LLOYD I. MALINER, MD
NEUROSURGEON

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home#:(____)_____Mobile#: (____)_____Email:_____@_____

Date of Birth: _____/_____/_____ **Last 4 Digits of Social Security#:** _____

Age: _____ **Sex:** _____ **Race:** _____ **Marital Status:** _____ **Number of children:** _____

Current living arrangements: Living with:_____ **Relationship:** _____

Right handed: _____ **Left Handed:**_____ **Ambidextrous:** _____

Current Employment Status: _____ **Occupation :** _____

Employer: _____ **Job Title:** _____ **Work#:(** _____**)**_____

Address: _____**City:**_____ **State:**_____ **Zip:**_____

Spouse/Partner's Name: _____

Mobile#:(____) _____ **Work#: (____)** _____ **Email:** _____**@**_____

Emergency Contact (<u>not living with you</u>):

Name:_____ **Tel#:(____)**_____ **Relationship:** _____

Referring Physician: _____
Tel#: (____) _____ **Fax#: (____)** _____ **Reason for referral:**_____

Primary Care Physician: _____
Tel#: (____) _____ **Fax#: (____)** _____ **Send report of visit? YES NO**

Reason for your visit today: _____

<u>Accident Information:</u>

AUTO Accident: YES NO Date of Accident:_____/_____/_____
Worker's Comp: YES NO Date of Incident: _____/_____/_____

<u>Attorney information</u>: (If your visit is due to a legal matter)

Name: _____ **Tel#:(** _____**)**_____ **Fax#: (____)**_____

LLOYD I. MALINER, MD
NEUROSURGEON

Confidential

Patient Name _____ Today's Date _____

Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

_____ _____

_____ _____

_____ _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

LLOYD I. MALINER, MD
NEUROSURGEON

LLOYD I. MALINER, M.D.

MEDICATIONS FORM

NAME: _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

Smoker: YES NO Former Packs per day: _____ **Quit Date:** _____

Pharmacy: _____ **Tel#:** _____

ALLERGIES: _____

Medications currently taking:

NAME	DOSAGE	FREQUENCY

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

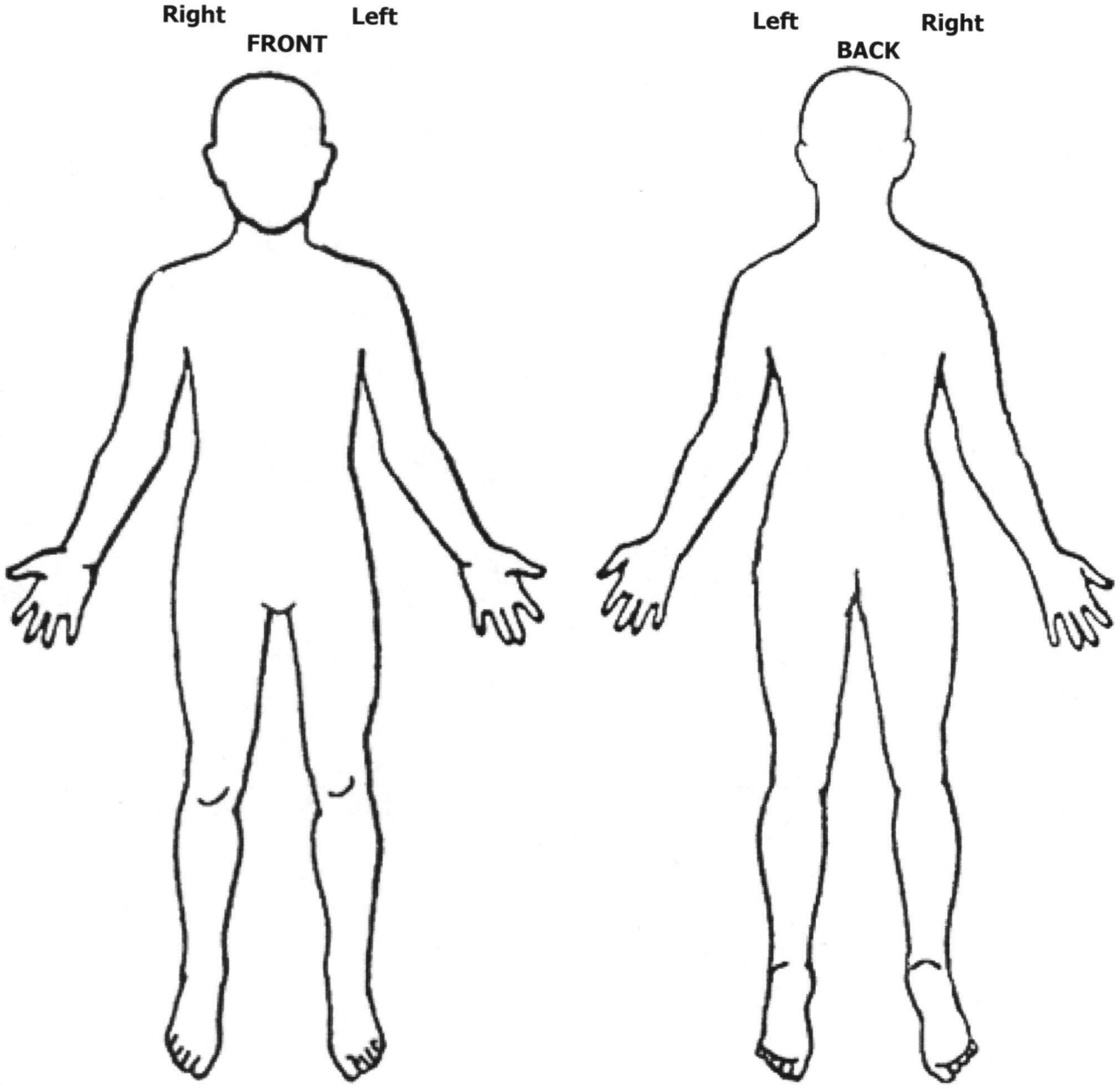
Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

0	1	2	3	4	5	6	7	8	9	10
no pain	mild	discomforting				distressing		horrible		excruciating

(Please indicate level of pain at the moment. Please indicate location of pain on diagram)



How long have you had pain? _____ days_____ weeks_____ months_____ years

Is pain? constant/ only when active/ only laying down /walking / standing / bending / sitting / other.
How often is your pain? all day / only morning / only afternoon / only evening/ no pattern

Physical Therapy: YES NO start date:____/____/____ end start: ____/____/____
Epidural Injections/Nerve Blocks: YES NO How many:_____ Date(s): ____/____/____

Signature: _____Date: _____/_____/_____

LLOYD I. MALINER, M.D.

MEDICAL RECORD RELEASE AND REQUEST FORM

I authorize **Lloyd I. Maliner, MD** to **REQUEST** all medical information from my **Health Insurance Carrier and any other Third-Party Payers.**

I authorize to **Lloyd I. Maliner, MD** to **OBTAIN** all medical information from my **Referring Physician, my Primary (Family) Physician, Hospitals and Diagnostic Centers** where I have been treated.

I authorize **Lloyd I. Maliner, MD** to contact my Insurance Company or Health Plan Administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the Insurance Company or Health Plan Administrator to release such information to **Lloyd I. Maliner, MD**

I agree that these provisions will remain in effect until I provide written revocation to **Lloyd I. Maliner, MD.**

Patient Name: _____

Date of Birth: _____/_____/_____ **Social Security Number: XXX - XX -** _____

Patient Signature: _____ **Date:** _____/_____/_____

I hearby AUTHORIZE, Lloyd I. Maliner, MD to release my confidential information, or a copy of my complete medical records, or a summary or narrative of my protected health information, to the PERSON listed below:

Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____/ _____/ _____

PLEASE FAX RECORDS TO 954-577-1931

Lloyd I. Maliner, M.D.

NOTICE TO PATIENTS

"Under Florida Law, physicians are generally required to carry medical insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

We are required by law to give you a copy of this notice to sign, acknowledge its receipt and keep in your patient file.

NOTIFICACIÓN A LOS PACIENTES

Bajo la ley de la Florida, se requiere que los medicos tengan un seguro médico o de otra manera demonstrar responsabilidad financiera para cubrir reclamos de negligencia medica. SU MEDICO HA DECIDIDO NO TENER EL SEGURO DE NEGLIGENCIA MEDICA. Esto es permitido bajo la ley de la Florida sujeto a ciertas condiciónes. La ley de la Florida impone penalidades en contra de los medicos que no estan asegurados y que no pueden satisfacér los reclamos de negligencia medica. Esta notificación es proveida mediante la ley de la Florida.

La ley requiere de nosotros que le demos esta notificación a los pacientes para que la firmen despues de que la lean y la comprendan. Una copia de esta notificación firmada por el paceinte sera guardada en su expediente.

Patient Name: _____

Patient Signature: _____

Date: _____

Lloyd I. Maliner, M.D.

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I, _____,
(PATIENT PRINTED NAME)

understand that as part of my health care, **LLOYD I. MALINER, MD,** originates and maintains paper and/or computerized records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with the ***Notice of Information Practices*** that provides a more complete description of information usage and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I understand that, **LLOYD I. MALINER, MD,** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or by revoking this consent, this organization may

I further understand that, **LLOYD I. MALINER, MD,,** reserves the right to change their notice and practices and prior implementation, in accordance with the section 164.520 of the Code of Federal Regulations.
Should **LLOYD I. MALINER, MD,,** change their notice, they will send a copy of any revised notice to address I've provided (whether US mail or, if I agree, email).

I wish to have the following restriction(s) to the usage or disclosure of my health information:

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted usages, including disclosures via fax.
I fully understand and accept/decline the terms of this consent.

Patient Signature/Guardian: _____ **Date:** _____