neurosurgeons and Orthopedic Surgeons

Patient Information

Name: ___________________ Date of Birth: ________ Sex: ____ Office: ___________ Date: _________

Address: ____ City: ______________________

State: ___________ Zip: ___________________ Social Security Number: __________________________

Home Phone: _________________________ Cell Phone: ____

Email: ____

May we leave a message? ________ Email? ________ Martial Status ______________________

Emergency Contact Name: ________________________________ Relationship: ___________________

Emergency Contact Phone: ____

Insurance Information: ______ Medical ______ Auto ______ Attorney ______ Work comp

Company: _____________________________________ Policy Number: ______________________________

Group #: ________________________________ Phone Number: ____________________________________

If you are not the policy holder: Name: ____

Date of Birth: ____________________ Social Security Number: ______________________________

Automobile ___ or Work Related ___ Injury: Insurance Company: __________________________

Date of Accident: ___________________________ Claim Number: ______________________________

Phone Number: ___________________________________ Adjuster: ______________________________

Attorney Name (If Applicable): _____________________________ Phone: _________________________

MEDICAL HISTORY

Reason for visit: ____

Current medications: ____

Allergies: ____

Social History:

Tobacco Use: Never Quit/when__________ Current smoker/packs per day __________

Alcohol Use: Never Rarely Moderate Daily How much? __________________

Drug Use: Never Rarely Type & Frequency __________________________________

Occupation: ____

Medical Office Locations

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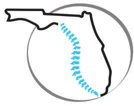

Florida Surgery Consultants
Neurosurgeons and Orthopedic Surgeons

Medical Questionnaire

Patient Name: ____________________ **Date of Birth:** ______________ **Date:** ________________

Review of Symptoms:	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
-Constitutional			**-Ear/Nose/Mouth/Throat**			**-Eyes**		
Good General Health	___	___	Hearing loss or ringing	___	___	Wear glasses/contacts	___	___
Recent Weight Change	___	___	Sinus problems	___	___	Blurred/double vision	___	___
Night Sweats, fever	___	___	Nose bleeds	___	___	Eye disease or injury	___	___
Fatigue	___	___	Sore throat/voice change	___	___	Glaucoma	___	___
-Cardiovascular			**-Respiratory**			**Gastrointestinal**		
Chest Pain	___	___	Shortness of breath	___	___	Nausea/vomiting	___	___
Palpitations	___	___	Cough	___	___	Abdominal pain	___	___
Heart Trouble	___	___	Wheezing/Asthma	___	___	Rectal bleeding	___	___
Swelling hands/feet	___	___	Coughing up blood	___	___	Bowel problems	___	___
-Musculoskeletal			**-Neurological**			**Instegumentary Skin/ Breast**		
Muscle pain or cramps	___	___	Frequent headaches	___	___	Change in hair or nails	___	___
Stiffness/swelling joints	___	___	Paralysis or tremors	___	___	Rashes or itching	___	___
Joint Pain	___	___	Convulsions/seizures	___	___	Breast lump	___	___
Trouble Walking	___	___	Numbness/tingling	___	___	Breast pain or discharge	___	___
-Endocrine			**-Hematologic/Lymphatic**			**Psychiatric**		
Excessive thirst/urination	___	___	Bruise easily	___	___	Insomnia	___	___
Thyroid disease	___	___	Slow to heal	___	___	Confusion/memory loss	___	___
Hormone problem	___	___	Enlarged glands	___	___	Depression	___	___
Genitourinary-Male Only			**Genitourinary- Female Only**					
Blood in urine	___	___	Blood in Urine	___	___			
Kidney Stones	___	___	Kidney Stones	___	___			
Sexual Problems	___	___	Sexual Problems	___	___			
Testical Pain	___	___	Menstrual problems	___	___			
Medical History:								
High Blood Pressure	___	___	Diabetes	___	___	Heart Trouble	___	___
Respiratory Problem	___	___	Stroke	___	___	Cancer	___	___
Bleeding Problems	___	___	HIV/Aids	___	___	Other Problems	___	___

Past Hospitalization/Surgeries/Injuries and Approx Dates: ______________________________

Family History: **Please list any medical problems involving relatives.**

Father: ____________________ Mother: ____________________ Others: ____________________

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Patient Signature: ______________________________ **Date:** ______________

Witness: ______________________________

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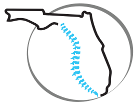

Florida Surgery Consultants
Neurosurgeons and Orthopedic Surgeons

Content and Disclosure

Patient Name: ________________________________ **Date of Birth:** __________________________

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I Promise to pay Florida Surgery Consultants for all charges incurred and to be incurred for any and all services rendered and assigns any and all insurance benefits to Florida Surgery Consultants. I understand that Florida Surgery Consultants will file claims with my insurance company as a courtesy on my behalf and I authorize Florida Surgery Consultants to release any and all information necessary to assure the payments of said claims. However, it is understood and agreed that the patient and/or the undersigned is responsible for assisting and following up on any insurance claims. Payment in full is expected at the time of service; including Copays, Co-Insurance, and Deductibles as assigned by your insurance. I furthermore understand that I am responsible for any additional services rendered, but not billed on the day of service, or any additional responsibility for charges my insurance may assign. I acknowledge that if my account is assigned to a collection agency, I am responsible to all expenses that may be incurred. Florida Surgery Consultants expects prompt payment in full for services rendered, if you think your bill is incorrect, please call or write us at the address shown on your bill as soon as possible.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Florida Surgery Consultants to use and disclose my protected health information (PHI) in order to carry out treatment, payment and healthcare operations (TPO), I have the right to request that Florida Surgery Consultants restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Florida Surgery Consultants may decline to provide treatment to me. I have the right to review the posted Notice of Privacy Practices prior to signing this consent. Florida Surgical Consultants reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Florida Surgery Consultants at 35111 US Hwy 19 N Suite 301, Palm Harbor, FL 34684

CONSENT FOR TREATMENT

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to and authorize the administration of the medical treatment that may be considered advisable or necessary in the judgment of the physician. I hereby authorize the above company to release any information in the course of my treatment to my insurance company or any physician needing this information for treatment.

________________________________ Date:__________________________
Signature of Patient or Responsible Party (Relationship)

____
Signature of Witness

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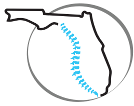

Auto/Work Related Injury Patients

Patient Name: ______________________ **Date of Birth:** ______________ **Date:** ________

Name of doctor(s) currently treating you for this injury? ______________________________

Emergency Room? ____ **Police at Scene?** ____ **Citation Issued?** ____ **Seat Belt?** ____

Were you the: ____ **Driver** ____ **Passenger** ____ **Pedestrian** **Other:** _________________

Please describe how this accident happened: **Date of Accident:** _________________

____

____

Have you ever been treated for any previous accidents? __Yes __No **When:** __________

Have you have any of the following treatments for your current injury?

Physical Therapy	__Yes __No	**Chiropractic Treatment**	__Yes __No
Traction	__Yes __No	**E-Stim/TENS Treatment**	__Yes __No
Trigger Point	__Yes __No	**Epidural Steroid Inject**	__Yes __No

Do you or your spouse own a vehicle? __Yes __No

If no, do you live with a family member who owns a vehicle? __Yes __No

Whose vehicle you were occupying at the time of the accident? ___________________

Please provide other insurance information (if Applicable)

Insurance Company: __________________________ **Insured:** __________________

Policy/Claim #: ______________________________ **Cost of damage to Car: $** _________

Phone #: _________________________ **Adjuster:** ____________________________

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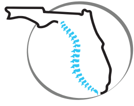
888-411-6824

727-785-5753

www.floridasurgeryconsultants.com



Florida Surgery Consultants
Neurosurgeons and Orthopedic Surgeons

Letter of Protection and Irrevocable Lien

Patient Name: ____________________________ **Date of Birth:** ______________ **Date:** ______________

Subject: IRREVOCABLE LIEN

TO WHOM IT MAY CONCERN:

I do hereby authorize Florida Surgery Consultants or its assigns, to furnish you upon request, my attorney, with a full report of any medical treatment and/or results of any diagnostic services performed on me in regard to the accident I was involved in.

Further, I hereby authorize and direct you, my attorney, to pay directly to Florid Surgery Consultants any sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bill due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Florida Surgery Consultants.

I hereby further give a priority lien on my case to Florida Surgery Consultants or its assigns against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I understand that I am directly and fully responsible to Florid Surgery Consultants for all of my medical bills submitted by their office for services rendered and that in consideration of their waiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

____ Date: ___________________________

Patient's Signature

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