

### Registration Information

Date \_\_\_\_\_ Chart# \_\_\_\_\_ D.O.B \_\_\_\_\_

Patient Name \_\_\_\_\_ SSN: \_\_\_\_\_

Employer \_\_\_\_\_ Drivers License # \_\_\_\_\_ Race \_\_\_\_\_

Current Home Address \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Previous Home Address \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Your Local Florida Address  
(i.e. family residence, hotel) \_\_\_\_\_

Local Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_ Spouse D.O.B \_\_\_\_\_

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**Emergency Contact:**

Person to Contact In Case Of Emergency \_\_\_\_\_

Phone # (Day) \_\_\_\_\_

Phone # (Night/Cell) \_\_\_\_\_

Nearest Relative Not Living With You \_\_\_\_\_

Phone # (Day) \_\_\_\_\_

Phone # (Night/Cell) \_\_\_\_\_

**If Patient Is A Minor:**

Parents' Names \_\_\_\_\_ Parents' Employers \_\_\_\_\_

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**Referral Source:**

Seminar (please list location) \_\_\_\_\_

Phone book \_\_\_\_\_

Newspaper (please list) \_\_\_\_\_

Doctor (name) \_\_\_\_\_

Walk-In Clinic (please list) \_\_\_\_\_

Patient (name) \_\_\_\_\_

Other \_\_\_\_\_

### Registration Information

**Insurance Information** *(Please specify your primary insurance)*

Insurance #1 \_\_\_\_\_ Policy # \_\_\_\_\_  
 Group or employer name \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Insured Person's Date of Birth \_\_\_\_\_  
 Send Claims to \_\_\_\_\_ *(If Blue Cross specify State)* State \_\_\_\_\_

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Insurance #2 \_\_\_\_\_ Policy # \_\_\_\_\_  
 Group or employer name \_\_\_\_\_ Group # \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Insured Person's Date of Birth \_\_\_\_\_  
 Send Claims to \_\_\_\_\_ *(If Blue Cross specify State)* State \_\_\_\_\_

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**Workman's Compensation or Auto Insurance**

Policy # \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Send Claims to \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Employer Name/ Address at time of accident \_\_\_\_\_

Is condition related to a) Auto Accident \_\_\_\_\_

b) Employment \_\_\_\_\_

c) Other (describe) \_\_\_\_\_

Date of first injury \_\_\_\_\_ Date symptom occurred \_\_\_\_\_

Was onset *Sudden* or *Gradual*? \_\_\_\_\_

Date first consulted physician \_\_\_\_\_

Is an attorney handling this case? \_\_\_\_\_ Attorney Name \_\_\_\_\_

Attorney address \_\_\_\_\_

Attorney Telephone \_\_\_\_\_ Family Physician \_\_\_\_\_

## Registration Information

### Authorization to Release Information And Assignment of Insurance Benefits

I hereby authorize the medical facilities and/or practices whose name(s) appear above to furnish my insurance company(s), attorneys, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign the medical facilities and/or practices, all money to which I am entitled for medical and/or surgical expense relative the service for which I receive, but not to exceed my indebtedness to said medical facilities and/or practices. It is understood that any money received from the above named parties, over and above my indebtedness will be refunded when my bill is paid in full. I understand I am financially responsible to said medical facilities and/or practices for charges incurred. I further agree and understand that if extended credit, I will keep my account on a current basis. It is also understood, that even though I may have an attorney or that this may be related to an auto accident, I must still keep my account on a current basis.

As a courtesy to you, our patient, we will submit claim forms to your primary insurance company. This service shall not be construed as an act of fiduciary or agent on your behalf. You, the patient, shall remain solely responsible for payment for any medical services and the compliance with any contractual obligation between you and your insurance carrier.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. We look to you for payment, not to the insurance company.

This consent specifically includes information concerning psychological conditions, psychiatric conditions, and/or infectious disease including, but not limited to, blood borne diseases, such as hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

#### ***How will you be paying for your services?***

Check \_\_\_\_\_ Cash \_\_\_\_\_ Master Card \_\_\_\_\_

Visa \_\_\_\_\_ American Express \_\_\_\_\_ Discover \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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### **AUTHORIZATION TO APPEAL ON MY BEHALF**

I \_\_\_\_\_ authorize the parties whose names appear above to appeal any and all insurance claims on my behalf until such claims are paid.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

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**Patient / Family History**

Name: \_\_\_\_\_ Chart : \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_ T: \_\_\_\_\_

Please indicate by a check (✓) next to your answer to each question. These answers will greatly help your doctor to give you his or her best care. If you do not understand any question (or your answer is uncertain) simply place a question mark (?) In the yes column

| Have you had or Still have                                    | Yes | No | Explanations | Have you had or Still have                 | Yes | No | Explanations |
|---------------------------------------------------------------|-----|----|--------------|--------------------------------------------|-----|----|--------------|
| A cold in the past 2 weeks                                    |     |    |              | High Blood Pressure                        |     |    |              |
| Bronchitis, a chronic cough                                   |     |    |              | Low Blood Pressure                         |     |    |              |
| Asthma                                                        |     |    |              | Chest Pain, Angina                         |     |    |              |
| Hay Fever                                                     |     |    |              | Heart Attack(s)                            |     |    |              |
| Pneumonia                                                     |     |    |              | Pacer                                      |     |    |              |
| Tuberculosis                                                  |     |    |              | Palpitations, Irregular or fast heart beat |     |    |              |
| Emphysema                                                     |     |    |              | Anemia                                     |     |    |              |
| Shortness of Breath                                           |     |    |              | Sickle Cell Illness                        |     |    |              |
| Any other lung trouble                                        |     |    |              | Jaundice, Hepatitis, liver trouble         |     |    |              |
| Do you smoke?                                                 |     |    |              | Infectious Mononucleosis                   |     |    |              |
| Do you drink alcoholic beverages                              |     |    |              | Gallbladder trouble                        |     |    |              |
| Daily                                                         |     |    |              | Back pain or injury                        |     |    |              |
| Occasionally                                                  |     |    |              | Slipped disc, sciatica                     |     |    |              |
| None                                                          |     |    |              | Convulsions, Epilepsy, Stroke              |     |    |              |
| Have you had blood transfusions                               |     |    |              | Polio, Paralysis                           |     |    |              |
| Dentures or loose teeth or caps?                              |     |    |              | Meningitis                                 |     |    |              |
| Have you or your family had an unusual reaction to anesthesia |     |    |              | Thyroid trouble                            |     |    |              |
| Have you or your family had any bleeding problems             |     |    |              | Parkinson's Disease                        |     |    |              |
| Unusually high fevers                                         |     |    |              | Diabetes                                   |     |    |              |
| Double vision, weak eye muscles                               |     |    |              | Low Blood Sugar                            |     |    |              |
| Frequent leg cramps                                           |     |    |              | Kidney Trouble                             |     |    |              |
| Legs go to sleep often                                        |     |    |              | Are you pregnant?                          |     |    |              |
| Rheumatic Fever                                               |     |    |              | Serious illness during pregnancy?          |     |    |              |
| Heart Murmur                                                  |     |    |              | Cancer (cured or not)                      |     |    |              |
| Metal in Body                                                 |     |    |              | Nausea with pain medications               |     |    |              |
|                                                               |     |    |              | Other Illness not mentioned above          |     |    |              |

### Patient History

|                 |                              |                                                                                                                                                                                                                                                             |
|-----------------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| List Allergies: | List Immunizations:          | Please list medications including over the counter and herbal medications:<br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>_____<br><br>Do you use any recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                 | 1 <sup>st</sup> Immunization |                                                                                                                                                                                                                                                             |
|                 | Measles                      |                                                                                                                                                                                                                                                             |
|                 | Mumps                        |                                                                                                                                                                                                                                                             |
|                 | Chicken Pox                  |                                                                                                                                                                                                                                                             |
|                 | Pneumonia                    |                                                                                                                                                                                                                                                             |

Previous operations. Please list date, procedure, and complications if any, begin with most recent surgery.

|                                                                    |               |              |                                   |                         |       |
|--------------------------------------------------------------------|---------------|--------------|-----------------------------------|-------------------------|-------|
| Please give the following information about your immediate family: |               |              |                                   | Stroke                  | _____ |
| Relationship                                                       | Age If Living | Age at Death | State of Health Or Cause of Death | Cancer                  | _____ |
| Father                                                             | _____         | _____        | _____                             | Diabetes                | _____ |
| Mother                                                             | _____         | _____        | _____                             | Asthma/Emphysema        | _____ |
| Brothers                                                           | _____         | _____        | _____                             | Bronchitis              | _____ |
| And                                                                | _____         | _____        | _____                             | Tuberculosis            | _____ |
| Sisters                                                            | _____         | _____        | _____                             | Cystic Fibrosis         | _____ |
| Spouse                                                             | _____         | _____        | _____                             | Blood Disease           | _____ |
| Children                                                           | _____         | _____        | _____                             | Glaucoma                | _____ |
| _____                                                              | _____         | _____        | _____                             | Epilepsy                | _____ |
| _____                                                              | _____         | _____        | _____                             | Rheumatoid Arthritis    | _____ |
| _____                                                              | _____         | _____        | _____                             | Gout                    | _____ |
| _____                                                              | _____         | _____        | _____                             | Peptic Ulcer            | _____ |
| _____                                                              | _____         | _____        | _____                             | Gallbladder Disease     | _____ |
| _____                                                              | _____         | _____        | _____                             | Colitis/Irritable Bowel | _____ |
| _____                                                              | _____         | _____        | _____                             | Gyn./Obstet. Problems   | _____ |
| _____                                                              | _____         | _____        | _____                             | Breast Problems         | _____ |
| _____                                                              | _____         | _____        | _____                             | Birth Defects           | _____ |
| _____                                                              | _____         | _____        | _____                             | Genetic Abnormalities   | _____ |
| _____                                                              | _____         | _____        | _____                             | Migraine Headaches      | _____ |
| _____                                                              | _____         | _____        | _____                             | Mental Problems         | _____ |
| _____                                                              | _____         | _____        | _____                             | Depression              | _____ |
| _____                                                              | _____         | _____        | _____                             | Suicide                 | _____ |
| _____                                                              | _____         | _____        | _____                             | Alcoholism              | _____ |
| _____                                                              | _____         | _____        | _____                             | Multiple Sclerosis      | _____ |
| _____                                                              | _____         | _____        | _____                             | AIDS                    | _____ |

|                                                                                                                   |         |               |
|-------------------------------------------------------------------------------------------------------------------|---------|---------------|
| Have any blood relatives had any of the following illnesses? If so, indicate relationship (mother, brother, etc.) | Illness | Family Member |
| High blood pressure                                                                                               | _____   | _____         |
| Heart Disease                                                                                                     | _____   | _____         |

**PATIENT QUESTIONNAIRE - BACK**

NAME: \_\_\_\_\_ CHART: \_\_\_\_\_ DATE: \_\_\_\_\_

THE ONSET OF YOUR CONDITION: DATE OF ONSET \_\_\_\_\_

GRADUAL                       SUDDEN                       ACUTE

ACCIDENT       WORK       HOME       AUTO       FALL

OTHER (DESCRIBE) \_\_\_\_\_

PRIOR INJURY TO BACK:                       YES  NO IF YES, \_\_\_\_\_

PRIOR TREATMENT TO BACK                       YES  NO IF YES, HOW LONG? \_\_\_\_\_

TREATMENT CONSISTED OF \_\_\_\_\_

PRIOR/PREVIOUS TREATMENT TO BACK:     YES                       NO

| Which health care provider have you used for your current condition? (CHECK ( ) all that apply) |                   |             |                       |                |
|-------------------------------------------------------------------------------------------------|-------------------|-------------|-----------------------|----------------|
| <i>Health Care Provider</i>                                                                     | <i>Dr.'s Name</i> | <i>Date</i> | <i>Length of time</i> | <i>Results</i> |
| <input type="checkbox"/> Acupuncturist                                                          |                   |             |                       |                |
| <input type="checkbox"/> Chiropractor                                                           |                   |             |                       |                |
| <input type="checkbox"/> Emergency Room                                                         |                   |             |                       |                |
| <input type="checkbox"/> General Practitioner<br><input type="checkbox"/> Internist             |                   |             |                       |                |
| <input type="checkbox"/> Massage Therapist                                                      |                   |             |                       |                |
| <input type="checkbox"/> Neurosurgeon                                                           |                   |             |                       |                |
| <input type="checkbox"/> Orthopedic Surgeon                                                     |                   |             |                       |                |
| <input type="checkbox"/> Osteopath                                                              |                   |             |                       |                |
| <input type="checkbox"/> Pain Clinic                                                            |                   |             |                       |                |
| <input type="checkbox"/> Physical Therapist                                                     |                   |             |                       |                |
| <input type="checkbox"/> Rheumatologist                                                         |                   |             |                       |                |
| <input type="checkbox"/> Work Hardening Clinic                                                  |                   |             |                       |                |
| <input type="checkbox"/> None of the above                                                      |                   |             |                       |                |

**PATIENT QUESTIONNAIRE – NECK/SHOULDER**

NAME: \_\_\_\_\_ CHART: \_\_\_\_\_ DATE: \_\_\_\_\_

THE ONSET OF YOUR CONDITION: \_\_\_\_\_ DATE OF ONSET \_\_\_\_\_

GRADUAL                       SUDDEN                       ACUTE

ACCIDENT       WORK       HOME       AUTO       FALL

OTHER (DESCRIBE) \_\_\_\_\_

PRIOR INJURY TO NECK:                       YES  NO    IF YES, \_\_\_\_\_

PRIOR TREATMENT TO NECK                       YES  NO    IF YES, HOW LONG? \_\_\_\_\_

TREATMENT CONSISTED OF \_\_\_\_\_

PRIOR/PREVIOUS TREATMENT TO NECK:     YES                       NO

| Which health care provider have you used for your current condition? (CHECK ( ) all that apply) |                   |             |                       |                |
|-------------------------------------------------------------------------------------------------|-------------------|-------------|-----------------------|----------------|
| <i>Health Care Provider</i>                                                                     | <i>Dr.'s Name</i> | <i>Date</i> | <i>Length of time</i> | <i>Results</i> |
| <input type="checkbox"/> Acupuncturist                                                          |                   |             |                       |                |
| <input type="checkbox"/> Chiropractor                                                           |                   |             |                       |                |
| <input type="checkbox"/> Emergency Room                                                         |                   |             |                       |                |
| <input type="checkbox"/> General Practitioner<br><input type="checkbox"/> Internist             |                   |             |                       |                |
| <input type="checkbox"/> Massage Therapist                                                      |                   |             |                       |                |
| <input type="checkbox"/> Neurosurgeon                                                           |                   |             |                       |                |
| <input type="checkbox"/> Orthopedic Surgeon                                                     |                   |             |                       |                |
| <input type="checkbox"/> Osteopath                                                              |                   |             |                       |                |
| <input type="checkbox"/> Pain Clinic                                                            |                   |             |                       |                |
| <input type="checkbox"/> Physical Therapist                                                     |                   |             |                       |                |
| <input type="checkbox"/> Rheumatologist                                                         |                   |             |                       |                |
| <input type="checkbox"/> Work Hardening Clinic                                                  |                   |             |                       |                |
| <input type="checkbox"/> None of the above                                                      |                   |             |                       |                |

**PATIENT QUESTIONNAIRE- BACK**

**NAME:** \_\_\_\_\_ **CHART:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Please Read:** This questionnaire is designed to enable us to understand how much your low **back** has affected your ability to manage everyday activities. Please answer each Section by selecting the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just select the one choice which closely describes your problem right now.

**SECTION 1 – Pain Intensity**

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

**SECTION 2 – Personal Care**

- A. I would not have to change my way of washing or rising in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increase the pain, and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do any washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

**SECTION 3 – Lifting**

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

**SECTION 4 – Walking**

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than ½ mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

**SECTION 5 – Sitting**

- A. I can sit in any chair as long as I like without pain.

- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

**SECTION 6 – Standing**

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I can't stand for more than 10 minutes without increasing pain.
- F. I avoid standing because it increases pain right away.

**SECTION 7 – Sleeping**

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- F. Pain prevents me from sleeping at all.

**SECTION 8 – Social Life**

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from social life at all.

**SECTION 9 –Traveling**

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

**SECTION 10 – Changing Degree of pain**

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

**NEW PATIENT QUESTIONNAIRE #3**

**Name:** \_\_\_\_\_ **Chart#:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- 1. a. Do you have any **back** pain? Yes No (Circle One)
- b. If yes, how long have you had back pain? \_\_\_\_\_
- c. If yes, circle to indicate the average daily pain level.

No Pain    1 2 3 4 5 6 7 8 9 10    Severe Pain

d. Where does it hurt? (Please refer to enclosed diagram labeled **Nerve Pathways**)

L1    L2    L3    L4    L5    S1    (Circle any that apply)

- 2. a. Do you have any leg pain? Yes No (Circle One)
- b. If yes, how long have you had leg pain? \_\_\_\_\_
- c. If yes, circle to indicate the average daily level.

**Right Leg:** No Pain    1 2 3 4 5 6 7 8 9 10    Severe Pain

**Left Leg:** No Pain    1 2 3 4 5 6 7 8 9 10    Severe Pain

d. Where does it hurt? (Please refer to enclosed diagram labeled **Nerve Pathways**)

**Right Leg:** L1    L2    L3    L4    L5    S1    (Circle any that apply)

**Left Leg:** L1    L2    L3    L4    L5    S1    (Circle any that apply)

- 3. For returning Patients:  
In the future, if your back condition required it, would you have another procedure performed at the Bonati Institute? Yes No (Circle One)  
If No, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. For returning Patients:  
Have you had spine X-Rays taken (not at the Bonati Institute) since your last surgery performed at the Bonati Institute?

Yes No (Circle One)

If yes, where were they taken? \_\_\_\_\_  
When were they taken? \_\_\_\_\_

5. For returning Patients:  
Have you had a CT Scan taken since your last surgery at the Bonati Institute?

Yes No (Circle One)

If yes, where were they taken? \_\_\_\_\_  
When were they taken? \_\_\_\_\_

6. For returning Patients:  
Have you had an MRI Scan taken since your last surgery at the Bonati Institute?

Yes No (Circle One)

If yes, where were they taken? \_\_\_\_\_  
When were they taken? \_\_\_\_\_

7. What medications do you take on a daily basis? Please include all pain medications and Dosages:

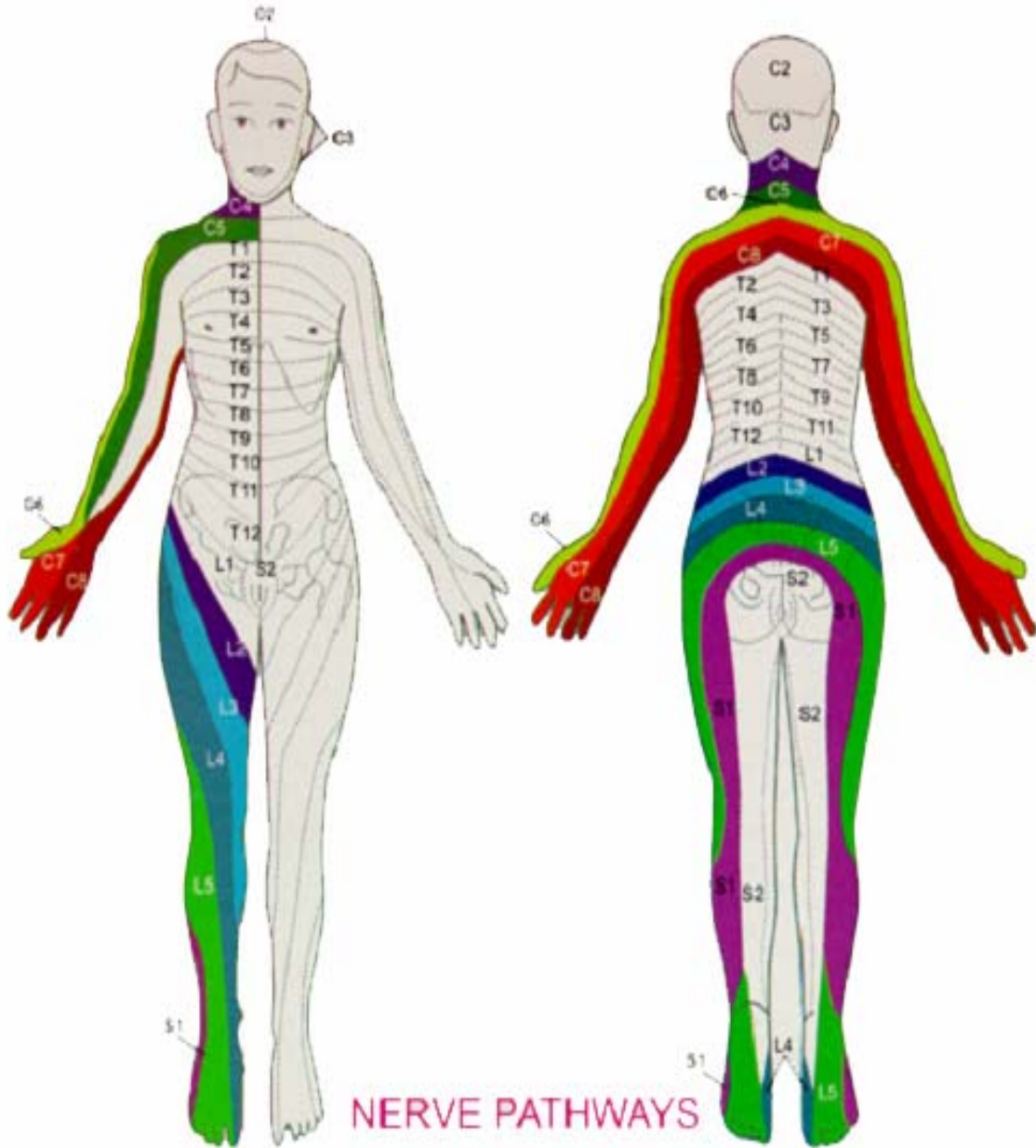
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. I certify that I have filled out this questionnaire myself, and that the answers are correct to the best of my ability to respond.

Signature \_\_\_\_\_

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

# Nerve Pathways



- C4 PATH
- C5 PATH
- C6 PATH
- C7 PATH
- C8 PATH

- L2 PATH
- L3 PATH
- L4 PATH
- L5 PATH
- S1 PATH

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# Your Health and Well-Being

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**This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!**

**For each of the following questions, please mark an  in the one box that best describes your answer.**

**1. In general, would you say your health is:**

|                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Excellent                             | Very good                             | Good                                  | Fair                                  | Poor                                  |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

**2. Compared to one year ago, how would you rate your health in general now?**

|                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Much better now than one year ago     | Somewhat better now than one year ago | About the same as one year ago        | Somewhat worse now than one year ago  | Much worse now than one year ago      |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

Patient's Initials \_\_\_\_\_

**3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

|                          |                             |                              |
|--------------------------|-----------------------------|------------------------------|
| Yes,<br>limited<br>a lot | Yes,<br>limited<br>a little | No, not<br>limited<br>at all |
| ▼                        | ▼                           | ▼                            |

- a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- c Lifting or carrying groceries..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- d Climbing several flights of stairs..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- e Climbing one flight of stairs..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- f Bending, kneeling, or stooping ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- g Walking more than a mile ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- h Walking several hundred yards ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- i Walking one hundred yards ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>
- j Bathing or dressing yourself ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub>

Patient's Initials \_\_\_\_\_

**4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

|                 |                  |                  |                      |                  |
|-----------------|------------------|------------------|----------------------|------------------|
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| ▼               | ▼                | ▼                | ▼                    | ▼                |

- a Cut down on the amount of time you spent on work or other activities ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- b Accomplished less than you would like ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- c Were limited in the kind of work or other activities ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- d Had difficulty performing the work or other activities (for example, it took extra effort) ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>

**5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

|                 |                  |                  |                      |                  |
|-----------------|------------------|------------------|----------------------|------------------|
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| ▼               | ▼                | ▼                | ▼                    | ▼                |

- a Cut down on the amount of time you spent on work or other activities ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- b Accomplished less than you would like ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- c Did work or other activities less carefully than usual ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>

Patient's Initials \_\_\_\_\_

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

|                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Not at all                            | Slightly                              | Moderately                            | Quite a bit                           | Extremely                             |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

7. How much bodily pain have you had during the past 4 weeks?

|                                       |                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| None                                  | Very mild                             | Mild                                  | Moderate                              | Severe                                | Very Severe                           |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> | <input type="checkbox"/> <sub>6</sub> |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

|                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Not at all                            | A little bit                          | Moderately                            | Quite a bit                           | Extremely                             |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

Patient's Initials \_\_\_\_\_

**9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

|                 |                  |                  |                      |                  |
|-----------------|------------------|------------------|----------------------|------------------|
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| ▼               | ▼                | ▼                | ▼                    | ▼                |

- a Did you feel full of life? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- b Have you been very nervous? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- c Have you felt so down in the dumps that nothing could cheer you up? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- d Have you felt calm and peaceful? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- e Did you have a lot of energy? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- f Have you felt downhearted and depressed? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- g Did you feel worn out? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- h Have you been happy? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- i Did you feel tired? ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>

**10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

|                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| All of the time                       | Most of the time                      | Some of the time                      | A little of the time                  | None of the time                      |
| ▼                                     | ▼                                     | ▼                                     | ▼                                     | ▼                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

Patient's Initials \_\_\_\_\_

**11. How TRUE or FALSE is each of the following statements for you?**

|                         |                     |                    |                      |                          |
|-------------------------|---------------------|--------------------|----------------------|--------------------------|
| Definitely<br>true<br>▼ | Mostly<br>true<br>▼ | Don't<br>know<br>▼ | Mostly<br>false<br>▼ | Definitely<br>false<br>▼ |
|-------------------------|---------------------|--------------------|----------------------|--------------------------|

- a I seem to get sick a little easier than other people..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- b I am as healthy as anybody I know..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- c I expect my health to get worse..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>
- d My health is excellent ..... <sub>1</sub> ..... <sub>2</sub> ..... <sub>3</sub> ..... <sub>4</sub> ..... <sub>5</sub>

***THANK YOU FOR COMPLETING THESE QUESTIONS!***

Patient's Initials \_\_\_\_\_

## **Acknowledgement of Review of Notice of Privacy Practices**

I, \_\_\_\_\_, a patient at The Bonati Institute,

(Please print name)

acknowledge review of the *Notice of Privacy Practices*, and that I have been provided with an opportunity to ask questions about its content. I am also aware that I may obtain a copy from Medical Records if I wish to do so.

\_\_\_\_\_

(Patient Signature)

\_\_\_\_\_

(Date)

-----

In the event that the patient refuses to sign this acknowledgement, an employee of The Bonati Institute will document the reason for refusal below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please return this document to Medical Records**

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## Communication of My Healthcare

I, \_\_\_\_\_, authorize my healthcare  
(Please print name)

information, including billing and collections information, written or verbal, to the below named family members, friend, Acting Power of Attorney or Healthcare Surrogate, to be disclosed for communicating results, finding, and care decisions to my family members and/or others responsible for my care or designated by me. I will provide those individuals names and/or other verification means specified by The Bonati Institute.

|                   |                |
|-------------------|----------------|
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| (Name)            | (Relationship) |
| _____             | _____          |
| Patient Signature | Date           |

**I will notify this office, in writing, if this information should change. This consent will remain in effect indefinitely, unless revoked by me as described above.**

Restriction on release of my healthcare information, including billing and collections information, written or verbal, to be disclosed for any purposes, to the below named.

|        |                |
|--------|----------------|
| _____  | _____          |
| (Name) | (Relationship) |
| _____  | _____          |
| (Name) | (Relationship) |

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## Doctor-Patient Arbitration Agreement

*(Please read carefully)*

This agreement is made between Gulf Coast Orthopaedic Center (GCOC), Medical Development Corporation of Pasco County, Inc., GCOC Physical Therapy, Inc., American Medical Care, Alfred O. Bonati, M.D., Jorge Weksler, M.D., Bruce Moffatt, M.D., John W. Grossmith, M.D., David Hirschauer D.O., Leonel P. Limonte M.D., Tonina Campoli, M.D., Agnes Green, M.D., Douglas E. Boler, M.D., Robert Dunn, M.D. George Bley, D.C., and their agents, employees, servants, or any of the foregoing referred to hereinafter as “doctors”, and \_\_\_\_\_ hereinafter referred to as “patient”. I have been advised that I may consult with counsel before signing this agreement.

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representative, guardians, or any persons deriving their claims through, and on behalf of the patient.

It is understood and agreed by the patient that he or she has voluntarily selected this center for treatment and he or she is not required to use this center nor any of the doctors involved in their treatment and that there are other competent orthopedic surgeons in Florida who perform surgery on the back, neck and arthroscopic surgeries.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Both the procedural and substantive laws of the State of Florida shall apply to the proceeding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and be enforced by a court of competent jurisdiction in, and for, Pinellas or Pasco Counties, Florida.

This agreement shall remain in effect for all treatment and surgery provided the patient, presently and at any future date.

**IN WITNESS WHEREOF**, we have hereunto set our hands this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

**PATIENT:**

By: \_\_\_\_\_  
(Patient Signature as Authorized Agent)

\_\_\_\_\_  
File #

\_\_\_\_\_  
(Patient's Spouse – if available)

**WITNESS:**

by: \_\_\_\_\_

STATE OF FLORIDA

COUNTY OF \_\_\_\_\_

The foregoing document was acknowledge before me this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_  
By \_\_\_\_\_, who is personally known to me or who produced  
\_\_\_\_\_ as identification, and who did/ did not  
take an oath.

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires: \_\_\_\_\_

**GULF COAST ORTHOPEDIC CENTER  
MEDICAL DEVELOPMENT CORPORATION  
GCOC PHYSICAL THERAPY  
AMERICAN MEDICAL CARE**

WAIVER OF THE CONSTITUTIONAL RIGHT PROVIDED IN ARTICLE 1  
SECTION 21, FLORIDA CONSTITUTION

Article 1, Section 21 of the Florida Constitution reads as follows:

Access to courts...The courts shall be open to every person for redress of any  
injury, and justice shall be administered without sale, denial or delay.

The undersigned patient understands and acknowledges that (initial each provision):

\_\_\_\_\_ I have been advised that signing this waiver releases an important constitutional right;  
and

\_\_\_\_\_ I have been advised that I may consult with counsel before signing this waiver; and

\_\_\_\_\_ By signing this waiver, I agree that if any controversy arises out of or in any way relating  
to the current or past diagnosis, treatment, or care that I have received from the physician or  
group of physicians listed below, or the physician(s) agents or employees, the maximum amount  
of any non-economic damages that can be awarded in any such action will be \$250,000. This  
limit applies regardless of the number of claimants or defendants in the proceeding. There is no  
limit on the amount of economic damages that a jury may award; and

\_\_\_\_\_ I have three (3) business days following execution of this waiver and prior to any surgical  
intervention in which to cancel this waiver; and

\_\_\_\_\_ I wish to engage the medical services of the physician or group of physicians listed  
below, but I am unable to do so because of the provisions of the constitutional limitation set forth  
above. In consideration of the physician or group of physicians' agreements to provide medical  
services to me and my desire to receive medical services from the physician or group of  
physicians listed below, I hereby knowingly, willingly, and voluntarily waive the right, in an  
action in a court of law for any controversy, including any malpractice claim arising out of or in  
any way relating to the diagnosis, treatment, or care of the patient by the undersigned physician,  
including any partners, agents, or employees of the physician, to recover non-economic damages  
in excess of \$250,000; and

\_\_\_\_\_ I have selected the physician or group of physicians listed below as my physician(s) of  
choice in this matter and would not be able to retain their medical services without this waiver;  
and I expressly state that this waiver is made freely and voluntarily, with full knowledge of its  
terms, and that all questions have been answered to my satisfaction.

ACKNOWLEDGEMENT BY PATIENT FOR PRESENTATION TO THE COURT

The undersigned patient hereby acknowledges, under oath the following:

I have read and understand this entire waiver of my rights under the constitutional provision set forth above.

I am not under the influence of any substance, drug or condition (physical, mental, or emotional) that interferes with my understanding of this entire waiver in which I am entering and all the consequences thereof.

I have entered into and signed this waiver freely and voluntarily.

I authorize my physician or group of physicians listed below to present this waiver to the appropriate court, if required. Unless the court requires my attendance at a hearing for that purpose, my physician or group of physicians are authorized to provide this waiver to the court for its consideration without my presence.

Name of Physicians

Alfred O. Bonati, M.D.  
Tonina Campoli, M.D.  
Robert P. Dunn, M.D.  
Agnes P. Green, M.D.  
John P. Grossmith, M.D.  
David R. Hirschauer, D.O.  
Leonel Perez-Limonte, M.D.  
Bruce D. Moffatt, M.D.  
Jorge O. Weksler, M.D.  
George Bley, D.C..

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 2009.

By: \_\_\_\_\_  
Patient

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ 2009  
by \_\_\_\_\_, who is personally known to me, or has produced the following  
identification \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 2009

**GULF COAST ORTHOPEDIC CENTER, INC.; AMERICAN MEDICAL CARE, INC.;**  
**MEDICAL DEVELOPMENT CORPORATION OF PASCO COUNTY – ALFRED**  
**O. BONATI, M.D. PA.**

(Patient Copy)

**PATIENT RIGHTS\***

- To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- To a prompt and reasonable response to questions and requests.
- To know who is providing medical services and who is responsible for his or her care.
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- To know what rules and regulations apply to his or her conduct.
- To be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- To refuse any treatment, except as otherwise provided by law.
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- To know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency

## **PATIENT RESPONSIBILITIES\***

- For providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting unexpected changes in his or her condition to the health care provider.
- For reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- For following the treatment plan recommended by the health care provider.
- For keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- For his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- For assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- For following health care facility rules and regulations affecting patient care and conduct.
- 

## **A NOTE REGARDING ADVANCED DIRECTIVES**

If you have a living will or healthcare proxy, it is our policy not to honor advanced directives. If you have questions regarding this, please ask to speak to a member of the administrative team.

\***Section 381.026**, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. This is a summary of your rights and responsibilities.