Today's Date: _____

Name: _____Middle Inial: _____ Date of Birth: _____

Address: _____

STREET CITY STATE ZIP CODE

Gender: ⬜ Male ⬜ Female Social Security #: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

E-mail: _____ Marital Status: _____Single _____Married _____Divorced _____ Widowed

Race/Ethnicity: _____American Indian _____Hispanic/Latino _____Asian _____African American _____White _____Other

Is your visit related to an Auto Accident? Yes No Open Claim ? **Yes No**

Is your visit related to a Work Accident? Yes No Open Claim ? **Yes No**

Is your visit related to a Slip & Fall? Yes No Open Claim ? **Yes No**

How were you referred? _____ Primary _____Specialty _____Friend/Family _____Advertising _____Other (please specify)

Referring Physician (if applicable): _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____

Address: _____

STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____ Work Phone: _____

2. Name: _____ Relationship: _____

Address: _____

STREET CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PROVIDER HISTORY

Primary Care Physician:

Name: _____Phone Number: _____ Fax: _____

Address: _____

STREET CITY STATE ZIP CODE

Other:

Name: _____ Phone Number: _____

Address: _____

STREET CITY STATE ZIP CODE

INSURANCE INFORMATION

Primary Insurance

Person Responsible: ___ Self ___ Other Relationship to Patient: _____

Name: _____ DOB: _____ Social Security #: _____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

Secondary Insurance

Person Responsible: ___ Self ___ Other Relationship to Patient: _____

Name: _____ DOB: _____ Social Security #: _____

Insurance Company: _____ ID Number: _____

Insurance Phone: _____ Group #: _____

Cancellation/No Show Policy:

Any Follow-up appointment cancellation or no-show in which a 24-hour notice is not provided, will result in a $30 charge.

After three occurrences you will be terminated from MAST Health. If we terminate our service with you, we will be happy to transfer a copy of your medical records to your new physician upon receipt of a signed authorization to release records.

Late Policy:

The clinic has limited waiting time for your appointment. If you are more than 15 minutes late, your appointment will be rescheduled or fit in the next available opening.

_____ _____

Signature of Patient of Legal Guardian Date

Name: _____ **Date:** _____

Social History:

Occupation: _____ When was the last time you worked? _____

___ Temporary Disability ___ Permanent Disability ___ Retired ___ Unemployed

Alcohol Use:

___ Social Use ___ Daily use of alcohol ___ Never ___ History of alcoholism ___ Current alcoholism

Tobacco Use:

___ Current user ___ Former user ___ How long has it been since you stopped smoking: _____

___ Packs per day: _____ ___ How many years: _____

Illegal Drug Use:

___ Denies any illegal drug use ___ Currently uses illegal drugs ___ Formerly used illegal drugs

Have you ever abused narcotic or prescription medications: ___ Yes ___ No

Family History:

Mark all appropriate diagnoses as they pertain to your parents and siblings:

___ Arthritis ___Diabetes ___Cancer ___Headaches/Migraines

___ High Blood Pressure ___Kidney Problems ___Liver Problems ___Osteoporosis

___ Rheumatoid arthritis ___Seizures ___Stroke Other Medical Problems: _____

___I have no significant family medical history

Past Medical History/Treatment:

LIST OF SURGERIES AND HOSPITALIZATIONS

Hospital Name, Date, Reason

_____

_____ I have NEVER had any surgical procedures performed.

Mark the following conditions/diseases that you have been treated for in the past*

Cancer/Oncology:

Cancer-Type: _____ Cancer-Type: _____ Cancer-Type:_____

Cardiovascular/Hematologic:

___ Anemia
___ Heart Attack
___ Coronary Artery Disease
___ Stroke/TIA
___Heart Valve Disorder
___ Peripheral Vascular Disease
___ Presence of stent/pacemaker/ defibrillator
___ High Blood Pressure

Gastrointestinal:

___ GERD (Acid Reflux)
___ IBS
___ Gastrointestinal Bleeding
___ Crohn's's Disease
___ Stomach Ulcers

Neurological:

___ Multiple Sclerosis
___ Seizures
___ Balance Disorder
___ Peripheral Neuropathy
___ Head Injury
___ Headaches
___ Migraine

Urological:

___ Chronic Kidney Disease
___ Kidney Stones
___ Urinary Incontinence
___ Dialysis

Respiratory:

___ Asthma
___ Bronchitis/Pneumonia
___ Emphysema/COPD

ENT:

___ Glaucoma
___ Vertigo
___ Hearing Problems
___ Nosebleeds

Musculoskeletal/Rheumatologic:

___ Bursitis
___ Osteoarthritis
___ Osteoporosis
___ Fibromyalgia
___ Carpal Tunnel Syndrome
___ Rheumatoid Arthritis
___ Chronic Joint Pains

Endocrinology:

___ Diabetes - Type: _
____ Hyperthyroidism
___ Hypothyroidism

Psychological:

___ Depression
___ Anxiety
___ ADD/ADHD
___ Schizophrenia
___ PTSD

Other Diagnosed Conditions:

_____
_____
_____
_____
_____

___ Bipolar Disorder
___ Other- Type: _____

MEDICATION HISTORY:

Please list all medications you are CURRENTLY taking. Attach additional sheet if required:
(Include all over the counter medications)

Name	Dosage	Directions	Reason for Medications

ACKNOWLEDGEMENT AND CONSENT FOR NOTICE OF PRIVACY

Acknowledge of Receipt

I have reviewed MAST Health Notice of Privacy, which explained how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: Yes No

_____ _____ _____

Name of Patient *(Please Print)* Signature of Patient of Legal Guardian Date

Consent to Release Medical Information to Personal Representative

I, _____, hereby consent to have my information released to the following individuals.

This consent will remain in effect until otherwise notified by me in writing.

Appointment times Medical Information Billing/Demographic Info

Do NOT release my information, except to health care providers and…

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

PATIENT AUTHORIZATION & CONSENT

I hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by MAST Health or their authorized designees, as they may in their professional judgment be necessary to provide appropriate medical, surgical or emergency care. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, all costs, and expenses, including but not limited to reasonable attorney's fees that may incur in such collection efforts.

I authorize MAST Health physicians to submit claims to my insurance for services rendered by my medical providers. I authorize the release of any medical information necessary to process this assignment on the claim. I authorize payment to be made to MAST Health physicians for services provided by them.

_____ _____
Signature of Patient of Legal Guardian Date

MAST Health

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I Authorize **MAST Health** to use and disclose the protected health information described below.
By signing,

- ***I authorize the release of my complete health record (including records related to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).***
- ***This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.***
- ***This authorization shall be in force and effect during my entire care at*** MAST Health.
- ***I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on*** the authorization ***or if*** the authorization ***was obtained as a condition of obtaining insurance coverage*** and the insurer ***has a legal right to contest a claim.***
- ***I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.***
- ***I may inspect and receive a copy of the information being used and disclosed pursuant to this Authorization form.***
- ***I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.***

_____ _____ _____

Printed Patient Name & DOB Patient Signature Date

Assignment of benefits, liens, direct payment authorization, authorization to release insurance information, and authorization to escrow unpaid medical & PIP benefits

MAST Health

Insurance Carrier_____

For and consideration of MAST Health agreeing to pursue the responsible insurance carrier for payment of benefits due and not requiring prepayment for services, I hereby irrevocably assign all rights and benefits to MAST Health for Medical Payment Coverage, and other benefits which I may have accordance with Florida Statute § 627.736. This includes any benefits from my insurance company and any other entity may be responsible for medical expenses incurred. I further authorize MAST Health to collect payments & prosecute any necessary actions to collect payments for services as they see fit and allowable by law and contract.

THIS DOCUMENT CONSTITUTES AN ASSIGNMENT OF RIGHTS AND BENEFITS.

This assignment concerns only the bills for MAST Health and those costs including, but not limited to, attorney's fees other costs, and interest necessary in procuring payment from the above-names 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 copayment not covered by any policy of insurance cited above . I understand that as a benefit and convenience to me, MAST Health will bill any pursuit 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 MAST Health on 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 MAST Health at the address on the bill. MAST Health medical care is being provided for a reasonable fee for treatment that I have sought out for under my above mentioned insurance carrier 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 MAST Health. I further instruct my insurance company to make payment for charges submitted by MAST Health in priority to any other request to escrow benefits,including a request by myself to reserve benefits for pending disability claims . I hereby give MAST Health limited power of attorney to endorse and sign my name on any draft for payment to either MAST Health or myself if said draft represents payment for charges related to services rendered by MAST Health.

I further direct my insurance carrier as the responsible entity to provide information to MAST Health which is otherwise available to me including but not limited to a copay of any applicable insurance policy, declaration page,all applicable endorsements, transcripts and/or copies of any recorded statements,examinations under oath and request for same,independent medical evaluations and requests for same, and peer review reports, this request includes the name of other medical providers to whom payments have been under my policy of insurance in favor of MAST Health. 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.

I am responsible for copays, co-insurances, and deductibles prior to my office visits and surgery date if surgery is necessary.

Patient Signature	Patient Name	Date

If patient is incapacitated or under the age of 18, please indicate the patient's name, guardian name and relation to patient and obtain guardian signature.

NEW PATIENT INFORMATION

Please make sure that a response is written in EVERY SPACE

Name: _____

Previous SPINAL Surgeries:

WHERE: **WHEN:** **WHO:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

When did your pain start? _____

Was there an event/injury that caused your pain to start?

_____

Was this due to a motor vehicle accident? _____If Yes, When? _____

Was this due to a Slip & Fall ? _____If Yes, Where? _____

Did this happen at work? _____

What makes your pain worse?

_____

_____

What makes your pain feel better?

_____

_____

Previous Treatment (please answer yes/no and details as applicable)

Bracing therapy _____ When _____ How long _____ Did it help _____

Physical Therapy _____ When _____ How long _____ Did it help _____

Chiropractor _____ When _____ How long _____ Did it help _____

Acupuncture _____ When _____ How long _____ Did it help _____

Massage Therapy _____ When _____ How long _____ Did it help _____

Pain Management _____ Doctor's name: _____ When _____ How long _____

Did it help _____ What did they do?

_____

Injections? _____ What part of the body? _____What kind? _____

When_____ How many _____ Did it help_____

Previous evaluated by spinal surgeon?(If so, who and for what?) _____

_____

Other tests/Doctors:

_____

_____

Review of Systems:

Mark the following symptoms that you **currently** suffer from within the last 2 weeks:

Constitutional:
- __Fevers
- __Chills
- __Sweats
- __Weakness
- __Fatigue
- __Decreased Activity
- __Malaise
- __Unexplained Weight Loss
- __Unexplained Weight Gain
- __Low Sex Drive
- __Difficulty Sleeping

Eyes:
- __Blurriness
- __Double Vision
- __Pain
- __Visual Disturbance
- __ Visual Change

Respiratory:
- __Sputum Production
- __Shortness of Breath
- __Cough
- __Wheezing

Ears/Nose/Throat/Neck:
- __Hearing Problems
- __Ear Pain
- __Sore Throat
- __Sinus Problems
- __Nose Bleeds

Integumentary:
- __Rash
- __Itching
- __Lesion
- __Bruising

Musculoskeletal:
- __Back Pain
- __Neck Pain
- __Joint Pain
- __Muscle Pain
- __Muscle Cramp
- __Muscle Spasm
- __Gait Disturbances
- __Joint Stiffness
- __Joing Swelling
- __Trauma

Neurological:
- __Abnormal Balance
- __Confusion
- __Numbness
- __Tingling
- __Dizziness
- __Headaches
- __Loss of Coordination
- __Memory Loss
- __Seizures
- __Tinnitus

Cardiovascular:
- __Chest Pain
- __Palpitations
- __Swelling in Feet
- __Bleeding Disorder
- __Blood Clots
- __Fainting
- __Shortness of Breath during sleep

Psychiatric:
- __Feeling Anxious
- __Depressed Mood
- __Suicidal Thoughts
- __Hallucination
- __Stress Problems
- __Suicidal Planning
- __Thoughts of harming others

Hematological:
- __ Anemia
- __ Blood Clots
- __ Easy bruising/bleeding
- __ Swollen Legs
- __ Transfusion

__Tremors
__Vertigo

Gastrointestinal:
__Nausea
__Vomiting
__Diarrhea
__Constipation
__Heartburn
__Abdonminal Pain

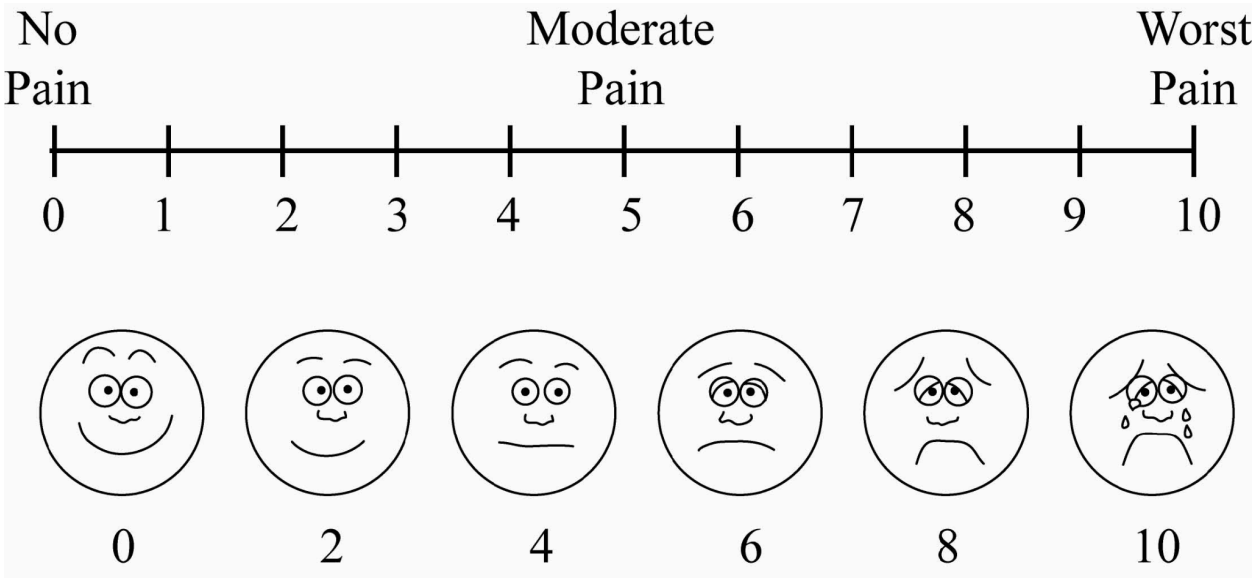
Genitourinary/Nephrology:
__Painful Urination
__Blood in Urine
__Change in Urine Stream
__Unusual Discharge
__Flank Pain
__Urinary Incontinence

Endocrine:
__ Cold Intolerance
__ Heat Intolerance
__ History of Diabetes
__ Thyroid Disease

Immunologic:
__ HIV Exposure
__ Hives
__ Persistent Infections

Pulmonary:
__ Chest Pain
__ Cough
__ Coughing up blood
__ Shortness of breath
__ Sputum production
__ Wheezing

Visual Analogue Scale



Rate your current **HEADACHE** based on the scale above: _____

Rate your current **NECK PAIN** based on the scale above: _____

Rate your current **UPPER BACK PAIN** based on the scale above: _____

Rate your current **MID BACK PAIN** based on the scale above: _____

Rate your current **LOW BACK PAIN** based on the scale above: _____

Rate your current **PELVIC PAIN** based on the scale above: _____

What area is the most bothersome:

_____

Other complaints in applicable:_____