



Joseph C. Flynn, Jr., MD	Geoffrey Stewart, MD	Javier A. Placer, MD
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EMAIL ADDRESS:					
Appointment:		Allergies:			
Last Name:		First Name:		MI:	
Home Phone:		Work Ph:		Ext:	Sex:
Street address:				DOB:	
City:		State:	Zip:	SS#:	
If Minor, Name of Parent:				Sex:	
Name of School or Employer:					
Address of Employer:					
Emergency Contact:			Relationship to you:		
Phone #:		Marital Status:			
Referring Physician:			Phone:		
Primary Physician:			Phone:		
Reason for visit:					
Do you have x-rays or MRI films?: Y or N			Advised to bring them: Y or N		
Have you ever seen another surgeon for this problem: Y or N					
If yes where:			When?		
Insurance Plan 1 Name:			Policy #:		
Insurance Address:					
City:		State:		Zip:	
Insurance Plan 2 Name:			Policy #:		
Insurance Address:					
City:		State:		Zip:	
Policy Holder:			DOB:		SS#:
Worker's Comp: Y or N		Auto Accident: Y or N		Date of Injury:	
Claim#:		Place of Accident:			

PLEASE SEE OTHER SIDE FOR DIRECTIONS TO OUR OFFICE



Welcome to The Spine & Scoliosis Center, PA. **Please remember to bring all paperwork we sent you, along with any and all films that you may have. Please bring in your Actual Films or CDS.** If your insurance requires you to have a referral to see a specialist, it is your responsibility to obtain this referral and bring it with you. If you don't have your FILMS or REFERRAL you will be RESCHEDULED. Please also remember that co-pays and coinsurance are due at time of service.

Please refer to the address checked below for the location of your visit.

☐ **ORLANDO**- 1131 SOUTH ORANGE AVE ORLANDO, FL 32806
Ph: 407-849-1200 Fax: 407-841-6940

From North Orlando, Take I-4 west to the Kaley East Exit and go left. Go left on Orange Ave. Go North on Orange Ave to Columbia Street. We will be on the right hand side of the street across from MD Anderson Cancer Center.

From South Orlando, Take I-4 east to the Kaley Exit, and go right. Go left on Orange Ave (there is an Einstein Brothers Bagels and a fire Station on the Corner). Go a little past the ORMC main hospital and ER (we are on the right side of the street). We are located at the dead-end of Columbia Street across from MD Anderson Cancer Center.

☐ **DAVENPORT**- 104 Park Place Blvd, SUITE A, DAVENPORT, FL 33837

Ph: 863-419-1277

From US 27 S take a right on Park Place Boulevard. Take the second right into our parking lot. We are the two story red roof building. Our office is opposite the Cypress Medical Office Building.

NOTE: The Heart of Florida Regional Medical Center is a physician-owned facility. Dr. Geoffrey Stewart is an investor in such.

☐ **CLERMONT**-1925 DON WICKHAM DRIVE, CLERMONT, FL 34711

Ph: 352-242-2826

From Citrus Tower Blvd turn into South Lake Hospital Parking Lot. Go to the third stop sign and make a right at the third stop sign. We are towards the end of the road on the right hand side at The National Training Center Sports Medicine Building.

**PLEASE VISIT OUR WEBSITE FOR FURTHER DIRECTIONS.
PLEASE CLICK ON LOCATIONS TO VIEW THE MAPS TO OUR FACILITIES.**

WWW.SPINEDOCTORS.MD



Name:		Date:
Allergies:		Date of Injury:
Referring Physician:		Family Physician
Chief Complaint:		
What was the initial cause of the pain?		
Previous Treatment:		
Are you R or L Hand Dominant: R or L		Have you lost bowel or bladder function? Y or N
Back pain: Y or N	Leg Pain: Right or Left or Both	
Neck Pain: Y or N	Arm Pain: Right or Left or Both	
Shoulder Pain: Y or N Right or Left or Both		
Numbness: Y or N	Where:	
Employment:		
Current Employer:		How long:
Still Working: Y or N	Last Date Worked:	
Current Medications and Frequency:		
Herbal/Mineral or Dietary Supplements:		

Family History:						
	Father	Mother	Brother	Sister	Son	Daughter
Heart Trouble						
High Blood Pressure						
Diabetes						
Arthritis						
Mental Illness						
Alcoholism						
Cancer						
Stroke						
Other:						



Past Medical History: List all Illnesses, Injuries, Surgeries and Dates:

Check Only Items you Now have or Have Had Recently and Add Items Not Shown

Constitutional:	Eyes	ENT	Cardiovascular
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Reading Glasses	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Heart or Chest Pain
<input type="checkbox"/> Hot or cold Spells	<input type="checkbox"/> Change in Vision	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Malaise	<input type="checkbox"/> Blurring	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Abnormal Heartbeat
		<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Badly Swollen Ankles
Respiratory	GI		
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hemorrhoids	GU	Skin/Breast
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Rashes
<input type="checkbox"/> COPD	<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Skin Ulcers
<input type="checkbox"/> Cough	<input type="checkbox"/> Abdominal Pain		<input type="checkbox"/> Masses
Endocrine	Neurological	Psych	Musculoskeletal
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Hand Trembling	<input type="checkbox"/> Depression	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Arthritis Pain
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Gait Disturbance		<input type="checkbox"/> Muscle Spasms

Social History

Alcohol Use	Caffeine	Children	Drug Use
<input type="checkbox"/> Never	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> None
<input type="checkbox"/> Occasional	Describe	<input type="checkbox"/> No	<input type="checkbox"/> Presently
<input type="checkbox"/> Moderate		No of children	<input type="checkbox"/> Past Problem
<input type="checkbox"/> Heavy			<input type="checkbox"/> Prescription only

Education	Exercise	Marital Status	Smoking
Years	<input type="checkbox"/> > 3 times a week	<input type="checkbox"/> Married	<input type="checkbox"/> Every day smoker
	<input type="checkbox"/> < 3 times a week	<input type="checkbox"/> Single	<input type="checkbox"/> Never a smoker
Degree	<input type="checkbox"/> None	<input type="checkbox"/> Divorced	<input type="checkbox"/> Heavy smoker
		<input type="checkbox"/> Widowed	<input type="checkbox"/> Light smoker

Do you have a Living Will? Yes or No

MEDICARE PATIENTS: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made either to me or on my behalf to The Spine and Scoliosis Center for any services furnished me by the listed provider/supplier authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved health claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:

Date:

ASSIGNMENT OF BENEFITS Patients with insurances please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other plans, to The Spine and Scoliosis Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:

Date:

MEDICAL RECORDS FAX: I authorize The Spine and Scoliosis Center to transmit my medical records electronically. If they are received by another party in error, I absolve The Spine and Scoliosis Center of any and all liability relating to such of said records.

Signature:

Date:

I have read, understood, and agreed to financial policy for payment of professional fees. The patient is ultimately responsible for all financial fees,. I further understand I am responsible for any legal fees in cost of collecting any unpaid balance.

Signature:

Date:

THE SPINE & SCOLIOSIS CENTER

PATIENT PAIN DRAWING

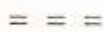
Name: _____ Date: _____

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

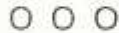
Aching



Numbing



Pins and needles



Burning



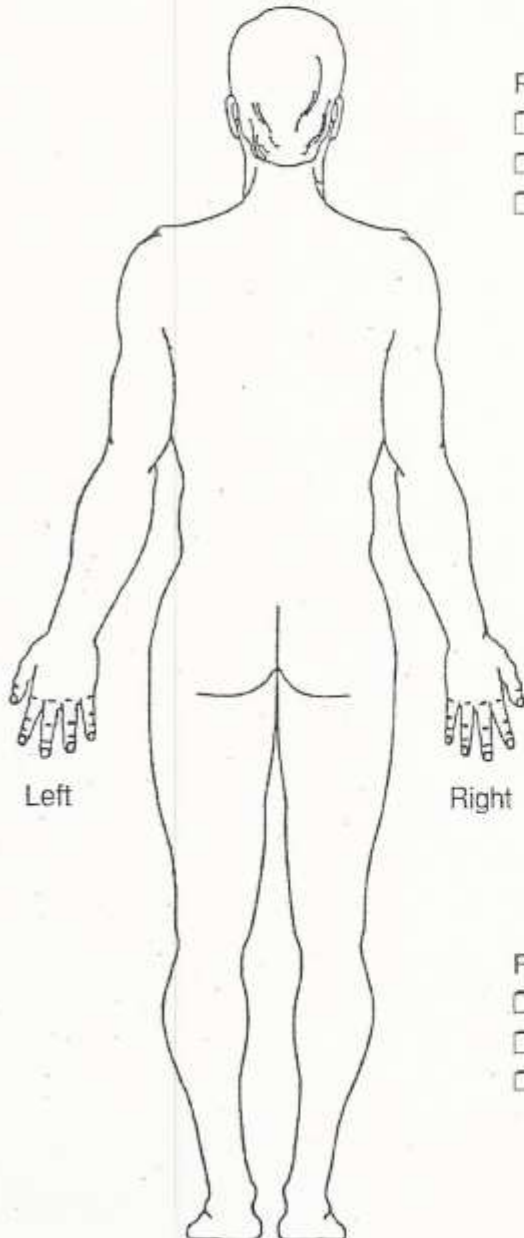
Stabbing



Other



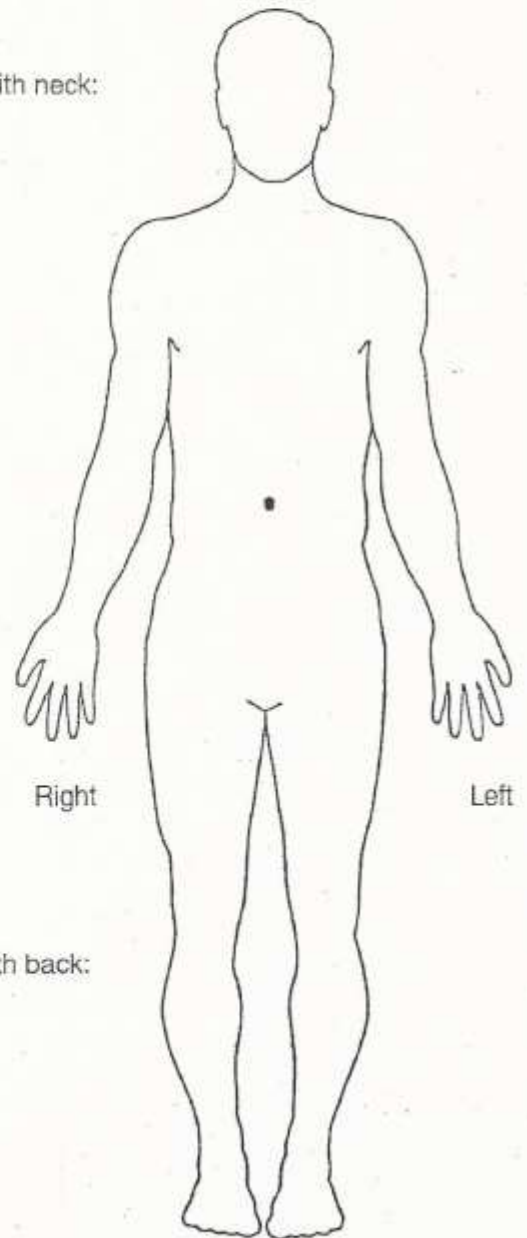
Back



Pain in arm(s) compared with neck:

- Worse than
- Same as
- Less than

Front



Pain in leg(s) compared with back:

- Worse than
- Same as
- Less than

