Please bring to your appt::

- **ID**
- **Insurance cards**
- **Disc of xrays,, MRI, CT, etc**

Geoffrey Stewart, MD	Joseph E. Snavely, MD	Narendren Narayanasamy, MD

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 Orlando Heart Institute.

☐ **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.

☐ **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.

☐ **WINTER HAVEN** –, 210 1st Street N, Winter Haven FL 33881

Ph: 407-849-1200

From I-4 West, take exit 48 toward Winter Haven. Merge onto Co Rd 557/Old Grade Rd, turn right onto Shinn Blvd. Use left lane to turn left onto US-17S, turn left onto Ave M, turn right onto E. Lake Silver Dr NE, continue on 1st St, N,

From I-4 East, take exit 48 toward Lake Alfred/Winter Haven. Turn left onto Co Rd 557/State Rd 557, continue onto E. Pomelo St, turn right onto Shinn Blvd, continue onto S. Lake Shore Way. Turn left onto US-17S. Turn left onto Ave M NW, turn right onto E Lake Silver Dr NE, continue on 1st St, N.

THE SPINE & SCOLIOSIS CENTER

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 Workng: 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
❒ Weight Change	❒ Reading Glasses	❒ Loss of Hearing	❒Heart or Chest Pain
❒ Hot or cold Spells	❒ Change in Vision	❒ Hoarseness	❒Palpitations
❒ Malaise	❒ Blurring	❒ Vertigo	❒Abnormal Heartbeat
		❒ Nosebleeds	❒Badly Swollen Ankles

Respiratory	GI		
❒ Shortness of Breath	❒ Hemorrhoids	GU	Skin/Breast
❒ Asthma	❒ Diarrhea	❒ Incontinence	❒ Rashes
❒ COPD	❒ Constipation	❒Frequent Urination	❒ Skin Ulcers
❒ Cough	❒ Abdominal Pain		❒ Masses

Endocrine	Neurological	Psych	Musculoskeletal
❒ Diabetic	❒ Hand Trembling	❒ Depression	❒ Neck Pain
❒ High Blood Pressure	❒ Loss of Memory	❒ Insomnia	❒ Back Pain
❒ Night Sweats	❒ Frequent Headaches	❒ Alcohol Abuse	❒ Arthritis Pain
❒ Hypoglycemia	❒ Gait Disturbance		❒ Muscle Spasms

Social History

Alcohol Use	Caffeine	Children	Drug Use
❒ Never	❒ Yes	❒ Yes	❒ None
❒ Occasional	Describe	❒ No	❒ Presently
❒ Moderate		No of children	❒ Past Problem
❒ Heavy			❒ Prescription only

Education	Exercise	Marital Status	Smoking
Years	❒ > 3 times a week	❒ Married	❒ Every day smoker
	❒ < 3 times a week	❒ Single	❒ Never a smoker
Degree	❒ None	❒ Divorced	❒ Heavy smoker
		❒ Widowed	❒ Light smoker

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

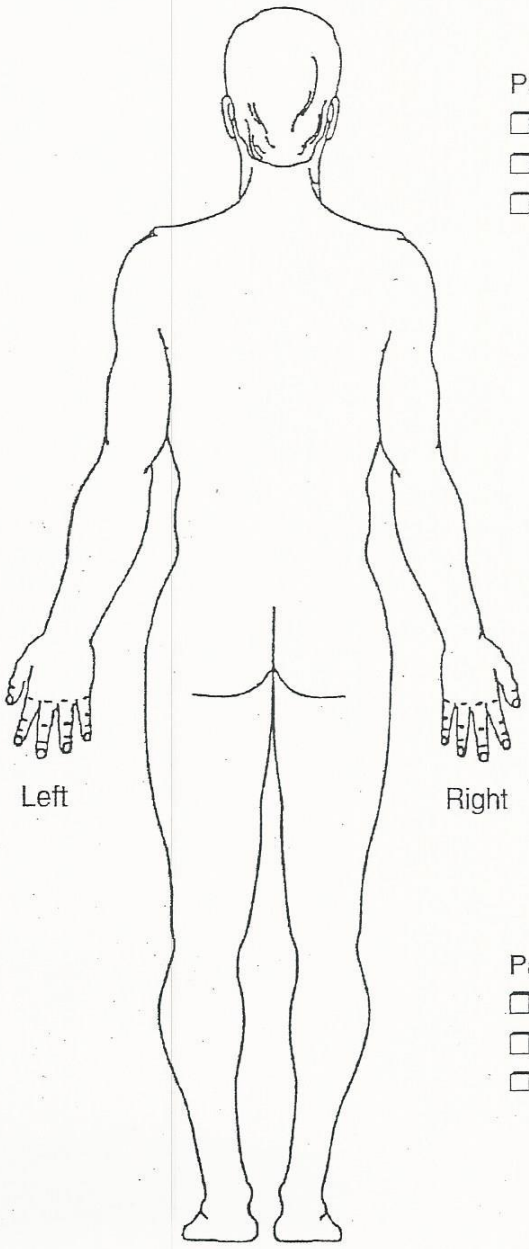
PATIENT PAIN DRAWING

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.

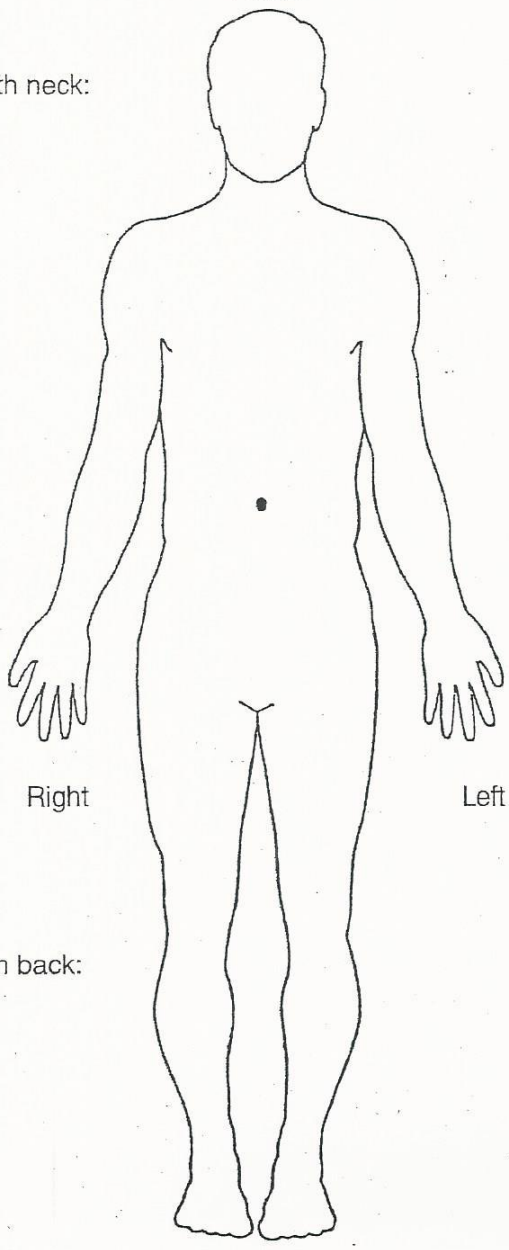
Aching	Numbing	Pins and needles	Burning	Stabbing	Other
▲ ▲ ▲	= = =	O O O	X X X	/ / /	• • •

Back



Left Right

Front



Right Left

Pain in arm(s) compared with neck:

- ❒ Worse than
- ❒ Same as
- ❒ Less than

Pain in leg(s) compared with back:

- ❒ Worse than
- ❒ Same as
- ❒ Less than

S77501 (3/00)

SPINE AND SCOLIOSIS CENTER

Name: _____DOB: _____Date: _____

What is your chief complaint?

☐ Neck pain ☐ Upper Back Pain

☐ Lower back pain ☐ Right Leg Pain

☐ Left Leg Pain ☐ Right Arm Pain

☐ Left Arm Pain ☐ Scoliosis

OTHER: _____

When did the pain start: _____

How did the Injury Occur?

☐ None ☐ Motor Vehicle Accident

☐ Fall ☐ Sports/Recreation

☐ Job Related

Other: _____

If Motor Vehicle Accident, were you?

☐ Driver ☐ Front seat passenger

☐ Rear Seat Passenger

Were you wearing a seat belt?

☐ Yes ☐ No

Did the pain start immediately or delayed onset?

☐ Immediate ☐ Delayed 1-4 days

☐ Delayed 1-2 weeks ☐ Delayed 2-4 weeks

☐ Delayed 4-8 weeks

Since the pain/condition began has it:

☐ Improved ☐ Worsened

☐ not changed ☐ continued to come and go

What aggravates the pain?

☐ Walking ☐ Standing

☐ Sitting ☐ Lying down

☐ Activity in general ☐ Nothing in particular

What makes the pain better:

☐ Walking ☐ Standing

☐ Sitting ☐ Lying down

☐ Nothing in particular

Do you have any difficulty walking?

☐ No ☐ yes can walk ony 1-2 blocks

☐ yes, non- ambulatory ☐ yes can walk < mile

Do you have any problems with bowel, bladder or sexual functions?

☐ None ☐ no but occasional constipation

☐ difficulty controlling bladder functions

☐ History of urinary tract infections

☐ Sexual problems secondary to pain

☐ Physical problems with sexual function other than pain

Other: _____

Have you tried any of the following for your pain?

☐ rest ☐ heat

☐ cold ☐ medications

☐ massage ☐ TENS unit

☐ physical therapy ☐ active exercise

☐ Sitting ☐ Lying down

☐ manipulation ☐ trigger point injections

☐ spinal injections:

○ Epidurals ○ joint or lesioning

☐ surgery ☐ pain psychology

☐ accupuncture

Other: _____

Do you participate in sports or athletics?

☐ Regularly 3x/week ☐ Regularly 2x/week

☐ Regularly 1x/week ☐ Irregularly

☐ None ☐ Medical Problems Prevent

Pharmacy Information: Name: _____

Address: _____

Phone #: _____

LIVING WILL: ( ) YES ( ) NO

Flu Shot	OSTEOPOROSIS	PNEUMONIA VACCINE
YES ☐	YES ☐	YES ☐
NO ☐	NO ☐	NO ☐
	DEXA SCAN:	
	YES ☐ DATE OF LAST SCAN _____	
	NO ☐	