Neurospine Institute
Robert Masson, M.D., Peter Indelicato, M.D., Mark J. Cuffe, M.D.
2706 Rew Circle
Ocoee, Florida, 34761
(407) 649-8585-phone
(407) 649-0151- fax

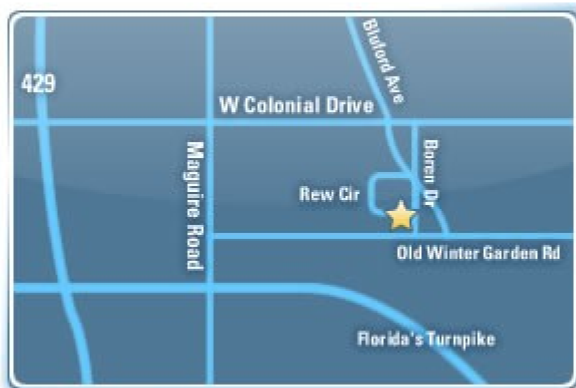
Welcome to Neurospine Institute. Your appointment is scheduled for __________________ at _____: ________ am/pm. Please arrive 30 minutes prior to appointment.

Please notify our office within 48 hours, if you are unable to keep this appointment.

Please bring with you the following information and items to your appointment. If the items are not available at the time of your visit, it may result in the rescheduling of your appointment.

1. MRI, CT scan report and films. Films must be no older than six months old.
2. Insurance Card
3. Authorization number or referral-if required from health insurance company
4. Auto claim information or Signed Letter of Protection from attorney
5. The enclosed Medical History and Patient Registration Forms

<u>Directions to our office:</u>



Neurospine Institute

Robert L. Masson, M.D., Peter Indelicato, M.D., Mark J. Cuffe, M.D.

Patient Health History Questionnaire

For Nurses Only	
WT:	BP:
P:	R:

Date: ______________________
Name: ______________________
Age: ______________________
Birthday: ______________________

Chief Complaint: What is the problem you are being seen for today? ____________
____
When did this begin? (Mo/day/year)? ____
How did this begin?

Medical History: Height: ______________ Average Weight: ______________
If you are a woman of childbearing years, is there a possibility you may be pregnant? Yes No
Mark any medical condition you have been diagnosed with:
Aids Hepatitis Any other blood disease/Name: __________________
Blood clots/What part of body ___________Diabetes/controlled by Diet Pills Insulin
Epilepsy Heart Problems/Type:____
High Blood Pressure Low Thyroid Irritable Bowel Syndrome
Ulcers Mitral Valve Prolapse Lung Disease/Type:____
Polio Rheumatoid Arthritis Tuberculosis
Psychiatric Disorder/Type:____
Please list any **other known** medical conditions or symptoms not listed above: ______________________
____
Please list any **injuries** including car accident, fall, lifting, etc: ____________________________________
____
Please list any **hospitalizations** (other than surgeries): ____
____
Please list any **surgeries: (Use the back of the form, if more than six)**

Procedure	Year	Surgeon	Hospital/City
1			
2			
3			

Family History:
Have any of your relatives ever had any of the following:
Yes Relationship (Mother, Father, Sister or Brother)
___ Hypertension ___ Tuberculosis ____ Diabetes _____ Kidney Disease ____ Heart Disease ___ Arthritis _____ Epilepsy _____ Convulsions ____ Cancer ____ Psychological_____ Drug or Alcohol Problems

Social History:
Employed? Yes No Most recent Occupation: ____________________________
Children? Yes No If yes, how many/ages? ________________________
Do you live: Alone Spouse Nursing Facility Other ______________
Are you at risk for AIDs? Yes No
Do you have a history of: Substance abuse/Type? ____________________________
Do you currently use alcohol? Yes No If yes, how often: Never Rarely Weekends Heavy No Comment
Are you a smoker? Yes No If yes: _____Packs per day for _____ years If no, when did you quit?

Review of Systems: Mark or Circle any of the following symptoms that you are having:

- **Constitutional symptoms**
  - Unusual Weight Change
  - Easy fatigue
- **Skin**
  - Rashes, Hives or Exzema with itching
  - Bruising,
  - Jaundice
  - Cyanosis
  - Change in color
  - Dryness
  - Lumps or growths
- **Head, Ears, Eyes, Nose, Throat (HEENT)**
  - Difficulty hearing
  - Ringing in ears
  - Dizziness
  - Sinus Trouble
  - Frequent Sore Throats
- **Respiratory**
  - Cough with sputum (color, consistency, odor, amount)
  - Asthma with wheezing
  - Chronic obstructive pulmonary disease
  - Hemoptysis (spitting of blood)
- **Cardiovascular**
  - Chest pain or discomfort
  - Palpitations, heart trouble
  - High blood pressure
  - Heart murmurs
  - Orthopnea (discomfort in breathing)
  - Dyspnea (shortness of breath)
  - Pedal edema,
  - Claudication (limping) or pain in legs when walking
  - Coldness of extremities
  - Past myocardial infarction
- **Gastrointestinal**
  - Nausea and/or vomiting
  - Hematemesis (vomiting blood)
  - Indigestion or heart burn
  - Dysphagia (difficulty swallowing)
  - Abdominal pain
  - Change in bowel movementsDiarrhea, Constipation or Melena (black stool due to blood)
- **Genitourinary**
  - Frequency or urgency of urination
  - Polyuria (excess urine output)
  - Dysuria (painful urination)
  - Incontinence
  - Hematuria (blood in urine)
- **Musculoskeletal**
  - Muscle or joint pain or stiffness
  - muscle wasting, swelling or redness
  - Limitation of motion
  - Arthritis,
  - Gout,
  - Backache or Neck pain (location and symptoms)
- **Neurological**
  - Syncope,
  - Weakness
  - Unsteadiness of gait
  - Paralysis
  - Paresthesias (numbing or tingling)
  - Loss of sensation
  - Loss of memory
  - Disorientation
- **Psychiatric**
  - Depression, Anxiety
- **Endocrine**
  - History of Thyroid Trouble or Diabetes
  - Heat or cold intolerance
- **Hematologic/lymphatic**
  - Anemia
  - Enlarged lymph nodes
  - Enlarged Spleen

To My Knowledge, I attest that the above information is true and accurate

____________________________ ________________________

Patient's Signature Date

Medications and Allergies

Medications:

List all medications that your are currently taking: **(Use back of form if more than five)**

Drug	Dose	How Often	Prescribed by	When

List any **diet pills, herbs, or vitamins** over-the-counter you may be taking:

Name	Dosage/How Often

Allergies

List any **ALLERGY** to **MEDICATIONS** and reaction:

Name of medication	Reaction
Xray Dye yes no	Reaction
Latex yes no	Reaction
Tape/type yes no	Reaction

List any previous problems with **Anesthesia**:

Type of Anesthesia	Date	Reaction

Neurospine Institute
Robert L. Masson, M.D., Peter Indelicato, M.D., Mark J. Cuffe, M.D.
Patient Information Questionnaire

How did you learn about our practice? Website Referring Physician Magazine (please name which magazine) Attorney Friend Other (please name)

____

Physician Referring You To Our Practice:

Dr. ____________________________ Phone # __________________________

Address ____

Primary Care Physician:

Dr. ____________________________ Phone # __________________________

Address ____

Patient Information:

Marital Status: Married Single Divorced Widowed Separated
Sex: Male Female

Last Name: ________________________ First Name: ________________________

Patient's Social Security #: __________________Date of Birth: ______________

Home Phone #:_______________________Mobile Phone # ____________________

Home Address: ____Apt #: ______

City: ___________________________State: _________________ Zip: __________

Alternate Address: ____

Email Address: ____

Would you like to receive a monthly email newsletter ☐ Yes ☐ No

Employment Information

Employment Status: Full Time Part Time Retired Disabled Other ________________

Employer: ________________________ **Occupation:** ______________________

Employer Address: ____

Primary Insured Person On Your Insurance (Guarantor):

Last Name: _____________________________ **First Name:** ______________ **M.I.** ___

Birthdate: _____________________________ **Social Security #:** _________________

Emergency Information: (Not living in the same household).

Please Notify (Name) ____________________________ **Phone #** _______________

Address _____________________________________ **Relationship to patient** _______

Insurance Information

Is your visit today related to an auto accident? Yes No
Is your visit today related to a work injury? Yes No

Is your injury in Litigation? Yes No
If so, explain circumstances of injury and what is the nature of your injury (ex: slip and fall, type of injury).____
____
____
Name of Attorney:____
Phone # and Fax #: ____

Health Insurance Information: (Please provide card at time of visit)

Primary Insurance Co: ____________________ **I.D.#** _______________ **Grp #** _____

Address: ________________________________ **Phone #:** ______________________

Secondary Insurance Co: ___________________ **I.D.#** _______________ **Grp #** ____

Address: _________________________________ **Phone #:** ______________________

Worker's Compensation Information

Insurance: _______________________________ Claim #: ___________________

Claims Address: __________________________Date of Injury: ______________

Adjuster Name: __________________________ Phone # ____________________

Attorney Name: __________________________ Phone # ____________________

Auto Carrier Information

Insurance: ______________________________ Claim #: _______________________

Claims Address: __________________________Date of Injury: ________________

Adjuster Name: __________________________ Phone # ______________________
Attorney Name: __________________________Phone # ______________________

Conditions of Treatment

Assignment of Insurance Benefits: In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, including but not limited to private and group health and hospitalization benefits, automobile liability, general liability, personal injury protection, medical payments and uninsured and underinsured medical benefits, such benefits or recovery are hereby assigned directly to the Neurospine Institute for application to the patient's bill, and I authorize direct payment to the Neurospine Institute of such benefits or recovery. I acknowledge that Section 817.234, Florida Statutes, provides that "any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Authorization to Release Confidential Information: I hereby authorize the Neurospine Institute and it's physicians and employees, to release all or part of the patient's records to any person or entity that is or may be liable for any of the Neurospine Institute's charges, including but not limited to public or private health insurers, managed care organizations, worker's compensation carriers and other third party payers, for the purpose of securing payment of any charges by the Neurospine Institute for services rendered or otherwise. The information to be released includes all information in the patient's record including where applicable, information about HIV testing and results, psychiatric treatment, and treatment for drug and alcohol abuse, unless specific instructions are given particular information below.

I request that the Neurospine Institute withhold the following information from release:

____

I understand that if I do not authorize release of this information for the purpose of securing payment, I will be billed directly for the Neurospine Institute's charges. The authorization will remain in effect until the Neurospine Institute has been paid or settled, and may be revoked prior to that time, except to the extent that action has already been taken in reliance on it. Patients with implantable devices authorize the release of their Social Security number to the device manufacturer to comply with the Safe Medical Devices Act.

Patient/Guarantor Agreement: Whether I sign as agent/representative or patient, in consideration of the services to be rendered to patient, I hereby individually obligate myself to pay and unconditionally guarantee payment to the Neurospine Institute of patient's co-payments, deductibles and non-covered charges, in accordance with the regulate

rates of the physicians of the Neurospine Institute or any of it's allied health staff, or such other rates and terms as are applicable to patient's account (s) by contract or regulation. Should any portions of the patient's account be referred to an attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees, whether suit is filed or not. For purposes of this agreement, non-covered charges are those charges not covered by a third party payer for any reason.

Consent for Evaluation and Treatment: The patient hereby consents to any evaluation and treatment the assigned physician of the Institute may deem necessary to the patient named above.

Assignment of Medicare Benefits: Patient Certification, Authorization to Release Information. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or is intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the Neurospine Institute or authorize the physician or the Neurospine Institute to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered services, including personal charges.

Execution of my signature below authorizes and agrees with all conditions above:

______________________________	______________________________
Signature of Patient	Date
______________________________	______________________________
Signature of Parent, Guardian, and/or Responsible Party	Date

Neurospine Institute
Robert L. Masson, M.D., Peter Indelicato, M.D. Mark J. Cuffe, M.D.
Patient Information-Privacy Notice

WRITTEN ACKNOWLEDGEMENT OF PATIENT OR PERSONAL REPRESENTATIVE OF PATIENT THAT THEY HAVE READ NEUROSPINE INSTITUTE'S PRIVACY PRACTICE PROVIDED VIA WEBSITE OR PHYSICAL ADDRESS LISTED BELOW:

_________________________________ _____________________

Signature of Patient/Personal Representative   Social Security Number

Date ______________________

REQUESTS FOR COPIES OF THE NEUROSPINE INSTITUTE PRIVACY PRACTICE CAN BE MADE IN WRITING TO THE FOLLOWING ADDRESS:

Neurospine Institute
2706 Rew Circle, Ste 200,
Ocoee, Florida 34761