South Florida Hand and Orthopaedic Center

Medical History

Patient Name: _____ DOB: _____ Age: _____ Sex: M / F
Height: _____ Weight: _____ BP: _____ Dominant Hand: LEFT / RIGHT / AMBIDEXTROUS

Medical History: Do you have now or have ever been treated for? ** **Please circle Y or N** **

Y / N Diabetes
Y / N Thyroid Problems
Y / N Circulatory/ Vascular Problems
Y / N Stroke
Y / N Heart Problems: _____
Y / N GI Problems
Y / N Respiratory/Lung Problems: _____
Y / N Arthritis
Y / N Liver Problems: Cirrhosis, Hepatitis
Y / N Kidney Stones or Problems

Y / N Anxiety / Depression / Bipolar
Y / N Anemia or Bleeding Disorder
Y / N Cancer: Type _____
Y / N Hypoglycemia
Y / N High Cholesterol
Y / N Hypertension/ High Blood Pressure
Y / N Seizure Disorder
Y / N HIV
Y / N Skin Problems
Y / N Eye Problems: Cataracts, Glaucoma
Y / N Sinus Problems

Other illnesses, medical problems or major injuries, past or present: _____
_____

Have you been treated by another Orthopaedic in the past 3 years? _____

Allergies to Medications/Latex/Adhesives? _____
What is the reaction? _____

Current Pharmacy name, address and phone number: _____
_____

Current Medications: _____
_____

Previous Surgeries: _____

Do you smoke? (Please Check One) Former _____ Current _____ Never _____
Do you drink alcohol? Y / N
Use drugs? Y / N
Are you or could you be pregnant? Y / N

Family Medical History: ** **Please circle Y or N** **

Y / N Diabetes
Y / N Heart Problems
Y / N Stroke
Y / N Asthma

Y / N Thyroid Problems
Y / N Hypertension/ High Blood Pressure
Y / N Cancer – Type: _____
Y / N Arthritis

Patient Signature: _____ Date: _____

1905 Clint Moore Rd, Suite 105 Boca Raton FL 33496 Phone: (561) 241-4758 Fax: (561) 998-4246

Pain Diagram

Name: _____ **DOB**: _____ **Age**: _____ **Sex**: M / F

Right Handed / Left Handed /Ambidextrous

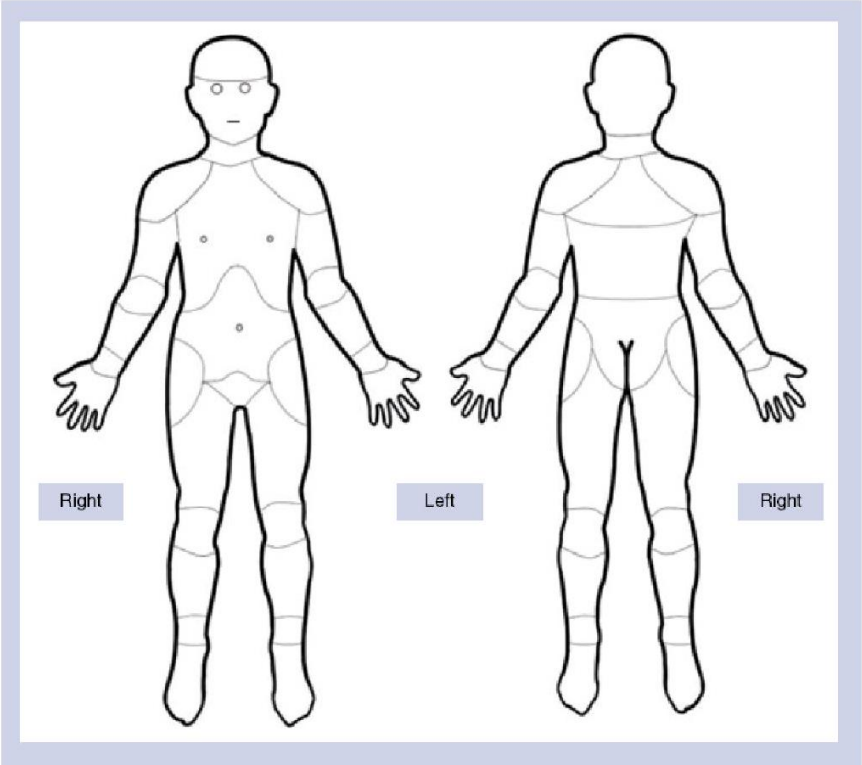
Reason for today's visit: _____

Date of Onset symptoms: _____ **Due to injury or accident?** Y / N Please Describe: _____

Since onset, the symptoms are: improving / worsening / staying the same

Pain is sharp / dull / achy / throbbing / other:

_____



Pain Rating:

0 = No Pain 10 = worst pain imaginable

At Best: 1 2 3 4 5 6 7 8 9 10

At Worst: 1 2 3 4 5 6 7 8 9 10

What make your pain better?

_____

What makes your pain worse?

_____

Does your pain wake you up at night? Y / N

Do you experience any clicking, popping, crunching at the area of pain? Y / N

Have you been treated previously for this issue?
Y / N

Surgery on this extremity? Y / N If yes, please describe: _____

Non- surgical treatment: ___ Physical therapy ____ Corticosteroid injection _____ Date of last injection: _____

____ Splinting/Bracing Other: _____

What pain medications are you taking for this problem?

___ Anti-inflammatory (ibuprofen/Motrin/Advil) ___ Acetaminophen (Tylenol) ___ Other: _____

Prior Diagnostic test: ___ EMG/NCV ___X-rays ___ CT scan ___ MRI ___ other: _____

What Activities is this issue preventing you from doing? _____

What do you do for work? _____ **Do you smoke?** Y / N **Amount**:_____ **How many years?** _____

1905 Clint Moore Rd, Suite 105 Boca Raton FL 33496 Phone: (561) 241-4758 Fax: (561) 998-4246

South Florida Hand and Orthopaedic Center

Date: _____

Patient Last Name: _____ First Name: _____ Initial_____

DOB: _____ Age: _____ Sex: _____ M D S W Spouses Name: _____

Permanent Address: _____

Home Phone: ( ) _____ Mobile ( ) _____ Email: _____

Referred by: _____ Family Physician (P.C.P) _____

Date Illness/Injury began _____ Is this related to your employment? _____

Type of Injury: Auto _____ At Work _____ Other Accident _____ Is this a liability case? Yes _____ No _____

Describe how injury occurred: _____

Describe Symptoms: _____

Insurance Information:

Primary Insurance: _____ ID# _____

Secondary Insurance: _____ ID # _____

Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process and insurance claim.

X_____

Authorization of Payment to Physician

I authorize payment of medical benefits to South Florida Hand and Orthopaedic Center

X _____

I give permission to South Florida Hand and Orthopaedic Center to administer medical treatment, including x-rays to my son/daughter (Must be signed by parent/guardian if the child is under 18 years of age)

Parent/ Guardian Signature: _____

To Our Patients:

Our doctors accept Medicare assignment and we will bill Medicare electronically for you. We will file your secondary insurance for you as well. In most cases, the secondary insurance forwards payment to us. In the event they send the check directly to you, we do require that you forward these funds immediately to us.

PPO, HMO, and Commercial Insurance Patients:

If we are a participating provider, we will be your insurance plan, but **YOU ARE RESPONSIBLE** to pay your co-pay, co-insurance and/or deductible at the time of visit. If a referral is required, THE PATIENT is required to obtain this referral and inform us **BEFORE** each visit that you have this referral.

I have read the above credit policy of South Florida Hand and Orthopaedic Center and agree to this by signing below

Patient Signature: _____ **Date**: _____

1905 Clint Moore Rd, Suite 105 Boca Raton FL 33496 Phone: (561) 241-4758 Fax: (561) 998-4246

Consent for Purpose of Treatment, Payment, Photography, and Healthcare Operations

I consent to the use or disclosure of any protected health information by South Florida Hand & Orthopaedic Center for the purpose of diagnosing or providing treatment to me and obtaining payment for my healthcare bills or to conduct health care operations of South Florida Hand & Orthopaedic Center. I understand that diagnosis or treatment of me by South Florida Hand & Orthopaedic Center may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is being used or disclosed to carry out treatment, payment, or health care operations of the practice. South Florida Hand & Orthopaedic Center is not required to agree to the restrictions that I may request. However, if South Florida Hand & Orthopaedic Center agrees to restriction that I request, the restriction is binding on South Florida Hand & Orthopaedic Center.

I have the right to revoke this consent in writing, at any time, except to the extent that South Florida Hand & Orthopaedic Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and collected or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe that this information may identify me.

I understand that I have the right to review South Florida Hand & Orthopaedic Center's Notice of Privacy Practices prior to signing this document. The South Florida Hand & Orthopaedic Center's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of healthcare operations of South Florida Hand & Orthopaedic Center. The Notice of Privacy Practices also describes my rights and the South Florida Hand & Orthopaedic Center's duties with respect to my protected health information.

South Florida Hand & Orthopaedic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next visit.

X-Rays taken in this office are a permanent part of your medical record and are therefore the sole property of South Florida Hand & Orthopaedic Center. If you require x-rays for any reason, we will be happy to **COPY THE FILMS FOR A FEE.** We are obligated by law to make this policy mandatory, there, no exceptions will be made.

X_____ X_____ _____

Patient Name (PRINT) Patient Signature Date

X_____

Description of Personal Representative's Authority

1905 Clint Moore Rd, Suite 105 Boca Raton FL 33496 Phone: (561) 241-4758 Fax: (561) 998-4246