



SPINE INSTITUTE OF SOUTH FLORIDA, P.A.

Mark S. Eskenazi, M.D.

Edward H. Chung, M.D.

Daniel T. Burkholz, PA-C

Patient Name _____ Age _____

Who is your internist? _____

Please list all of your current medications for any medical conditions? _____

Please list any medications you are allergic to: _____

Please circle if you have/had any of the following:

- | | | |
|--------------------|---------------------|-------------------------------------|
| Aids | Heart Disease | Asthma |
| Anemia | Hepatitis | Emphysema |
| Bleeding Disorders | High Blood Pressure | Ulcers |
| Cancer | Kidney Disease | Glaucoma |
| Type _____ | Liver Disease | Epilepsy |
| Diabetes | Parkinsons | Rheumatoid Arthritis/Osteoarthritis |
| Stroke | Abnormal Heartbeat | Osteoporosis |
| Poor Circulation | Cholesterol | Thyroid Problems |

Please list any other medical conditions you have:

Please list **all** surgeries that you have had and the dates:

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Do you currently, or have you ever had any of the following?

Constitutional Symptoms

Fever
Chills
Night Sweats

Eyes

Blurred Vision

Neurologic

Seizures
Dizzy Spells
Numbness/Tingling

Respiratory

Wheezing
Frequent Cough
Shortness of Breath

Integumentary

Skin Rash
Persistent Itch
Psoriasis

Musculoskeletal

Joint Pain
Neck Pain
Back Pain

Genitourinary

Urine Retention
Urinary Incontinence
Urinary Frequency

Hematologic

Blood Clotting Problems
Swollen Glands

Psychologic

Depression
Anxiety
Bipolar

Ear/Nose/Throat

Ear Infections

Gastrointestinal

Abdominal Pain
Nausea/Vomiting

Marital Status: Single Married Divorced Widowed

Alcohol Use: Never Rarely Moderately Daily

Tobacco Use: Never Previously, but quit Current packs per day _____

Working: Occupation _____ Retired

Hobbies/Sports: _____

Have you had any of the following tests? If yes, please give approximate date.

Test	Date
X-Ray	
Cat Scan	
MRI	
Bone Scan	
Nerve Test (EMG)	
Myelogram	

Patient Information

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Patient Name _____ SS# _____

Home Phone # _____ Cell Phone # _____ DOB _____

Address _____
Street City State Zip

Primary Care Doctor: _____ Phone #: _____

Referring Physician Name: _____ Phone #: _____

If this appointment is related to an injury, please provide the information requested below in the appropriate category:

Worker's

Compensation: _____ Adjuster/Claim Manager: _____
Date of Injury Name

Motor Vehicle

Accident: _____ Adjuster/Claim Manager: _____
Date of Injury Name

****INSURANCE INFORMATION****

INSURANCE COMPANY NAME: _____

Policy Holder's Name & DOB: _____

I hereby assign insurance company benefits, on my behalf, to SPINE INSTITUTE OF SOUTH FLORIDA, P.A.

Print Name: _____ Signature: _____ Date: _____

MEDICARE ASSIGNMENT: I request that payment of authorized Medicare Benefits be made on my behalf to, Spine Institute of South Florida, P.A., for any services rendered to me by the physician. I authorize any holder of medical information (about me) to be released to the Health Care Financing Administration and/or its agents, any information to determine benefits payable for related services. I understand that I am responsible for any deductibles, co-pays and unpaid but approved Medicare services.

Print Name: _____ Signature: _____ Date: _____

MEDIGAP (Secondary Insurance) Beneficiary Signature Authorization:

I request that payment of authorized Medigap benefits be made on my behalf to Spine Institute of South Florida, P.A., for services furnished. I authorize any holder of medical information about me to release to:

(Your secondary insurance company name) _____ any information needed to determine these benefits payable for related services.

INSURANCE COMPANY: _____ any information needed to determine these benefits payable for related services. If your secondary insurance company does not pay the 20% as approved by Medicare, you are financially responsible.

Secondary Insurance Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Print Name: _____ Signature: _____ Date: _____