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?** _____ **Marital 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

Largo
1000 S Belcher
Suite A6
Largo, FL

Tampa
3030 N Rocky Point Dr
W. Suite 665
Tampa, FL

Brooksville
12202 Cortez Blvd
Brooksville, FL

Bradenton
6320 Venture Dr
Suite 201
Bradenton, FL

Lakeland
604 Robin Rd
Suite 1
Lakeland, FL

Gainesville
3760 NW 83rd St
Suite 3
Gainesville, FL

Ocala
1015 SE 17th St #200
Ocala, FL

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Medical Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Review of Symptoms:	YES	NO
-Constitutional		
Good General Health	☐	☐
Recent Weight Change	☐	☐
Night Sweats, fever	☐	☐
Fatigue	☐	☐
-Cardiovascular		
Chest Pain	☐	☐
Palpitations	☐	☐
Heart Trouble	☐	☐
Swelling hands/feet	☐	☐
-Musculoskeletal		
Muscle pain or cramps	☐	☐
Stiffness/swelling joints	☐	☐
Joint Pain	☐	☐
Trouble Walking	☐	☐
-Endocrine		
Excessive thirst/urination	☐	☐
Thyroid disease	☐	☐
Hormone problem	☐	☐
Genitourinary-Male Only		
Blood in urine	☐	☐
Kidney Stones	☐	☐
Sexual Problems	☐	☐
Testical Pain	☐	☐

	YES	NO
-Ear/Nose/Mouth/Throat		
Hearing loss or ringing	☐	☐
Sinus problems	☐	☐
Nose bleeds	☐	☐
Sore throat/voice change	☐	☐
-Respiratory		
Shortness of breath	☐	☐
Cough	☐	☐
Wheezing/Asthma	☐	☐
Coughing up blood	☐	☐
-Neurological		
Frequent headaches	☐	☐
Paralysis or tremors	☐	☐
Convulsions/seizures	☐	☐
Numbness/tingling	☐	☐
-Hematologic/Lymphatic		
Bruise easily	☐	☐
Slow to heal	☐	☐
Enlarged glands	☐	☐
Genitourinary- Female Only		
Blood in Urine	☐	☐
Kidney Stones	☐	☐
Sexual Problems	☐	☐
Menstrual problems	☐	☐

	YES	NO
-Eyes		
Wear glasses/contacts	☐	☐
Blurred/double vision	☐	☐
Eye disease or injury	☐	☐
Glaucoma	☐	☐
Gastrointestinal		
Nausea/vomiting	☐	☐
Abdominal pain	☐	☐
Rectal bleeding	☐	☐
Bowel problems	☐	☐
Instegumentary Skin/ Breast		
Change in hair or nails	☐	☐
Rashes or itching	☐	☐
Breast lump	☐	☐
Breast pain or discharge	☐	☐
Psychiatric		
Insomnia	☐	☐
Confusion/memory loss	☐	☐
Depression	☐	☐

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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1500 SE Magnolia Ext
Suite 103
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Consent 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

Medical Office Locations

Largo	Tampa	The Villages	Bradenton	Lakeland	Gainesville	Ocala
1000 S Belcher Suite A6 Largo, FL	3030 N Rocky Point Dr W. Suite 665 Tampa, FL	301 Skyline Dr. Suite 3 Lady Lake, FL	6320 Venture Dr Suite 201 Bradenton, FL	604 Robin Rd Suite 1 Lakeland, FL	3760 NW 83rd St Suite 3 Gainesville, FL	1500 SE Magnolia Ext Suite 103 Ocala, FL

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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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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 Florida 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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