



Marshall E. Stauber M.D., Roland D. Kaplan, D.O. FAAPM&R, Vania E. Fernandez, M.D.,  
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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician Name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Telephone #: \_\_\_\_\_

Chief complaint for your visit today? \_\_\_\_\_ When Did It Start \_\_\_\_\_

Is your visit due to: **(Worker Compensation: YES/NO) (Auto Accident: YES/NO) (Slip & Fall: YES/NO)**

#### SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Widower ☐ Minor

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you smoke or Chew Tobacco? \_\_\_\_\_ If yes, how many years? \_\_\_\_\_ How many packs per day? \_\_\_\_\_

Do you Drink Alcohol? \_\_\_\_\_ If yes, how long and many drinks per day? \_\_\_\_\_

Is there any substance and or drug abuse past or present? {i.e., marijuana, cocaine, heroin, etc.} ☐ No ☐ Yes

If yes, how long and what substance: \_\_\_\_\_

Other Conditions: \_\_\_\_\_

#### PERSONAL

**Allergies to Medication / Food / Environment: ☐ LATEX ☐ IODINE ☐ NONE**

Name of Allergy	Reaction
_____	_____
_____	_____

#### Present Medications: (Include Name, Dose (mg) & how often you take it)

Medication	Dose (mg)	Time per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

#### Prior Surgery/Hospitalizations:

When and Why \_\_\_\_\_

## PAST MEDICAL HISTORY

Please check if you have or are treated for any of the following:

CNS	YES	GI	YES	MS	YES
Glaucoma		Acid Reflux/GERD		Osteoarthritis	
Stroke		Gastritis		Rheumatoid Arthritis	
Headaches		Ulcers		Stenosis of Spine	
Seizures		Liver Problems		Fibromyalgia	
<b>CV</b>		Hepatitis		Gout	
High Triglycerides		Irritable Bowel Disease		<b>PSY</b>	
High Cholesterol		<b>GU</b>		Depression	
High Blood Pressure		Kidney Failure		Anxiety Disorder	
Coronary Artery Disease		Kidney Stones		Mood Disorder	
Heart Attack		Stress Urinary Incontinence		PTSD	
Arrhythmia		Large Prostate		Schizophrenia	
<b>RESP</b>		<b>HEME</b>		Other	
Asthma		Hemophilia		<b>IMMUNE</b>	
Emphysema		Von Willebrands Disease		Cancer	
COPD		Use of Blood Thinners		HIV	
Obstructive Sleep Apnea		Clots in Legs (DVT's)		Multiple Sclerosis	
<b>ENDO</b>		<b>INTEG</b>		COVID	
Diabetes Type 1 2		Skin Condition			
Thyroid Problems					

Any Family History of the problems/diseases identified above? Please Identify the family member & the problem or disease.

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## PAIN

- ☐Tender    ☐Pain/sensitive with just light touch    ☐Achy    ☐Shooting    ☐Stiff  
☐Electric Shock-Like    ☐Sore    ☐Tingling    ☐Crampy    ☐Numb    ☐Stabbing  
☐Burning or Hot    ☐Sharp    ☐Other \_\_\_\_\_  
 \* When does your pain occur?    ☐Continuous    ☐Comes and Goes

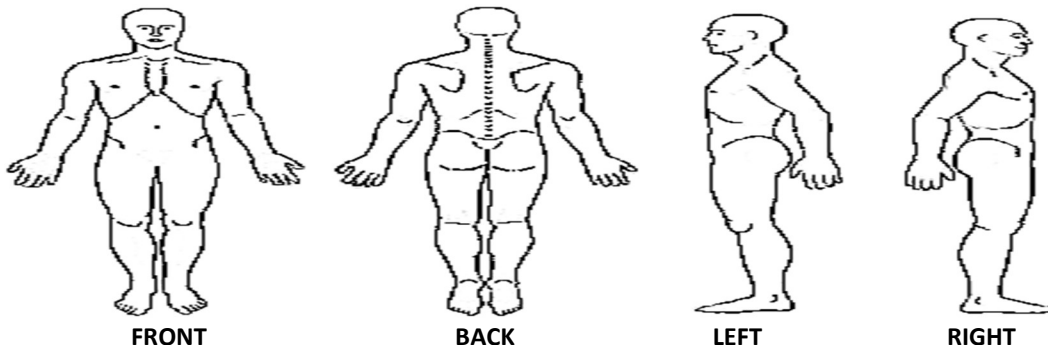
**What makes your pain WORSE?**

- ☐Sitting    ☐Coughing/Sneezing    ☐Standing    ☐Bending    ☐Walking    ☐Driving    ☐Lying Down

**What makes your pain BETTER?**

- ☐Sitting    ☐Coughing/Sneezing    ☐Standing    ☐Bending    ☐Walking    ☐Driving    ☐Lying Down    ☐Other

\*\*\*\*\* Please indicate where you have pain by marking the areas on your body:\*\*\*\*\*



## TREATMENT

**Have you recently had any of the following tests done:**

☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ Other

**Have you received any of the following treatments in the past 6 months and continued to do in the last 6 weeks?**

☐ Physical Therapy ☐ Massage ☐ TENS (Electrical Stim) ☐ Traction ☐ Acupuncture  
☐ Home Stretching/Exercise ☐ Pain Management ☐ Chiropractor ☐ Heat or Ice  
☐ Over the counter medication \_\_\_\_\_  
☐ Injections: \_\_\_\_\_ By: \_\_\_\_\_ When: \_\_\_\_\_  
☐ CT Scan: \_\_\_\_\_ By: \_\_\_\_\_ When: \_\_\_\_\_  
☐ MRI: \_\_\_\_\_ By: \_\_\_\_\_ When: \_\_\_\_\_

## REVIEW OF SYSTEMS

**CHECK IF YOU ARE EXPERIENCING ANY OF THE FOLLOWING**

**GENERAL:** \_\_\_ Feeling Well \_\_\_ Appetite Loss \_\_\_ Fatigue \_\_\_ Weight Gain

**HEENT:** \_\_\_ Headache \_\_\_ Facial Numbness/Tingling \_\_\_ Blurred Vision \_\_\_ Wears Glasses/Contacts \_\_\_ Decreased Hearing

**NECK:** \_\_\_ Neck Mass \_\_\_ Neck Pain \_\_\_ Neck Stiffness \_\_\_ Neck Swelling \_\_\_ Swollen Glands

**RESPIRATORY:** \_\_\_ Cough \_\_\_ Difficulty Breathing \_\_\_ Difficulty Breathing on Exertion

**CARDIOVASCULAR:** \_\_\_ Chest Pain \_\_\_ Difficulty Breathing Lying Down \_\_\_ Edema \_\_\_ Fainting/Black Out  
Leg Cramp \_\_\_ Leg Pain/Swelling \_\_\_ Night Cramps \_\_\_ Palpitations

**GASTROINTESTINAL:** \_\_\_ Heartburn \_\_\_ Nausea \_\_\_ Vomiting \_\_\_ Abdominal Pain  
Diarrhea \_\_\_ Constipation \_\_\_ Change in Bowel Habits

**GENITOURINARY:** \_\_\_ Blood in Urine \_\_\_ Change in Bladder Habits \_\_\_ Change in Urinary Stream \_\_\_ Flank Pain  
Hesitancy \_\_\_ Absence of Menstruation \_\_\_ Pelvic Pain Stress \_\_\_ Incontinence

**MUSCULOSKELETAL:** \_\_\_ Back Pain \_\_\_ Backache \_\_\_ Calf Pain \_\_\_ Decreased Range of Motion \_\_\_ Fasciculations  
Joint Pain \_\_\_ Joint Redness \_\_\_ Joint Stiffness \_\_\_ Joint Swelling \_\_\_ Muscle Atrophy \_\_\_ Muscle Cramps  
Muscle Pain \_\_\_ Muscle Weakness \_\_\_ Swelling of Extremities

**NEUROLOGICAL:** \_\_\_ Attention Deficit \_\_\_ Decreased Memory \_\_\_ Dizziness \_\_\_ Fainting \_\_\_ Numbness \_\_\_ Tremor  
Trouble Walking \_\_\_ Unsteadiness \_\_\_ Weakness in Extremities \_\_\_ Muscle Twitching \_\_\_ Tingling

**PSYCHIATRIC:** \_\_\_ Anxiety \_\_\_ Depression \_\_\_ Disorientation \_\_\_ Easily Irritated \_\_\_ Fearful \_\_\_ Frequent Crying  
Hallucinations \_\_\_ Hypersomnia \_\_\_ Panic Attacks \_\_\_ Suicide Ideation \_\_\_ Suicidal Planning \_\_\_ Trouble Falling Asleep

**HEMATOLOGY:** \_\_\_ Abnormal Bleeding \_\_\_ Anemia \_\_\_ Blood Clots \_\_\_ Easy Bruising \_\_\_ Enlarges Lymph Nodes

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **PAIN LEVEL 1-10** \_\_\_\_\_.



# STOP

Return the top 4 pages to the front desk.  
Then complete.

Under Florida Law, Physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. **YOUR DOCTOR'S MARSHALL E. STAUBER M.D. AND VANIA FERNANDEZ M.D. HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fall to satisfy adverse judgments arising from claims of medical malpractice. This notice is to provide pursuant to Florida Law. By law we must inform you that your physician may or may not have a financial interest in a diagnostic center or treatment facility you may be attending. **PLEASE NOTE: BROWARD SPINE INSTITUTE DOES NOT ACCEPT MEDICAID AND SOMEOTHER INSURANCES. THEREFORE YOU WILL BE RESPONSIBLE FOR THE PERCENTAGE YOUR INSURANCE DOES NOT COVER. (PLEASE INQUIRE WITHIN)**

**ALL COPAYMENTS OR DEDUCTIBLES ARE DUE AT THE TIME OF VISIT.**

**IF YOU HAVE AN HMO INSURANCE POLICY, YOU WILL NEED A REFERRAL FOR EACH VISITS.**

Please allow 7-10 days to obtain authorization for all diagnostic test (i.e., MRI, Bone Scan, CT Scan, etc.) and procedures. As part of your responsibilities, you will be asked to call your insurance company and find out if the insurance will cover a specific procedure or treatment. You will also be responsible to retrieve any actual films or diagnostic CD images before your appointment date. **Also please notify the front desk of any changes to your address, phone number, pharmacy, and Insurance Plans.**

As part of your relationship with BSI LLC, you can expect that all plan of care and treatment will be explained to you before started and also have the right to refuse.

**When requesting medical records, please allow 48 hours for processing and copying. PATIENTS MUST PICK UP RECORDS OR HAVE THEM MAIL TO ADDRESS ON FILE, FAXING RECORDS IS NOT ALLOWED.**

**All X-RAYS/MEDICAL RECORDS** taken by this office are the property of Broward Spine Institute, LLC. If copies are requested, there will be a **charge of \$15.00 per CD** for labor and film materials. This charge is to be paid in advance.

I authorize Broward Spine Institute, LLC to release / share my medical records and/or information acquired in the course of my examination or treatment to my insurance company, primary care physician, instrumentation representative or referring physician and to inquire and receive any and all information pertaining to the processing of any and all claims submitted by them on my behalf. **In the event that I request a release of my information to a third party, not previously considered, a new release form will need to be signed. (I can revoke this agreement in writing at any time.)**

**CONCERNING PERSCRIPITON REFILLS**, please allow 24-48 hours for them to be processed. ALL requests for medications that need to be monitored may require an office visit for follow-up and/or lab work before being filled. Requests should be made before you run out of your medication so that we have time to approve your refill or notify you that an appointment is needed. Prescription refills will be handled during regular business hours.

**CONCERNING MISSING APPOINTMENTS**, I am aware that a \$25.00 charge will be charged to my account for any same day cancelations, in the event the cancelation is pertaining a procedure appointment \$75.00 will be accessed.

**CONCERNING A REQUEST FOR FORMS**, I am also aware that in the event forms, letters or any notices would be required to be completed by my provider a preprocessed fee will be required prior to its completion.

I hereby acknowledge what has been said above

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of Broward Spine Institute LLC. 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. 12<sup>th</sup> 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: \_\_\_\_\_

(Patient/Parent/Conservator/Guardian)

Date: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I hereby appoint as my authorized representative, and assign to Broward Spine Institute LLC. all the pertinent power and responsibility in relationship to all claim payments, appeals and any necessary avenues to recover payment for services rendered to me. ALL MEDICARE patients must sign an ABN form.

Here by, I also authorize BSI, LLC. To proceed on my behalf while,

1. File any required appeal to my health plan for payment of medical claims submitted on my behalf
2. File a complaint, when necessary, with the State Insurance Department, or any other regulatory agency in regards to claim payment.
3. File any required litigation or arbitration against my health plan and/or health insurer for payment of medical claims submitted byon my behalf, and to exert or receive any other rights or benefits under my health plan with respect to the treatment rendered by Broward Spine Institute, LLC. I hereby also assign to Broward Spine Institute, LLC. the right to recover its full billed charges and any expenses and fees incurred for pursuing the claim, as well as all rights, statutory or contractual, to any additional recovery related to my health benefits such as treble damages, punitive damages and/or penalties.
4. Discuss my personal health information with my health plan and/or health insurer.

## DISCLOSURE

As a leader in the Spine industry and the development of innovative technology, Broward Spine Institute and Dr. Marshall E. Stauber, M.D., are constantly working to develop new devices, techniques and study protocol for the treatment of spinal disorders. In exchange for our time and recognized expertise in the spine industry we often charge a consulting and/or licensing fees, possible royalties for the use of our designs and we reserve the right to invest capital in the development of these devices. They include Medtronic Sofamor Danek, NuVasive, Kyphon, Zimmer, Stryker, Globus, Synthes, Trans 1, and others. We remain completely independent and have no exclusive contract with any company but financially we could benefit by the success or failure of a device. We choose an implant based on the patients indications. At no time do we make our decision to use a device for a financial benefit but rather the reverse. We at BSI have a completely open policy with regard to these incentives. Please feel free to ask us any specific questions regarding them, especially if surgery is being contemplated. Please understand that this disclosure, at this time, is completely voluntary and not required by law. However, we at Broward Spine Institute believe that we need to inform our patients of these possible monetary incentives, so that there is a lasting relationship built on honesty and trust. We would also like to disclose that I, or my immediate family have partial ownership and/or investment interest in The Miami Medical Center. This is being disclosed in accordance with the requirements of the Medicare program. Thank you for putting the care of yourself and your loved ones in our hands. We hope to always earn and maintain that trust