Brain and Spine
INSTITUTE FOR CHILDREN
B·A·S·I·C

Dr. Keyne K Johnson, MD FAANS
P: 407-255-2152
F: 407-264-8395
201 N Lakemont Ave Suite 500
Winter Park FL, 32792

Children - New Patient Intake Form

Name_____ Date _____ Email_____

Email will not be shared and will only be used for occasional office announcements and appointment reminder

Address_____ City_____ State _____ ZIP_____

Sex ☐ M ☐ F Other ☐ Birth Date _____ Age _____ Social Security Number _____

Cell Phone _____

Primary Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ White ☐ Black or African American

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Guardian's Name _____ Guardian's number _____

Guardian's Occupation _____ Employer _____ Phone _____

Child's Primary Care Physician _____ Phone _____

How did you hear about us _____ Name of person who referred you _____

Insurance Information

☐ Automobile Accident Workman Comp. ☐ Other ☐ (If yes, please explain) _____

Name of Insurance Company _____ Policy Number _____

Name of Insured _____ Group Number _____

Address of Insurance Company _____ State _____

City_____ ZIP _____ (Auto) Claim Number _____

Name of Secondary Insurance (If applicable) _____

Policy Number _____ Group Number _____

Address of Insurance Company _____ State _____

City _____ ZIP _____

Height _____ Weight _____

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Allergies (Include Drugs, Reaction, and Age of onset)

_____

_____

Current Problems

_____

_____

Current Medications

_____

_____

_____

_____

Pharmacy Name _____ Phone number _____

Hand Preference ☐ Right ☐ Left Are you allergic to Adhesive Tape? ☐ Yes ☐ No

Are you allergic to CT Contrast/Kidney Dye/Iodine? ☐ Yes ☐ No

Are you allergic to latex ☐ Yes ☐ No Are you allergic to Gadolinium/MRI Contrast? ☐ Yes ☐ No

Child's Medical History

Condition	Yes or No	Condition	Yes or No
ADD/ADHD		Allergic Rhinitis	
Anemia		Asthma	
Congenital Heart Disease		Constipation	
Developmental Delay		Diabetes	
Eczema		Food Allergies	
GE Reflux		Mental Illness	
Murmur		Prematurity	
Recurrent Otitis (Ear Infections)		Recurrent Strep Throat	
Seizures		Substance Abuse	
UTI (Urinary Tract Infection)		Vision Problems	
Vesicoureteral Reflux		Wheezing	

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Child's Surgical History

Surgeries	Date	Doctor/Hospital/Comments

Child's Social History

Home Environment

Number of People at Home: _____

Lives with Biological Parents: Yes ☐ No ☐

Foster Care: Yes ☐ No ☐

Primary Care Givers (Circle): Parents Daycare Relatives Other: _____

Daycare (Hours/Day): _____

Pets: _____

Parents Status

Parent's Martial Status (circle): Married Divorced Single Other: _____

Mother's Occupation: _____

Father's Occupation: _____

Immunization/Vaccines

Are the childhood immunizations up-to-date? Yes ☐ No ☐

Are the sibling's immunizations up-to-date? Yes ☐ No ☐

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Child's Family History

Medical Conditions in Your Family (Father, Mother, Brother, Sister, Paternal and Maternal Grandparents, Aunts, Uncles)			
Condition	Relative & Name	Age of Onset	Alive or Deceased
ADD/AD			
Allergies			
Anemia			
Asthma			
Cancer			
Diabetes			
Eye Disease			
GI Problems			
Heart Disease			
High Cholesterol			
Hypertension			
Kidney Disease			
Mental Disease			
Migraines			
Seizures			
Substance Abuse			
Thyroid Disease			
Other			

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By voluntarily signing, I authorize Brain and Spine Institute for Children to use and/or disclose certain protected health information (phi) about me to

_____

_____

This authorization permits Brain and Spine Institute to use and/or disclose the following individually identifiable health information about me:

Medical Records Claims/Billing Information Lab Results Imaging

I do have to sign this authorization in order to receive treatment from the Brain and Spine Institute for Children. When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization upon this authorization. My written revocation must be submitted to the privacy office at:

Brain and Spine Institute for Children
Phone: 407-255-2152
Fax: 407-264-8395
Email: Admin@basicorlando.com

Signed by: _____

Signature of Patient or Legal Guardian *Relationship to Patient*

_____

Print Patient's Name *Date*

_____

Print Name of Patient or Legal Guardian if applicable

I elect to not allow discourse of my protected health information to any individual or party that I have not authorized.

_____

Signature of Patient or Legal Guardian *Relationship to Patient* *Date*

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To All Insured Patients:

Welcome to Brain and Spine Institute for Children. We are pleased that you have chosen us to provide your medical and surgical care. We are always striving to provide you and your family with the best surgical and professional service available.

Insurance companies sometimes deny claims because of the lack of information on the patient's part. They will not pay these claims until this information is provided to them by you. If your insurance company has denied our claim because you have not provided the information, they may need to process our claims, we may transfer the balance to your responsibility.

For patients who are required to obtain authorization to see us, it will be the patient's responsibility to obtain the authorization. If we do not obtain the authorization, we may transfer the balance to the patient's responsibility. It is our goal to provide you with excellent care, both surgically and professionally. We need your cooperation and appreciate your prompt attention to this matter. Please sign on the space below to verify that this form has been read and is understood.

Thank you,

Brain and Spine Institute for Children Staff

Signature: _____ Date: _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Name of legal guardian or parent of minor: _____

I do hereby request that Brain and Spine Institute for Children (BASIC) release my medical records to:

Organization/Individual: _____ Attn:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

I hereby request that the following record be sent:

_____ Operative Reports ____ Consultation Records _____ Lab/Pathology Reports
_____ EMG/NCT Reports ____ Office Notes _____ X-Ray/Test Results
_____ All Medical Records _____ Other

Purpose of release:

_____ Continuing care _____ Copies for own use _____ Transfer to another physician
_____ School use _____ Legal _____ Other (Please specify) _____

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment.
- I can cancel this authorization at any time by writing to the Business/Practice Manager. I understand that once information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release and distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire one (1) year from the date signed below unless another date or event is entered here _____

_____ _____
Patient or Legal Guardian/Parent Signature Date

CONFIDENTIALITY NOTE

Keyne K. Johnson, MD FAANS

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____ EMG/NCT Reports	_____ Office Notes	_____ X-Ray/Tests Results
____ All Medical Records	_____ Other	

_____ _____
Patient or Legal Guardian/Parent SIgnature Date

CONFIDENTIALITY NOTE

Keyne K. Johnson, MD FAANS