



SunCoast SpineCare
 409 6th Ave. East Bradenton, FL 34208
 941-365-6400 Fax: 845-507-1153
 drschwartz@SunCoastSpineCare.com



PATIENT INFORMATION

Name: _____ Sex: _____ SS #: _____ Marital Status _____ Age _____

Address): _____ City _____ State _____ Zip _____

DOB _____ Home Tel: _____ Work Tel: _____ Cell Phone: _____

Email Address: _____ Occupation: _____ Primary Physician: _____

Spouse Name: _____ Referred by _____

Employer _____ EmployerAddress _____

MEDICAL HISTORY

What is your major complaint? _____

On a scale of 0-10 (with 0 being none), how severe is your pain? _____ How frequent? _____

When did it start? _____ How did it start? _____

What types of treatment have you tried and which doctors have you seen? _____

What makes your condition worse? _____

What makes it better? _____

Check symptoms you have experienced since the accident:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Light sensitive | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head seems heavy | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Constipation | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pain in Arms | <input type="checkbox"/> Pain in Legs |

What medications are you taking and for what conditions? _____

Have you had xrays? _____ MRI? _____ Are you diabetic? _____

List any surgical procedures you have had and when: _____

List any Medications that you are currently taking: _____

Have you had a CT scan? Yes No MRI? Yes No EMG? Yes No Other: _____

For Females: Are you pregnant or is there a chance you are pregnant? Yes No

This next section is very important. These days insurance companies are more concerned about how your condition is affecting your lifestyle rather than how much pain it causes you. Therefore in addition to asking about your pain level, we will be asking you to explain how it affects your life. What types of things you cannot do because of your condition. In



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other words, how does it affect your ability to sit and for what length of time? How does it affect your walking? How many yards or blocks can you walk before you experience the pain? These things will improve as you undergo treatment and you need to communicate these improvements with us. Don't just say you can't stand. Tell us how long you can stand before the pain starts. If you can't lift, how much can you lift before experiencing your symptoms. Can you sit at a computer? How long? Can you brush your hair? Brush your teeth? Can you sit on a toilet? Can you wash dishes? Please explain:

How does your condition affect your life? _____

INSURANCE INFORMATION

Is your Condition due to a reported On-The-Job injury? ____ Due to an Auto Accident? ____

Name of Insurance Company: _____ Your ID# _____

Insured's Name _____ Patient's Relationship to Insured _____

Insured's Employer _____ Employer's Address _____

Insured's Sex ____ Insured's DOB _____ Insured's ID # _____ Group # _____

Authorization and Assignment:

I hereby authorize that payment from the insurance company(s) direct benefits for services go directly to:

Dr. Jay H. Schwartz/SunCoast SpineCare, LLC

This is a direct assignment of my rights and benefits under my policy.

I understand that this office will prepare any necessary reports or forms to assist me in making collection from the insurance company; thereof, I also authorize the release of any information pertinent to the processing of this claim to the above mentioned insurance company(s) and or attorney(s) involved in my case. This agreement also applies to any insurance company or plan that I switch to in the future.

Patient Signature _____ Date _____

Notice of Receipt of Privacy Notice:

By signing below, I acknowledge that I have received and reviewed the privacy notice of SunCoast SpineCare, LLC in and all of my questions have been answered to my satisfaction in language that I can understand.

Patient signature: _____ Date _____