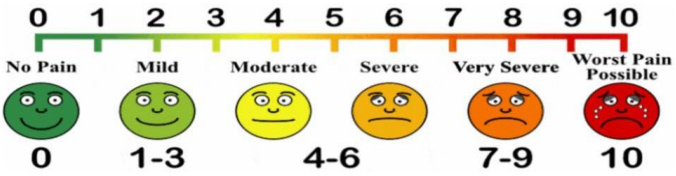
The Saville Spine Institute
Dr. Phil Saville, M.D P.A.

Patient Name:_____ Today's Date:_____ DOB:_____ MR# _____

Why are you here today? _____

Review of Systems: Please check (√) off any symptoms you **currently** have.

Constitutional	Gastrointestinal	Psychiatric	Hematologic	Cardiovascular
☐ Chills ☐ Fatigue ☐ Fever ☐ Malaise ☐ Night sweats ☐ Weakness ☐ Weight loss ☐ Weight gain	☐ Abdominal pain ☐ Constipation ☐ Black tarry stools ☐ Diarrhea ☐ Heartburn ☐ Yellowing of skin ☐ Loss of appetite ☐ Nausea ☐ Vomiting	☐ Anxiety ☐ Depression ☐ Insomnia	☐ Easy bleeding ☐ Easy bruising **Metabolic** ☐ Cold intolerance ☐ Hair Loss ☐ Heat intolerance	☐ Chest pain ☐ Bluing ☐ Heart murmur ☐ Leg swelling ☐ Fainting ☐ Irregular heart beat/ Palpitations
HEENT	**Genitourinary**	**Integumentary**	**Immunologic**	**Neurological**
☐ Blurred vision ☐ Double vision ☐ Difficulty swallowing ☐ Ear drainage ☐ Headache ☐ Hearing loss ☐ Hoarseness ☐ Ringing in ears ☐ Vertigo ☐ Vision loss	☐ Painful urination ☐ Frequent urination ☐ Blood in urine ☐ Urge incontinence ☐ Urinary incontinence	☐ Contact allergy ☐ Itchy skin ☐ Rash ☐ Skin infections ☐ Skin lesion	☐ Asthma ☐ Contact dermatitis ☐ Environmental allergies ☐ Food allergies	☐ Difficulty walking ☐ Dizziness ☐ Poor coordination ☐ Memory loss ☐ Muscle weakness ☐ Numbness ☐ Seizures ☐ Tremors
Respiratory	**Musculoskeletal**	**Other**		
☐ Chest pain (in lungs) ☐ Cough ☐ Difficulty breathing ☐ Recent infection ☐ Known TB Exposure ☐ Wheezing	☐ Back pain ☐ Joint pain ☐ Joint swelling ☐ Muscle weakness ☐ Neck Pain ☐	 **PLEASE INDICATE YOUR PAIN LEVEL RIGHT NOW** _____ **WHAT IS YOUR WORST PAIN LEVEL?** _____ **WHAT IS YOUR BEST PAIN LEVEL?** _____		

Medications: List all medications you are taking (prescribed and over the counter)

Medication Name	Dosage	How often?

MR# _____

Allergies: List all known allergens including medications, food, and other.

Allergen description	Severity (Mild, Moderate, Severe)	Reaction
(circle): Sulfites/Red Wine or Eggs, Contrast or Shellfish		

Social History: Please complete.

Have you **ever** used tobacco? ☐ Yes ☐ No	**If you answered yes:** What type?_____ Daily? ☐ Yes ☐ No How much per day?_____For how long? _____ Age started:_____Age stopped:_____(if applicable)
Do you drink alcohol? ☐ Yes ☐ No	**If you answered yes:** What type?_____How often? _____ How much?_____When was your last drink? _____
Do you drink/consume caffeine? ☐ Yes ☐ No	**If you answered yes:** What type?_____How much? _____

Medical History: Please check (√) off any symptoms you **have or have had in the past.**

☐ Aids	☐ Alzheimer's disease	☐ Anemia
☐ Angina	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Cancer	☐ Chicken Pox
☐ Congestive heart failure	☐ COPD	☐ Coronary artery disease
☐ Deep Vein Thrombosis (DVT)	☐ Degenerative Joint Disease	☐ Depression
☐ Diabetes; Non-insulin dependent	☐ Diabetes – Insulin dependent	☐ Drug abuse
☐ Elevated lipids	☐ Emphysema	☐ Fibromyalgia
☐ Gout	☐ Headache, migraine	☐ Heart attack
☐ Heart Disease	☐ Heart Valve Disease	☐ Hepatitis, liver disease
☐ Herpes	☐ HIV Positive	☐ Hypertension
☐ Inflammatory bowel disease	☐ Kidney disease	☐ Lupus
☐ Lyme disease	☐ Osteoporosis	☐ Pace Maker
☐ Parkinson disease	☐ Psoriasis	☐ Rheumatic Fever
☐ Scoliosis	☐ Seizure disorder/epilepsy	☐ Shingles
☐ Sleep apnea	☐ Stroke	☐ Thyroid disease
☐ Tuberculosis	☐ Ulcers	☐ Vaginal Infection
☐ Venereal Disease	☐ Other:	☐ Other:

Surgical History: Please list any surgical interventions and procedures you have had.

Surgery or procedure	Description, Side, or Note	Date	Outcome

MR# _____

Family History: Please fill in any known health information about your relatives.

Relationship	Condition/diagnosis	Age of Onset	Was this the cause of death? (if applicable)
Mother ☐ Alive ☐ Deceased			☐ Yes Age? _____
Father ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____
Other_____ ☐ Alive ☐ Deceased			☐ Yes Age? _____

Therapeutic History: Please place a check (√) by any therapy you are undergoing or have undergone for your neck and/or back complaints.

Treatment/Therapy	**Description of treatment (duration of treatment, location of treatment, dose, outcome, etc.)**
☐ Anti-inflammatory medications	
☐ Activity modification	
☐ Chiropractic care	
☐ Exercises	
☐ Ice/heat	
☐ Injections	
☐ Pain medications	
☐ Physical therapy	
☐ Other	

Spinal History: (Office Use Only)

☐ Neck pain	☐ Mid-back pain	☐ Low back pain

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

Patient Name (Print):_____ Date_____

Patient Signature: _____

The Saville Spine Institute
Dr. Philip Saville, M.D. P.A
300 Village Square Xing Ste 202
Palm Beach Gardens, FL 33410
561-630-3870
561-630-3680 FAX

Name:_____ **DOB**: _____

The Saville Spine Institute will need to call you regarding your healthcare and account. By completing the information below you are giving us authorization to contact you and to leave a message or send a text reminder of your appointment.

□ Home Phone: _____
□ Cell Phone: _____
□ Work Phone: _____
□ Email: _____
□ Fax: _____
□ Other: **By checking this box I choose to opt out of The Saville Spine Institute Email correspondences.**

I hereby authorize the continuous release of all my medical records/films/x-rays, and billing statements to the following persons. This authorization is in full force and effect unless and until revoked by me in writing. (Examples: Spouse, Children, Attorney, Employer etc.)

NAME	PHONE/FAX/EMAIL	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who should we contact in case of an emergency?

NAME:_____
RELATIONSHIP:_____
PHONE: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I am entitled to the Spine Center's Privacy Notice upon my request.

Patient Signature _____ **Print Name** _____

Date _____

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Name:_____ **DOB**: _____

CONSENT FOR THE RELEASE OF MEDICAL RECORDS
By signing below, I agree that Philip Saville, M.D., P.A. has the right to request any and all previous medical records. I understand that my health or medical information may be used or released for purposes of treatment, payment or health care operations.

I authorize Philip Saville, M.D., P.A., to release copies of my records as necessary to process claims, obtain reimbursement or payment from an insurance company, HMO, or other third party payer or attorney. I further authorize Philip Saville, M.D., P.A., to furnish information from my medical records to other treating physicians, other medical care facilities, hospitals, home health agencies, ancillary service providers or other health care providers for my continued care and treatment. I understand that my health information and medical records may be transmitted to me, my insurers or other health care providers by telephone, regular mail, email or facsimile.

ASSIGNMENT OF BENEFITS, INSURANCE AUTHORIZATION, AND PAYMENT
I, the patient herby authorize any and all of my insurance company to make medical benefit payments otherwise payable to me for services rendered by Philip Saville, M.D., P.A., but not to exceed the charges of those services payable to and mailed directly to: Philip Saville, M.D., P.A. Furthermore I hereby IRREVOCABLY ASSIGN to Philip Saville, M.D., P.A., the rights and benefits under any insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Philip Saville, M.D., P.A..

I direct payment of the benefits I am entitled to under the provision of my insurance policy directly to Philip Saville, M.D., P.A. I understand that I am fully responsible for any balance not paid by my insurance including co-payments, deductibles, and out of pocket network disallowments.

I agree that if my insurance company pays me for any services provided by Philip Saville, M.D., P.A.; I will forward any payments in full within 5 days of the explanation of benefits to Philip Saville, M.D., P.A. I understand that failure to forward any payments made for services rendered by Philip Saville, M.D., P.A., will be considered insurance fraud and I will be responsible for the cost to recover these payments including collection fees, attorney fees, and all legal free involved in collecting this debt.

I understand that I am fully responsible for any balance not paid by my insurance, and I agree to pay any outstanding balance including co-payments and deductible amounts. If my account has to be referred to a collection agency or an attorney, I will pay all costs of the collection, including reasonable attorney's fees and costs.

I will also be financially responsible for any scheduled appointments not cancelled 24 hours prior to appointment time. There is a 24-hour cancellation policy for all office visits. If any appointment is not cancelled or if I fail to show, I understand that my account will be charged as follows: Follow up, New Patient, and X-Ray appointments will be charged the full fee of the visit. MRI appointments will be charged $750.00.

LIMITED POWER OF ATTORNEY
I hereby appoint Philip Saville, M.D., P.A. and any of its duly authorized agents to be my agent and attorney-in-fact for the limited purpose of endorsing and depositing, for the benefit Philip Saville, M.D., P.A.., any and all checks and/or paperwork received for payment of services rendered up to the amount of my bill. This appointment means that Philip Saville, M.D., P.A., or its authorized agents may deposit any and all checks or other financial instruments received from my insurer or any person as payment for my treatment services without my endorsement.

I have read and fully understand the conditions listed above with respect to the release of information, assignment of benefits, and financial responsibility. I understand that this form will remain in effect for so long as I am being treated by Philip Saville, M.D., P.A., unless it is revoked by me in writing.

Signature of Patient _____ **Print Name** _____

_____ _____

Witness signature **Date**

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Patient:_____ Date:_____ MR# _____

Please answer the questions below by choosing the ONE answer that describes your typical NECK PAIN, and/or limitations within the last week or two.

Section 1 - Pain intensity
__I have no pain at the moment. 0
__The pain is mild at the moment. 1
__The pain is moderate at the moment. 2
__The pain is fairly severe at the moment. 3.
__The pain is very severe at the moment. 4
_The pain is the worst imaginable at the moment. 5

Section 2 - Personal Care
(Washing, Dressing etc.)
_I can look after myself without causing extra pain. 0
_I can look after myself normally but it causes extra pain. 1
_It is painful to look after myself and I am slow and careful.2
_I need some help, but manage most of my personal care. 3
__I need help every day in most aspects of self-care. 4
_I cannot get dressed or wash without assistance, and am bedridden. 5

Section 3 - Lifting
__I can lift heavy weights without extra pain. 0
_I can lift heavy weights, but it causes extra pain. 1
_Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table. 2
_Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 3
__I can lift very light weights. 4
__I cannot lift or carry anything at all. 5

Section 4 - Reading
_I can read as much as I want with no pain in my neck. 0
_I can read as much as I want with slight pain in my neck. 1
_I can read as much as I want with moderate pain in my neck. 2
_I cannot read as much as I want because of moderate pain in my neck. 3
_I cannot read as much as I want because of severe pain in my neck. 4
__I cannot read at all. 5

Section 5 - Headache
__I have no headaches at all. 0
_I have slight headaches which come in-frequently. 1
_I have moderate headaches which come in-frequently. 2
_I have moderate headaches which come frequently. 3
_I have severe headaches which come frequently. 4
__I have headaches almost all the time. 5

Section 6 - Concentration
_I can concentrate fully when I want to with no difficulty. 0
_I can concentrate fully when I want to with slight difficulty. 1
_I have a fair degree of difficulty in concentrating with I want to. 2
_I have a lot of difficulty in concentrating when I want to. 3
_I have a great deal of difficulty in concentration when I want to. 4
__I cannot concentration at all. 5

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Section 7 - Work
__I can do as much work as I want to. 0
__I can only do my usual work, but no more. 1
__I can do most of my usually work, but no more. 2
__I cannot do my usual work. 3
__I can hardly do any work at all. 4
__I cannot do any work at all. 5

Section 8 - Driving
__I can drive my car without neck pain. 0
__I can drive my care as long as I want with slight pain in my neck. 1
__I can drive my car as long as I want with moderate pain in my neck. 2
__I cannot drive my car as long as I want because of moderate pain in my neck. 3
__I can hardly drive my care at all because of severe pain in my neck. 4
__I cannot drive my car at all. 5

Section 9 - Sleeping
__I have no trouble sleeping. 0
__My sleep is slightly disturbed (less than 1 hour sleepless).1
__My sleep is mildly disturbed (1-2 hours sleepless). 2
__My sleep is moderately disturbed (2-3 hours sleepless) 3
__My sleep is greatly disturbed (3-5 hours sleepless) 4
__My sleep is completely disturbed (5-7 hours sleepless). 5

Section 10 - Recreation
__I am able to engage in all recreational activities with no pain in my neck at all. 0
__I am able to engage in all recreational activities with some pain in my neck. 1
__I am able to engage in most, but not all recreational activities because of pain in my neck. 2
__I am able to engage in only a few of my usual recreational activities because of pain in my neck. 3
__I can hardly do any recreational activities because of pain in my neck. 4
__I cannot do any recreational activities at all. 5

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Patient:_____Date:_____MR#: _____

Please answer the questions below by choosing the ONE answer that describes your typical LOW BACK PAIN, and/or limitations within the last week or two.

Section 1 - Pain Intensity
__I have no pain at the moment. 0
__The pain is very mild at the moment. 1
__The pain is moderate at the moment. 2
__The pain is fairly severe at the moment. 3
__The pain is very severe at the moment. 4
_The pain is the worst imaginable at the moment. 5

Section 2 - Personal Care
(Washing, Dressing etc.)
__I can look after myself normally without causing extra pain. 0
_I can look after myself normally, but it causes extra pain.1
_It is painful to look after myself and I am slow and careful. 2
_I need some help but manage most of my personal care. 3
_I need help every day in most aspects of self-care. 4
__I cannot get dressed or wash without assistance, and am bed ridden. 5

Section 3 – Lifting
__I can lift heavy weights without extra pain. 0
_I can lift heavy weights but it gives extra pain. 1
_Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). 2
_Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 3
__I can lift only very light weights. 4
__I cannot lift or carry anything at all. 5

Section 4 – Walking
_Pain does not prevent me walking any distance. 0
__Pain prevents me walking more than 1 mile. 1
_Pain prevents me walking more than ½ of a mile. 2
_Pain prevents me walking more than 100 yards. 3
__I can only walk using a stick or crutches. 4
_I am in bed most of time and must use a wheelchair to go to the bathroom. 5

Section 5 – Sitting
__I can sit in any chair as long as I like. 0
_I can only sit in my favorite chair as long as I like. 1
_Pain prevents me from sitting for more than 1 hour. 2
_Pain prevents me from sitting for more than 1/2 an hour. 3
_Pain prevents me from sitting for more than 10 minutes. 4
__Pain prevents me from sitting at all. 5

Section 6 – Standing
_I can stand as long as I want without extra pain. 0
_I can stand as long as I want but it gives me extra pain. 1
_Pain prevents me from standing for more than 1 hour. 2
_Pain prevents me from standing for more than1/2 an hour. 3
_Pain prevents me from standing for more than 10 minutes. 4
__Pain prevents me from standing at all. 5

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Section 7 – Sleeping
__My sleep is never disturbed by pain. 0
__My sleep is occasionally disturbed by pain. 1
_Because of pain, I have less than 6 hours sleep. 2
_Because of pain, I have less than 4 hours sleep. 3
_Because of pain, I have less than 2 hours sleep. 4
__Pain prevents me from sleeping at all. 4

Section 8 – Sex Life (if applicable)
_My sex life is normal and causes no extra pain. 0
_My sex life is normal but causes some extra pain. 1
_My sex life is nearly normal but is very painful. 2
__My sex life is severely restricted by pain. 3
__My sex life is nearly absent because of pain. 4
__Pain prevents any sex life at all. 5

Section 9 – Social Life
_My social life is normal and causes no extra pain. 0
_My social life is normal but increases the degree of pain. 1
_Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports 2
_Pain has restricted my social life and I do not go out as often. 3
_Pain has restricted my social life to my home, and/or social media only. 4
__I have no social life because of pain. 5

Section 10 – Traveling
__I can travel anywhere without pain. 0
__I can travel anywhere but it gives extra pain. 1
_Pain is bad but I manage journeys of over two hours. 2
Pain restricts me to journeys of less than 1 hour. 3
__Pain restricts me to short necessary journeys less than 30 minutes. 4
_Pain prevents me from traveling except to receive treatment. 5