Please complete all forms included in this packet.
Please call (833) 367- 4968 with any questions

11809 N. Dale Mabry Hwy
Tampa, FL 33618

PERSONAL INFORMATION

DATE:_____

FIRST NAME_____MI_____LAST NAME_____

MALE □ FEMALE □ OTHER □ DATE OF BIRTH_____AGE _____

SOCIAL SECURITY # _____

ADDRESS_____CITY_____STATE_____ZIP _____

HOME PHONE #_____CELL PHONE # _____

EMAIL ADDRESS _____

HEIGHT_____FEET_____INCHES WEIGHT_____POUNDS

MARITAL STATUS: □ Single □ Married □ Partnered □ Divorced □ Widowed

EMERGENCY CONTACT INFORMATION

By signing below, the following information may be discussed with my emergency contacts:

☐ Appointment information

☐ My personal medical information (including symptoms, diagnosis, treatment plan and medications

☐ Lab results, tests and imaging

☐ Location in facility and progress updates

*****Authorization cancellation must be submitted in writing*****

CONTACT NAME_____RELATIONSHIP _____

HOME PHONE #_____CELL # _____

CONTACT NAME_____RELATIONSHIP _____

HOME PHONE #_____CELL # _____

Signature Required

Patient/Guardian Signature _____

Printed Name_____**Date** _____

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF INSURANCE CARD – FRONT AND BACK

AUTO ACCIDENT ☐ **SLIP & FALL** ☐ **OTHER** ☐ _____

YOUR AUTO INSURANCE:

COMPANY NAME_____ CLAIM # _____

COMPANY ADDRESS_____ CITY_____ STATE_____ ZIP _____

POLICYHOLDER'S NAME_____ RELATIONSHIP _____

POLICY #_____ STATE IN WHICH ACCIDENT OCCURRED _____

CASE MANAGER/ADJUSTER_____ PHONE # _____

HAS AT FAULT PARTY ACCEPTED LIABILITY? YES ☐ **NO** ☐

ATTORNEY INFORMATION: *If you are represented by an attorney for this condition, please complete the following:*

FIRM_____ ATTORNEY NAME _____

CASE MANAGER/PARALEGAL_____ PHONE # _____

ADDRESS_____ FAX # _____

EMAIL ADDRESS _____

SYMPTOM HISTORY

1. What is the main reason you are seeking treatment?_____

   _____

   _____

2. When did you start to experience symptoms? _____
3. Where are you experiencing pain/symptoms: Cervical (Neck) ☐ Lumbar (Low Back/Legs) ☐ Both ☐
4. What side of your body do you experience symptoms? Right ☐ Left ☐ Both ☐
5. Were you injured in an accident? YES ☐ or NO ☐ If YES, when did accident occur? _____

   EXPLAIN _____
6. Are you experiencing radiating symptoms? YES ☐ NO ☐ If YES, please check all apply:

   NECK: Pain ☐ Numbness ☐ **T**ingling ☐ Burning ☐ Stinging ☐ Weakness ☐

   Shoulders ☐ Arms ☐ Hands ☐ Fingers ☐ Headaches ☐ Blurry Vision ☐ Facial Numbness/Tingling ☐

   LOW BACK Pain ☐ Numbness ☐ Tingling ☐ Burning ☐ Stinging ☐ Weakness ☐

   Low Back ☐ Hips ☐ Buttocks ☐ Groin ☐ Legs ☐ Feet ☐ Toes ☐
7. What causes your symptoms to increase? Sitting ☐ Standing ☐ Laying Down ☐ Walking ☐

   Other_____
8. What helps to alleviate your symptoms? _____
9. What conservative treatments have you tried so far?

   Physical Therapy ☐ Chiropractic Treatments ☐ Pain Management/Injections ☐ Facet Injections ☐

   Radiofrequency Ablation ☐ Pain Relievers ☐ Anti-inflammatories ☐ Tens Unit ☐ Stimulator ☐
10. Do your symptoms affect your daily lifestyle? YES ☐ NO ☐ If YES, HOW? _____
11. What type of work do you do?_____Are you still working? YES ☐ NO ☐

    If NO, when did you stop?_____WHY? _____
12. Have you experienced any prior significant neck or back pain? YES ☐ NO ☐ **IF YES, WHEN**? _____
13. Have you had previous spine surgery? YES ☐ NO ☐ Body Part? NECK ☐ BACK ☐

    If **YES,** please complete:

    Surgeon Name_____Phone # _____

    Address_____City _____ State ____ Zip_____

    Date of Surgery_____Level(s)_____Type of surgery Performed _____

    Date of Surgery_____Level(s)_____Type of surgery Performed _____

AUTO ACCIDENT/PERSONAL INJURY INFORMATION

ACCIDENT INFORMATION:

1. ACCIDENT DATE: _____ TIME: _____ AM or PM

2. WHERE DID THE ACCIDENT OCCUR? CITY_____STATE_____

3. WERE YOU THE: DRIVER □ PASSENGER □ PEDESTRIAN □

4. WAS THE IMPACT FROM: THE FRONT □ BACK □ LEFT SIDE □ RIGHT SIDE □

5. WERE YOU RESTRAINED/WEARING YOUR SEAT BELT? YES □ NO □

6. AT WHAT SPEED WERE YOU GOING UPON IMPACT? _____

7. WERE YOU IMMEDIATELY TRANSPORTED TO THE HOSPITAL VIA AMBULANCE/POV?

   YES □ NO □

8. IF NO, DID YOU GO TO HOSPITAL ON YOUR OWN ACCORD? YES □ NO □

9. WERE YOU ADMITTED OR TREATED AS AN OUTPATIENT? _____

10. WERE X-RAYS TAKEN? YES □ NO □ MRI/CT SCAN? YES □ NO □

11. ARE YOU CURRENTLY UNDER A DOCTOR'S CARE? YES □ NO □

12. IF YES, WHAT IS THE DOCTOR'S NAME? _____

DETAILS OF ACCIDENT (WITH AS MUCH DETAIL AS POSSIBLE, PLEASE EXPLAIN):

_____

_____

_____

_____

_____

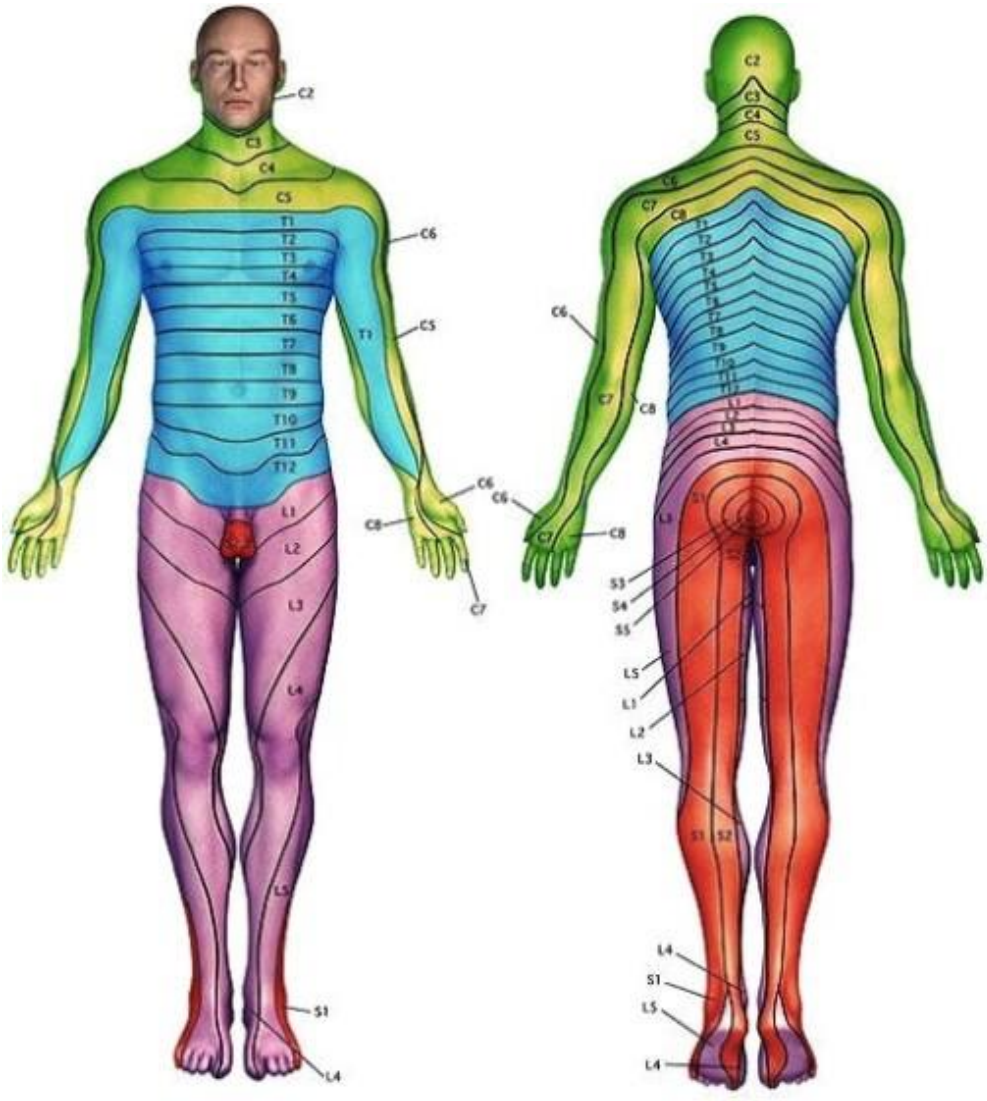
_____

_____

SYMPTOM HISTORY

Using the following symbols, please draw in the location of your symptoms on the diagrams.

X = Pain - **O** = Numbness/Weakness - ***** = Tingling/Pins & Needles



If you have NECK PAIN, what percentage is Neck_____% and_____% Arm, (Total 100%)
If you have BACK PAIN, what percentage is Back_____% and_____% Leg. (Total 100%)

Mark an **X** on the line indicating your usual amount of pain.
(0 Meaning No Pain, 10 Meaning Worst Pain)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

CONSERVATIVE TREATMENT

CHIROPRACTIC: PROVIDER NAME: _____ PHONE #:_____

PERCENTAGE OF RELIEF _____ NUMBER OF WEEKS TREATED _____ SESSIONS/WEEK _____

PHYSICAL THERAPY: PROVIDER NAME: _____ PHONE #:_____

PERCENTAGE OF RELIEF _____ NUMBER OF WEEKS TREATED _____ SESSIONS/WEEK _____

IF YOU DID NOT COMPLETE 6-12 WEEKS OF PHYSICAL THERAPY, PLEASE EXPLAIN WHY:

_____

_____

MASSAGE: PROVIDER NAME: _____ PHONE #:_____

PERCENTAGE OF RELIEF _____ NUMBER OF WEEKS TREATED _____ SESSIONS/WEEK _____

ACUPUNCTURE: PROVIDER NAME: _____ PHONE #:_____

PERCENTAGE OF RELIEF _____ NUMBER OF WEEKS TREATED _____ SESSIONS/WEEK _____

PAIN MEDICATION: PRESCRIPTION

Are you currently taking pain medication prescribed by a physician? **YES** □ **NO** □

If YES, who prescribes the medication to you?

PROVIDER NAME:_____PHONE # _____

PAIN MANAGEMENT: PROVIDER NAME: _____ PHONE #:_____

Treatments	Cervical/Lumbar (Circle)	Date(s)	Percentage of Relief
Cortisone/Prednisone	CS LS		
Epidural Steroid (ESI)	CS LS		
Facet Injection	CS LS		
Radio Frequency Ablation (RFA)	CS LS		
Selective Nerve Root Block (SNRB)	CS LS		
Steroid Pack			
Pain Patches			

NEW PATIENT MEDICAL HISTORY

MEDICAL HISTORY: ***Place a ✓ next to all that apply***

Alcohol/Substance Abuse		Emphysema		Multiple Sclerosis	
Angina		Fibromyalgia		Nervous System Disease	
Arthritis		Gastrointestinal Disease		Prior Infections	
Asthma		GERD		Pulmonary (Lung) Disease	
Bleeding Disorders		Headaches/Migraines		Rheumatic Fever	
Blood Clot(s)		Heart Attack		Seizures	
Cancer		Heart Murmur		Skin Disorders	
Cataracts		Heart Rhythm Abnormalities		Sleep Apnea	
Cholesterol Disease		Hepatitis		Strokes/TIA	
Congestive Heart Failure		High Blood Pressure		Tremors	
Coronary Heart Disease		HIV/AIDS		Thyroid Disease	
Depression/Anxiety		Kidney/Bladder Disease		Tuberculosis	
Diabetes		Liver Disease		Vascular Disease	
Diverticulitis		MRSA		Other	

SURGICAL HISTORY: ***Place a ✓ next to all that apply***

Abdominal		Foot		Nerve Stimulator/Pump	
Anesthesia Complications		Gallbladder		Pacemaker/Defibrillator	
Angioplasty/Stents		Hand		Prostate	
Ankle/Knee/Hip		Hernia		Thyroid	
Appendix		Dura Leak History		Tonsils	
Arm		Leg		Wisdom Teeth/Adenoids	
Breast		Cervical Spine/Neck		Uterus/Ovary	
Chest/Lung		Thoracic Spine/Mid Back		Varicose Veins	
Coronary Artery Bypass		Lumbar Spine/Low Back		Wrist/Shoulder/Elbow	

PAST SURGERIES/HOSPITALIZATIONS – Please provide if checked above

TYPE (specify left/right	DATE	LOCATION/FACILITY

NEW PATIENT MEDICAL HISTORY

Do you take blood thinners? (Plavix, Coumadin, Aggrenox, Ticlid, Pletal, Other)
Yes □ No □

MEDICATION HISTORY:

List ALL Current Medications: If more space is needed please attach another sheet of paper.

Medication Name	Dosage (milligrams, grams)	How Many Times Per Day?	How Long?

SUPPLEMENTS: List ALL Current Supplements Being Taken:

Name	Dosage	Date Last Taken	**Name**	Dosage	Date Last Taken

ALLERGIES:

Are you allergic to latex? Yes □ No □ **Are you allergic to Iodine/Shellfish?** Yes □ No □

List ALL Known Allergies:

Drug Or Food Name	Type of Reaction Example: Rash – Hives – Swelling - etc

NEW PATIENT MEDICAL HISTORY

OTHER PROVIDERS/SPECIALISTS: ***PLEASE PROVIDE ALL INFORMATION REQUESTED***

Specialist	Physician's Name	Phone #	Last Visit
Cardiologist			
Gastroenterologist			
Neurologist			
Oncologist			
Pulmonologist			
Other_____			
Other_____			
Other_____			
Other_____			

FAMILY HISTORY:

CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer Type: ____	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: ____	Other: ____
Mother																	
Father																	
Brother																	
Sister																	
Child																	
MGM																	
MGF																	
PGM																	
PGF																	
Other																	

NEW PATIENT SOCIAL HISTORY

TOBACCO USE:

Do you currently use tobacco OR nicotine products? Yes □ No □

Age/Year Started:_____ Age/Year Quit: _____

If you are currently using tobacco/nicotine products, please indicate quantity per day:

Tobacco/Nicotine Type	Daily Amount
Chewing Tobacco/Smokeless Tobacco	
Cigars	
Cigarettes	
E - Cigarette	
Nicotine Patch	

CAFFEINE/ALCOHOL USE:

Do you currently drink caffeinated or alcoholic beverages? Yes □ No □

Type	Daily Amount
Coffee	
Tea	
Soda	
Energy Drinks	
Alcohol	

PLEASE SIGN AND DATE UPON COMPLETION OF REGISTRATION FORMS:

Signature Required

Patient/Guardian Signature _____

Printed Name_____**Date** _____

HIPAA Authorization For Use Or Disclosure of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth:_____**SSN:** _____

I. My Authorization: I authorize the following using or disclosing party: **360 Ortho and Spine** **to use or disclose the following health information.**

☐ - All of my health information

☐ - My health information relating to the following treatment or condition: _____

☐ - My health information covering the period from_____(date) to_____(date)

☐ - Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Phone_____Fax_____Email _____

Name (or title) and organization _____

Phone_____Fax_____Email _____

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: _____

This authorization ends:

☐ - On (date)_____

☐ - When my case/claim is settled and is closed.

HIPAA Authorization For Use Or Disclosure of Health Information

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient:_____Date: _____

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date:_____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: _____

Date:_____ Time: _____

ASSIGNMENT OF BENEFITS, LIENS, DIRECT PAYMENT AUTHORIZATION, AUTHORIZATION TO RELEASE INSURANCE INFORMATION, AND AUTHORIZATION TO ESCROW UNPAID MEDICAL & PIP BENEFITS

360 ORTHO AND SPINE, LLC

For and in consideration of 360 ORTHO AND SPINE, LLC agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to 360 ORTHO AND SPINE, LLC for Personal Injury Protection, extended Personal Injury Protection, Medical Payment Coverage, and other benefits which I may have in accordance with Florida Statute §627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize 360 ORTHO AND SPINE, LLC to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

I hereby further give a lien to 360 ORTHO AND SPINE, LLC against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by 360 ORTHO AND SPINE, LLC as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of my rights and benefits to the extent of the charges for services provided. I agree to cooperate with 360 ORTHO AND SPINE, LLC and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to 360 ORTHO AND SPINE, LLC including, but not limited to, disclosing my medical condition, being available for factual discovery or other cooperation.

This assignment concerns only the bills for 360 ORTHO AND SPINE, LLC and those costs including, but not limited to, attorney's fees, other costs, and interest necessary in procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible or co-payment not covered by any policy of insurance cited above. I understand that as a benefit and convenience to me, 360 ORTHO AND SPINE, LLC will bill and pursue collection against the insurance company or other responsible entity on my behalf. I hereby instruct and direct my insurance company to pay my benefits directly to 360 ORTHO AND SPINE, LLC at the address provided on the bill. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company or other responsible entity to make the check payable to me and mail it to 360 ORTHO AND SPINE, LLC at the address on the bill. 360 ORTHO AND SPINE, LLC's medical care is being provided for a reasonable fee for treatment causally related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. If any portion of the charge for these services is either reduced or denied in whole or in part, my insurance company or other entity is to place funds equal to the amount of the reduced or denied charges into escrow and hold the escrowed funds until agreement or resolution of legal action by 360 ORTHO AND SPINE, LLC. I further instruct my insurance company to make payment for charges submitted by 360 ORTHO AND SPINE, LLC in priority to any other requests to escrow benefits, including a request by myself to reserve benefits for pending disability claims. I hereby give 360 ORTHO AND SPINE, LLC limited power of attorney to endorse and sign my name on any draft for payment to either 360 ORTHO AND SPINE, LLC or myself if said draft represents payment for charges related to services rendered by 360 ORTHO AND SPINE, LLC.

I further direct my insurance carrier or responsible other entity to provide information to 360 ORTHO AND SPINE, LLC which is otherwise available to me including but not limited to a copy of any applicable insurance policy, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath and requests for same, independent medical evaluations and requests for same, peer review reports, and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP log". This request includes the name of other medical providers to whom payments have been made under my policy of insurance. This agreement is intended to serve as an assignment of rights and benefits under my policy of insurance in favor of 360 ORTHO AND SPINE, LLC. If any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

Date:_____

Patient Printed Name: _____

Patient Signature: _____