



Patient Intake Form

Today's Date: _____

Last Name		First Name		Middle
Birth Date	Age	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address	City		State	Zip
Social Security No	Home Phone		Work Phone	
Employer	Employer Address			
Spouse Name	Spouse Work Phone			
Spouse Employer/Address				
Spouse Social Security No		Spouse DOB		
Nearest Friend or Relative		Home Phone ()		
Primary Care Physician Phone Number		Referred By Phone Number		
Email Address		Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		

Race: <input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Other Race <input type="checkbox"/> Declined
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined		

Primary Insurance Company		Phone ()
Insurance Co Address		
Insured Person Name		
Insured Person Social Security No		Insured Person Birth Date
Your Relationship to Insured Person		Group #
Policy / ID #		Copayment Amount
Secondary Insurance Company Name		Phone ()
Insurance Co Address		
Insured Person Name		
Insured Person Social Security No		Insured Person Birth Date
Your Relationship to the Insured Person		Group #
Policy / ID #		Copay Amount

Is this injury related to an auto / vehicular accident? ____ Yes ____ No Work Comp? ____ Yes ____ No

Note: We do not accept auto / vehicular related cases. We only accept Marriott International and Choice Medical Management Workers' Compensation.

If yes above, date of the accident / injury : _____ Claim #: _____

Adjustor Name: _____ Phone: _____

Attorney Name and Address: _____

Preferred Pharmacy : _____



Medical and Social History

Patient Name: _____ Date: _____

Please list your current symptoms: _____

Past Medical History: Please check if you have been *diagnosed with or treated* for the following disorders.

<input type="checkbox"/> Anemia, Iron Deficiency	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Angina (Ischemic Chest Pain)	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Arrhythmia (irregular heart rate/ rhythm)	<input type="checkbox"/> Increased Cholesterol
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Asthma	<input type="checkbox"/> Murmurs
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Brain Mass: Intracranial Mass	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Stroke
<input type="checkbox"/> COPD	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer: (Please give details)
<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Gastric Reflux	
<input type="checkbox"/> Gout	
<input type="checkbox"/> High Blood Pressure	

Please explain all Ticked boxes for the above disorders:

Are you Right handed or Left handed? _____ Right _____ Left

How long have you had your symptoms? _____

Past Surgical History:

Past tests/ treatments for these symptoms: (please check/List all that apply)

☐ Physical Therapy Date: _____ Facility _____

☐ Chiropractic Treatment Date: _____ Physician _____

☐ EMG/Nerve Conduction Study Date: _____ Physician _____

☐ Have you taken any NSAIDs (Non steroidal anti inflammatory Medications like Advil, Aleve ,Tylenol etc) If so please list:

☐ Traction Date: _____ Facility _____

Spinal Injections: ☐ Epidural injections ☐ Facet blocks ☐ Facet Rhizotomies ☐ Trigger point injections

Date(s) _____ Physician/Facility _____

Please list all surgeries and major hospitalizations: (Date/ Procedure)

☐ If none, please check.

Medications: List Name, Strength, and how often taken

☐ If none, please check.

Medication/Prescription Over the counter	Dosage MG	Frequency #Times/ Day	Reason/ Condition Treated	Prescribing Doctor

****Attach list if you need more space**

List Allergies:

☐ If none, please check.

Family Medical History:

Any family illness (es)? If so, please explain

Social History:

Are you a smoker? _____ If so, how long? _____ How much? _____ If quit, when? _____

Do you drink alcohol? _____ Never _____ On Occasion _____ Moderately

Marital Status: _____ Married _____ Divorced _____ Single _____ Widowed

Occupation: _____

Names of any current specialist/referring doctor:

Symptoms: Please mark Yes or No if you have had the following symptoms in the past 6 month

Y N Constitutional

<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Body Aches
<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Chills

<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention
<input type="checkbox"/>	<input type="checkbox"/>	Frequency
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Voiding
<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	Possible Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Skipped Menstrual Cycle

Y N Eyes

<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision
<input type="checkbox"/>	<input type="checkbox"/>	Visual Loss/Change in vision

Y N Neurologic

<input type="checkbox"/>	<input type="checkbox"/>	Muscular Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance/Falls
<input type="checkbox"/>	<input type="checkbox"/>	Memory Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries
<input type="checkbox"/>	<input type="checkbox"/>	Tingling or numbness

Y N Ears, Nose, & Throat

<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Mass
<input type="checkbox"/>	<input type="checkbox"/>	Vertigo
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Pain
<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat

Y N Cardiovascular

<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Syncope/Loss of Consciousness
<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beats
<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Edema/swelling
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate

Y N Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain/Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Arm pain
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain

Y N Respiratory

<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Cough

Y N Endocrine

<input type="checkbox"/>	<input type="checkbox"/>	Unusual Loss of Hair
<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance/cold intolerance
<input type="checkbox"/>	<input type="checkbox"/>	Decreased Libido

Y N Gastrointestinal

<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Difficult Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain

Y N Psychiatric

<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Feeling Confused
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping

Y N Genitourinary

<input type="checkbox"/>	<input type="checkbox"/>	Urgency
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Patient Name: _____

Account #: _____

D.O.B: _____

Doctor: _____

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone #: _____

Fax# _____

*** we must have this information Before you see the doctor*** Thank You!



**CONSENT TO USE OR DISCLOSE INFORMATION FOR
TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

PAGE ONE

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by Orlando Neurosurgery (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient:

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please initial the appropriate categories listed below):

- ☐ HIV / AIDS Information
- ☐ Mental Health Information
- ☐ Substance Abuse Information
- ☐ Sexually Transmitted Disease Information
- ☐ If Patient is under the age of eighteen (18), Pregnancy Information

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

PAGE TWO

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____

Signature of Patient (or Authorized Representative*)

Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient:

Christopher J. Baker, M.D.
Donald L. Behrmann, M.D.
Michael P. Bellew, M.D.
Melvin Field, M.D.
Cory Hartman, M.D.
Frank Hellinger, M.D.
Ravi Gandhi M.D.
Ankur Garg, M.D.
John A. Jenkins M.D.
David Rosen M.D.
Paul D. Sawin, M.D.

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful and your experience in this office being pleasant. The following is our financial policy and we would appreciate you reading this carefully. Should you have any questions, please feel free to contact our billing department at (407) 539-3985.

We will not be able to complete our recommended treatment plan unless you understand and sign this form.

In most cases, we will bill your insurance for you. **Please understand that this is a courtesy to our patients.** Your insurance contract is between you and your insurance company. It is **YOUR** responsibility to understand the terms and benefits, which are a part of your contract. **We do require you to pay your co-payments, co-insurance or deductibles at the time of service.** If you are unsure what your benefits are, you should contact your benefits department for verification prior to your visit with Drs. Baker, Behrmann, Bellew, Field, Hartman, Hellinger, Gandhi, Garg, Jenkins, Sawin or Rosen. **PLEASE NOTE: THIS OFFICE DOES NOT ACCEPT AUTO INSURANCE OR WORKER'S COMPENSATION INSURANCE.**

In the event your insurance requires a referral from your primary doctor, it is **YOUR** responsibility to make arrangements with your primary care doctor's office to get that referral to us prior to your appointment. **If the appropriate referral or authorization is not in our office at the time of your appointment, you will be rescheduled until we receive this referral.** Being a specialist physician, we **cannot** render care to a patient without the authorization of the primary doctor.

If your insurance company has not paid your bill in full within 60 days, you will be expected to take care of that bill. Any balance due from you after your insurance has been paid will be due within 30 days from receipt of your statement. We will always send you a statement once your insurance company has paid its portion. In the event of a large balance due from an operation, we can arrange a payment plan suitable for all parties concerned.

We will try our best to work with you to make paying your bill as easy as possible. We accept cash, checks, Visa and MasterCard.

Diagnostic Films Review for Established Patients:

For those patients who have imaging studies performed after their initial appointment with the physician. You may chose to bring those films and the imaging report to the office for your physician to review without an appointment. When the physician has reviewed the films, he will dictate a letter to you outlining the results and any future treatment plan that may be needed. There is a charge of \$50.00 for this service, which will be requested by one of our billing staff over the telephone prior to the review, as this is a non-covered service by your insurance company.

I have read and understand the above policy, and I will adhere to it.

Also, I give my consent at this time to release my medical records and information to my insurance company, any hospital or any other physician involved in my care with Dr. Baker, Dr. Behrmann, Dr. Bellew, Dr. Field, Dr. Hartman, Dr. Hellinger, Dr. Gandhi, Dr. Garg, Dr. Jenkins, Dr. Sawin or Dr. Rosen. I also authorize payment of medical benefits to my provider.

Patient Signature/ Date

Christopher J. Baker, M.D.
Donald L. Behrmann, M.D., Ph.D.
Michael P. Bellew, M.D.
Melvin Field, M.D.
Ravi H. Gandhi, M.D.
Ankur Garg, M.D.
Cory Hartman, M.D.
Frank R. Hellinger, Jr., M.D., Ph.D.
John A. Jenkins, M.D.
David S. Rosen, M.D.
Paul D. Sawin, M.D.



Account#: _____

**NOTICE TO PATIENTS
OF ORLANDO NEUROSURGERY, P.A.**

Regarding the Dispensing of Opioid (Narcotic) Pain Medications

Dear Patient:

In their response to the "Opioid Crisis". The State Legislature of Florida unanimously passed the Controlled Substances Bill (CS/CS/HB 21) on March 9, 2018. This bill was signed into law by Governor Rick Scott on March 19, 2018 and takes effect on July 1, 2018. This new law impacts all Florida Licensed Physicians, regardless of specialty, and their patients.

The Controlled Substances law regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These drugs are often used to treat "acute pain", such as the pain associated with surgery. Examples of Schedule II drugs include pain medications like Percocet (oxycodone) and Dilaudid (hydromorphone). Schedule III drugs include Tylenol + codeine.

This new law mandates the following restrictions for prescriptions used to treat acute (post-surgical) pain:

Schedule II drugs

- Limited to 3-day supply only
- With an "acute pain exception", a 7-day supply can be provided under special circumstances
- All dispensing will be limited to the 14 days immediately post-surgery

Schedule III drugs

- Limited to a 14-day supply
- All dispensing will be limited to the 14 days immediately post-surgery

These new regulations significantly impact the pain management your surgeon and staff are allowed to provide you after surgery. Narcotic pain medications, which have been the staple of post-surgical pain control, are now permitted by law to be dispensed only in small quantities and for a short period of time. We regret any inconvenience and discomfort that these new restrictions may cause you as you recover from your procedure.

Should you have any questions regarding the new Controlled Substances regulations, please ask your surgeon or his staff.

Any comments regarding how this new legislation has impacted you (as a patient recovering from surgery) should be directed to your State Senator or House Representative. A list of these individuals and their contact information will be provided upon request.

FOR THE PATIENT:

I have read and understand this information.

X _____
Print Name

X _____
Signature

X _____
Date