



Dr. Keyne K Johnson, MD FAANS

P: 407-255-2152

F: 407-264-8395

201 N Lakemont Ave Suite 500

Winter Park FL, 32792

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 _____

Cel Phone _____ Work Phone _____

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

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

Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐

Occupation _____ Employer _____

Spouse's Name _____ Spouse's number _____

Emergency Contact _____ Phone _____ Relation to patient _____

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

Insurance Information

☐ Automobile Accident ☐ Workers 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 _____



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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 disclosure 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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Current Problems

Auto accident ☐ Other ☐

Please Describe

Date Symptoms Appeared _____ Date of Injury (If applicable) _____

Did your pain come on: ☐ Suddenly ☐ Gradually Is the pain: ☐ Mild ☐ Moderate ☐ Severe

Do you experience the pain every day? ☐ Yes ☐ No

Do your symptoms interfere with daily life? ☐ Yes ☐ No

Does the pain wake you up? ☐ Yes ☐ No

Are your symptoms worse at certain times of the day? ☐ Yes ☐ No

Which activities aggravate your symptoms

Hand Preference ☐ Right ☐ Left

Are you pregnant? ☐ Yes ☐ No Is it possible that you may be pregnant? ☐ Yes ☐ No ☐ Not Applicable

Date of your last menstrual _____

Tobacco use: ☐ None ☐ Smoke per day _____ Years smoked _____ ☐ Chewing Tobacco/Snuff ☐ Cigars

Did you ever smoke? Yes ☐ No ☐ If yes, when did you quit? _____

Alcohol use: ☐ None ☐ Occasional/Social ☐ Daily

Have you ever used any illicit Use ☐ Yes ☐ No, If Yes, list which drugs _____

Height _____ Weight _____



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

Current Medications (Dosage and Frequency)

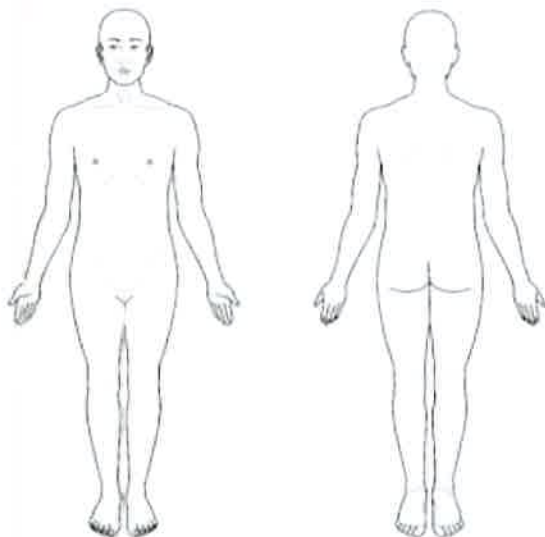
Pharmacy Name _____ Phone number _____

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

Please mark on the picture where you are feeling pain and/or irritation



Numbness =====

Pins & Needles ○○○○○○

Burning X X X X X X

Stabbing // // // //

Ache ★ ★ ★ ★ ★



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Pain arm(s)/leg(s) compared to neck/back? ☐ More than ☐ Same as ☐ Less than

Is there weakness in your arms Yes ☐ No ☐ Is there weakness in your legs Yes ☐ No ☐

Do you experience numbness/tingling in your hands? Yes ☐ No ☐

Do you experience numbness/tingling in your legs? Yes ☐ No ☐

Do you experience numbness/tingling in your feet? Yes ☐ No ☐

Are you unable to stand for long periods? Yes ☐ No ☐

Are you unable to sit for long periods? Yes ☐ No ☐

Are you unable to walk for long periods? Yes ☐ No ☐

Have you had trouble controlling your bowels? Yes ☐ No ☐ If yes, is this a new problem? Yes ☐ No ☐ (If yes, please state when this occurrence began): _____

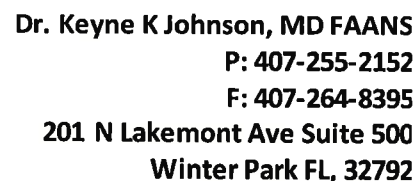
Have you had trouble controlling your bladder? Yes ☐ No ☐ If yes, if this a new problem? Yes ☐ No ☐ (If yes, please state when this occurrence began): _____

In the past twelve months have you had Physical Therapy, Chiropractic treatment, Medications, Steroid Injections or imaging studies for your pain? (Circle accordingly) Yes ☐ No ☐ (If yes, please state facility and date)

The information above is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled/ I will not hold my physician or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form

Patient's or Patient's Guardian Signature: _____

Date: _____



Medical Conditions in Your Family (Father, Mother, Brother, Sister, Paternal and Maternal Grandparents, Aunts, Uncles)			
Condition	Patient	Relative	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			

[illegible]



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

The information contained in this transmission is absolutely confidential and intended for the use of the addressee listed above and no one else. If you are not the intended recipient, or the employee or agent responsible to deliver this document to the intended recipient, you are hereby notified that any dissemination or copying of this facsimile is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone.

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Brain and Spine Institute for Children (BASIC)

Phone: 407-255-2152

Fax: 407-264-8395

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☐ EMG/NCT Reports	☐ Office Notes	☐ X-Ray/Tests Results
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