FLORIDA INSTITUTE
of Orthopaedic
SURGICAL SPECIALISTS

GENERAL MEDICAL HISTORY

Which Dr. are you seeing today? ________________

Date:________________ Date of Birth:__________________ Age:__________ Sex: M / F

Name:____

Occupation:____

Employer:____

Dominant Hand: *Left / Right* **Height:**__________ **Weight:**__________

Who referred you to us? Name:____

Primary Care Physician: Name:____

Address:____

Fax Number:____

□Would you like your records forwarded from your visit?

1. Presenting Complaint:
   Affected Side: □ Left □ Right □Both
   Body Area: □ Knee □ Shoulder □ Hip □Ankle □Elbow □Foot
   □ Hand □ Wrist □ Spine Other: __________

2. How long have you had the problem?______________________________________
   Have you experienced this before?_______________________________________
   What makes the problem worse?____
   What makes the problem better?____
   Pain Scale 0- no pain and 10- worse pain 1 -2- 3- 4- 5- 6- 7- 8- 9- 10

3. Pharmacy Name:____
   Pharmacy Phone Number:____
   Pharmacy Address:____

4. Was this a result of an injury?□YES □NO
   If yes, describe how it happened____

5. Is this a workman's compensation injury? □YES □NO (if no, advance to question #6)
   If yes, please answer the following: Job Title:____________ Date of Injury:__________
   Are you: □ Off work □ Modified duty □ Full duty

6. Is your problem getting: □ Worse □ Better □ Staying the same

7. What studies have been done? □CT □MRI □Bone Scan
□Other:______________________

8. Have you had injections? □Yes □No
If so, where?_______________ ____
How much did it help?______________________ For how long?____________________

9. How would you describe the pain?

Quality:	□Dull	□Throbbing	□Sharp
Timing:	□Intermittent	□Constant (even at rest)	□Related to activity
Severity:	□Mild	□Moderate	□Severe
Associated symptoms:	□ Swelling	□Bruising	□Catching/Locking
	□Heat	□Numbness	□Weakness
	□Burning	□Giving away	
	□Other:__________________________		

10. Past Medical History and Review of Symptoms
Have you had any of the following? (check all that apply) **□NONE**

□Bleeding disorder	□Sciatica/Radiating pain	
□High blood pressure (hypertension)	□Seizures	□Diabetes
□Heart attack (MI) Date:_______	□Angina	□Thyroid disease
□ Back pain/disc disorder	□MRSA Infection	□Cancer
□Gout	□Sickle cell disease	□Kidney disease
□Hepatitis/Jaundice	□Unusually high fever	□HIV, AIDS, TB
□Emphysema, lung disease, (COPD)	□Recent cold	□Blood clots
□Asthma	□Ulcers	□Phlebitis
□Mitral valve prolapse	□Rash/skin lesion	□Eye disorder
□Arrhythmia (i.e. atrial fibrillation)	□ Psychological disorders	
□Other:____________________________		

11. Do you currently have any of the following? (check all that apply) **□NONE**

□Fevers, night sweats	□Bladder problems	□Sore throat, earache
□Unexplained weight loss	□Pain when urinating	□Urinary infections
□Chest pain	□Difficulty breathing	□Stomach pain
□Vision difficulties	□Skin rash	□Depression/Anxiety
□Numbness: (location)______________________	□Other:__________	

12. List Allergies: **□NONE**

____

13. Do you take oral contraceptives? □Yes □No

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SURGICAL SPECIALISTS

14. List current medications (**give doses**, Include any over-the-counter or herbal meds) □**NONE**

____
____
____

15. List any surgery or hospitalizations that you have had (give dates): □**NONE**

____
____
____

16. Social History:

Marital Status: □Single □Married □Divorced □Widow

Do you use any of the following: Tobacco □Yes □No How much per day?__________
Alcohol □Yes □No How much per week?________

History of substance abuse: □Yes □No If so, what?________________

History of military service: □Yes □No

17. Family History (check all that apply) □**NONE**

□Arthritis □Osteoporosis □Diabetes
□Obesity □Cancer □Problems with anesthesia
□Other:____

OFFICE USE ONLY

Reviewed by:______________________________ Date:__________________

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SURGICAL SPECIALISTS

Last Name: ________________ **First Name:** ________________ **Middle Initial:** ______

Address: ____

City: ________________ **State:** ________________ **Zip:** ________________

Home Phone: ______________ **Mobile Phone:** ______________ **Work Phone:** ___________

Preferred form of contact: □ Home □ Mobile □ Work

Gender: ______________ **Date of Birth:** ______________ **Marital Status:** ________

Patient email: ____

Referred by: ____

Primary Care Physician: ________________ **Office number:** ________________

Guarantor Information (to whom statements are sent)

Guarantor Last Name: ________________ **Guarantor First Name:** ________________

Relationship to Patient: ________________ **Guarantor Date of Birth:** ________________

Emergency Contact Information

Name: ________________________

Relationship: ________________________ **Contact Number:** ________________________

Insurance Information

Primary Insurance Plan Name: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: ______________ **Policy Holder's Gender:** ______________

Policy Holder's Address (if different from Patient): ________________________

____

Secondary Insurance Plan Name: ____

Policy Holder's Name: ____

Policy Holder's Date of Birth: ______________ **Policy Holder's Gender:** ______________

Policy Holder's Address (if different from Patient): ________________________

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SURGICAL SPECIALISTS

ACKNOWLEDGEMENT AND AUTHORIZATION:

• To the best of my knowledge the above demographic and insurance information is complete and accurate

Signed______________________________________ Date: ____________________

• I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed______________________________________ Date: ____________________

• I authorize Florida Institute of Orthopaedic Surgical Specialists to release medical information required to process my claim

Signed______________________________________ Date: ____________________

• I have read and understand the Financial Policy for Florida Institute of Orthopaedic Surgical Specialists

Signed______________________________________ Date: ____________________

• I authorize Florida Institute of Orthopaedic Surgical Specialists to obtain/have access to my medication history

Signed______________________________________ Date: ____________________

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SURGICAL SPECIALISTS

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or by Dr. Burke, Caldwell, or Carreira as a physician of Florida Institute of Orthopaedic Surgical Specialists and his/her designee(s).

FINANCIAL AGREEMENT

The undersigned individually obligates him/herself and guarantees prompt payment of all charges for services rendered to the patient when not covered by insurance carries or others. Payment of any unpaid balance is due within 30 days of final billing. If payment is not received within 30 days of the date of final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which t which time the undersigned shall be liable for attorney's fees and/or collection agency's fees and expenses. The undersigned understands that Florida Institute of Orthopaedic Surgical Specialists has the right to examine credit bureau files for financial information regarding collection or unpaid debt.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Florida Institute of Orthopaedic Surgical Specialists for services rendered to me. I authorize payment directly to Tenet Florida Physicians Services of all such insurance benefits payable to me. Such insurance includes, but is not limited to, private commercial insurance, auto/liability insurance , or any governmental program such as Medicare, Medicaid or Worker's Compensation and authorize Florida Institute of Orthopaedic Surgical Specialists to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is accurate and current.

RELEASE OF INFORMATION

I also authorize Tenet Florida Physicians to release all or part of my medical record information when required or permitted by law or government regulation, including any physician(s) or healthcare provider responsible for continuing my care.

INSURANCE PRECERTIFICATION

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by insurance.

LIFETIME MEDIGAP SIGNATURE AUTHORIZATION

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services.

____

Name of Medigap Insurer

____

Name of Beneficiary

____

Medigap Policy Number

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____

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____

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____

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SURGICAL SPECIALISTS

Release of Confidential Medical Information

I, ______________________________________, DOB ________________ authorize the staff of
Print Name
Florida Institute of Orthopaedic Surgical Specialists (FIOSS) to coordinate the release of confidential medical information in the following manner:

FIOSS may leave messages on my home answering machine related to recent test results.	YES	NO
FIOSS may leave messages on my home answering machine related to upcoming appointments and/or scheduling issues with future appointments.	YES	NO
FIOSS may contact me using an automated phone messaging system for purposes of billing and/or insurance follow up.	YES	NO
FIOSS may contact me using an automated phone messaging system for purposes of appointment follow up or rescheduling.	YES	NO

Please list any family members or others whom may be involved in coordinating your care or payment for care. Also, please indicate what kind of information may be shared with each individual.

Name	Relationship	All	Scheduling/ Appointments	Medical	Billing/ Insurance
________________	________________	___	___	___	___
________________	________________	___	___	___	___
________________	________________	___	___	___	___

We will continue to rely on the information on this form when communicating with you and your family members or others involved in your care unless you request changes. Please promptly notify your physician office if you wish to alter designations as outlined above.

Signature of Patient/Guardian/
Legal Representative: ______________________________ Date: ________________

FLORIDA INSTITUTE of Orthopaedic SURGICAL SPECIALISTS

NOTICE OF PRIVACY PRACTICES (HIPPA) ACKNOWLEDGEMENT

A **Notice of Privacy Practices (NPP)** is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

____________________ Name of Patient

____________________ Signature of Patient

_____ / _____ / _____ Date Signed

____________________ Name Patient's Personal Representative

____________________ Signature of Patient's Personal Representative

_____ / _____ / _____ Date Signed

FOR INTERNAL USE ONLY

____________________ Name of Employee

____________________ Signature of Employee

If applicable, reason patient's written acknowledgement could not be obtained:

- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other ____________________