BROWARD SPINE INSTITUTE, LLC

Daniel A. Wasserman D.O.M,

DOCTOR OF ORIENTAL MEDICINE
DIPLOMATE OF ACUPUNCTURE

Name:_____ Email:_____

Address:_____ _____
Street Address City, State, Zip code

Cell Phone:_____ Emergency#:_____

☐ Selfpay
☐ Insurance Name:_____ Insurance ID#:_____

D/O/B:_____ Age:_____ Male_____ Female_____

Referred By: _____ Primary Doctor:_____

Single:_____ Married:_____ Divorced:_____ Widowed:_____

Occupation:_____ Employer:_____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE FILL IN THE FOLLOWING:

Mother's Name:_____ Father's Name:_____

Occupation:_____ Employer:_____

Address:_____ _____
Street Address City, State, Zip code

Referred By:_____

I understand that I am ultimately responsible for payment of services rendered. I hereby authorize Daniel A. Wasserman, DOM to release my information including the diagnosis and the records of any treatment or examination rendered by me. I understand and acknowledge that I am responsible for any attorney's fees and cost incurred by the provider for the collection of payments due from me.

Patient's Name (PRINT)_____ Date:_____

Signature:_____

3702 Washington Street Suite 101 Hollywood, Florida 33021 Office (954) 272-2225 Fax (954) 272-0554
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INFORMED CONSENT FOR TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the person named below, for whom I am legally responsible) by the above named licensed physician and/or other licensed physician who now or in the future treat me while employed by, working or associated with or serving as a back up for the treating physician named above, including those working at this office or any office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, homeopathy, manual therapy, cranio-sacral therapy, visceral manipulation, electrical stimulation, Chinese or western herbal medicine, vitamin supplementation, and nutritional counseling and lifestyle, stress and wellness counseling.

I have had the opportunity to discuss with the physician named above and/or with other office personnel the nature and purpose of acupuncture treatment and other procedures.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considering safe in the practice of Chinese Medicine. If I experience any gastro-intestinal upset or allergic reaction to the herbs I will inform physician.

I do not expect the physician to be able to anticipate and explain all risks and complications, and I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels at the time, based upon the facts then known, and is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

If I need to cancel an appointment for any reason, I understand that it is my responsibility to call within 24 hours. Failure to respect this policy will result in a charge of $50 for the space and time reserved for me.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature:_____ Date:_____

Are you pregnant? Yes No

To be completed by the patients representative i.e. if the patient is a minor or is physically or legally incapacitated.

Name of Patient (PRINT):_____ Date:_____

Representative Name (PRINT):_____

Representative Signature:_____

NOTICE OF PRIVACY PRATICES

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** ACKNOWLEDGEMENT OF RECEIPT **

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Broward Spine Institute Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any questions about our ***Notice of Privacy Practices***, please contact our Compliance office at:

Medicompliance Solutions, Inc.
350 N.W. 12th Ave, Suite 150
Deerfield Beach, Florida 33442
(866) COMPLY 8 (toll free)

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt of the ***Notice of Privacy Practices*** of Broward Spine Institute, LLC.

Signature:_____ Date:_____
(Patient/Parent/Conservator/Guardian)

** INABILITY TO OBTAIN ACKNOWLEDGEMENT **

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment and the reason why the acknowledgment was not obtained:

Signature of provider representative:_____ Date:_____

An acknowledgment was not obtained because:

[ ] Patient refused to sign.

[ ] Patient was unable to sign or initial because:_____

[ ] There was a medical emergency (the staff member will attempt to obtain acknowledgement at the next available opportunity).

Other Reason:_____

(CONFIDENTIAL)

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Patient Name:_____ Today's Date:_____

Age:_____ D/O/B:_____ Last Physical Exam:_____

Reason for today's visit:_____

SYMPTOMS Check ☑ symptoms you currently have or have had in past years

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 the ears
- Sinus problems
- Vision-flashes
- Vision-Halos

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

MEN ONLY
- Breast lump
- Erection difficulties
- Lump on testicles
- Penis discharge
- Sore on penis
- Other

WOMEN ONLY
- Abnormal Pap Smear
- Bleeding between Periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period_____
Date of last Pap smear_____
Have you had a mammogram?_____
Are you pregnant?_____
Number of children_____

Conditions Check ☑ symptoms you currently have or have had in past years

- Aids
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorder
- 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 Problems
- Psychiatric care
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide Attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

Medication List medications you are currently taking

_____

_____

Allergies

_____

_____

Pharmacy Name:_____ Phone Number:_____

Health History

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FAMILY HISTORY

Fill in health information about your 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	
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 & 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 substances you use and how many you use

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check ☑ if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other
	Occupation		

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ Date:_____

Functional Rating index

In order to properly assess your condition, we must understand how much your problems have affected your ability to manage everyday activities. For each item below,

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please circle the number which most closely describes your condition right now.

1. Pain

No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Sleep

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, ect.)

No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Greatly pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, Etc.)

No pain on long trip	Mild pain on long trip	Moderate pain on long trip	Moderate pain on short trip	Severe pain on short trip

5. Work

Can do Usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% usual work	Can do 25% usual work	Can not work

6. Recreation

Can do	Can do	Can do	Can do	Can not do

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all activities	most activities	some activities	a few activities	any activities

7. Frequency of pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain with heavy weight	Increased with heavy weight	Increased with moderate weight	Increased with light weight	Increased with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain after all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain after any standing

Signature:_____ Date:_____

Reviewed by:_____ Date:_____

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