Dear new patients,

Thank you for trusting Total Pain & Spine Care of Florida for your healthcare needs. It is our desire to provide you with personalized interventional pain care in a state-of-the-art facility.

We are here to answer your questions about your health, medical conditions and treatments.

In order to simplify and expedite your initial visit with us, **please bring the following to your first visit**:

- ✓ Completed Patient Intake Form Packet
- ✓ Insurance card, secondary Insurance card (if applicable)
- ✓ Photo ID (driver's license, school photo ID, passport)
- ✓ A list of all prescribed medications you are currently taking
- ✓ Workers compensation automobile personal injury insurance claim information if applicable, including:
    - Insurance company address
    - Claim number
    - Date of accident
    - Adjuster/case manager's name and phone number
    - Your attorney's name, address and phone number MRI, CT scan or X-Ray films and reports
    - List of all medications that you are currently taking

Please arrive at least 15 minutes prior to your scheduled appointment.

We look forward to your visit and hope we can be of continuing service. If you have any questions, please do not hesitate to contact our clinic at 863-732-7246.

Sincerely,

Staff at Total Pain & Spine Care of Florida

COVID-19 Screening Questionnaire

Due to worldwide healthcare concerns over the Novel Coronavirus (COVID-19) and in an effort to protect patients and staff, we will be asking all patients to complete a screening form for symptoms of potential exposure to Novel Coronavirus (COVID-19) prior to their appointment. Based on the responses from the screening form, patients may be asked to reschedule their visit.

Complete temperature screening with infra-red thermometer at front entrance.	Temperature at time of arrival:	
Have you been tested for COVID-19 in the past 14 days and is pending results?	Date:	
Circle Yes or No to the following questions:		
Fevers	YES	NO
Myalgias (fatigue)	YES	NO
Respiratory symptoms (shortness of breath or cough)	YES	NO
URI symptoms (headache, rhinorrhoea, sore throat)	YES	NO
GI symptoms (diarrhea, nausea, vomiting)	YES	NO
ENT symptoms (loss of taste or smell)	YES	NO
Eye symptoms (conjunctivitis)	YES	NO
Have you travelled internationally in the last 14 days?	YES	NO
Have you travelled in an airplane or on a cruise ship in the last 14 days?	YES	NO
Have you visited or do you reside in a community with confirmed community spread of COVID-19?	YES	NO
Have you been exposed to anyone who has tested positive or is under investigation for COVID-19?	YES	NO

Patient Name: ________________________________ **Appointment Date:** ________

Date of Screening: ____________________________ **Staff Name:** _______________