New and Updated Patient Form

PLEASE PRINT ALL INFORMATION NEEDED BELOW, THANK YOU

Today's Date _____

Patient's Name: _____ **Gender: □Male □Female**
Last First MI

Patient Mailing Address: _____
Street Address City State Zip

Best Phone: ( ) _____ 2nd Phone: ( ) _____

Date of Birth: _____ Social Security #: _____

Marital Status: □ Single / Soltero □ Married / Casado □ Divorced / Divorciado □ Seperated / Separado □ Widowed / Viudo(a)
□ Domestic partner / Compañero doméstico Spouse's Name: _____

PREFERRED LANGUAGE: _____ **EMAIL ADDRESS**: _____

If patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ Social Security #: _____

Phone # (if different from above): _____ (day) _____ (evening)

Address (if different from above):

_____
Street Address City State Zip

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to patient:_____

Home Phone: ( ) _____ Work Phone: ( )_____

Primary Care Physician: _____ **Referring Physician (if different):**_____

Phone Number: ( ) _____ Fax Number: ( )_____

PRIMARY INSURANCE COVERAGE INFORMATION

Insurance Company Name:

_____

Insurance Co. Address:

_____
Street/ P.O. Box City State Zip

Policy ID #: _____ Effective Date of Coverage:_____

Group #: _____

Policy Holder's Name: _____
Last First MI

Policy Holder's Address:

_____
Street Address City State Zip

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Patient's Relationship to Policy Holder: □ SELF □ SPOUSE □ CHILD □ OTHER: _____

SECONDARY INSURANCE COVERAGE INFORMATION

Insurance Company Name:

_____

Insurance Co. Address:

_____

Street/ P.O. Box City State Zip

Policy ID #: _____ Effective Date of Coverage:

_____

Group #: _____

Policy Holder's Name: _____

Last First MI

Policy Holder's Address:

_____

Street Address City State Zip

Patient's Relationship to Policy Holder: □ SELF □ SPOUSE □ CHILD □ OTHER: _____

_____

ACCIDENT INFORMATION

AUTO ACCIDENT □YES □NO Date of Injury: _____

OTHER ACCIDENT □YES □NO Date of Injury: _____

WE DO NOT PROVIDE 3RD PARTY BILLING

WORKER'S COMPENSATION INJURY: □□YES □□NO Date of Injury: _____

Employer at Time of Injury:

_____

Employer Address: _____

Street/ P.O. Box City State Zip

Employer Phone: ( ) _____

Describe your injury (including body part involved):

_____

_____

_

NO SHOW POLICY

Please be advised that Orthopaedic Associates, USA has a "No Show" Policy. This means that if you do not keep your appointment OR cancel your appointment within 24 hours of the scheduled time, a $50.00 charge will be incurred.

New and Updated Patient Form
Medical History Questionnaire

Please answer all of the following questions to the best of your ability and sign your name at the end of this form.
Por favor, responda todas las preguntas lo mejor que usted pueda y firme su nombre al final de este formulario.

Patients Name / *Nombre del Paciente:* _____ **Age/** *Edad***:_____**

Dominant Hand: □Right □Left **Occupation** / *Ocupación*: _____

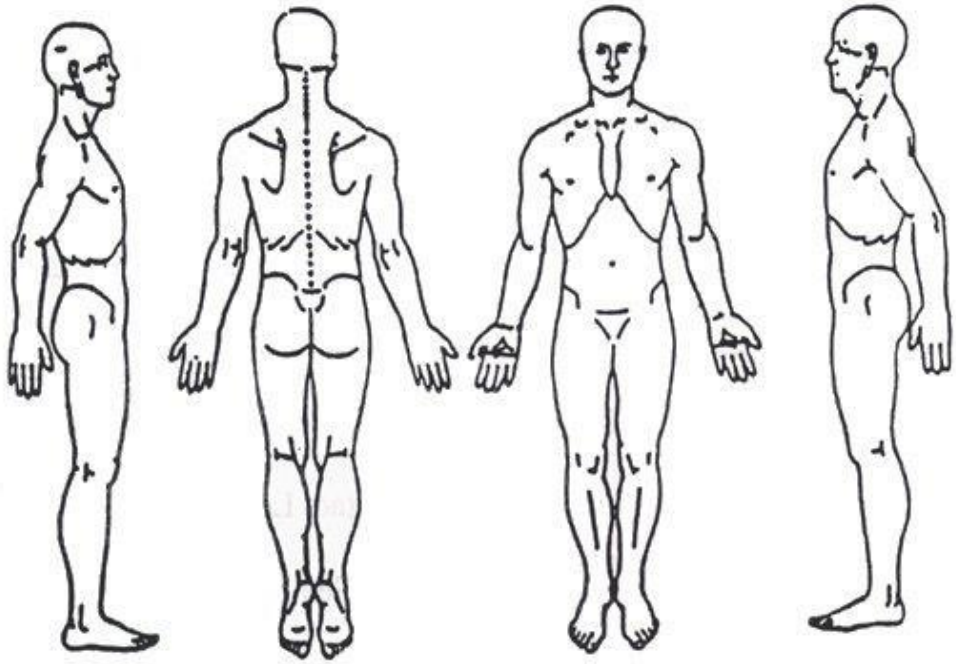
Height / Estatura: _____ **Weight** / Peso: _____

History of Present Illness

What did you injure? / *¿Qué parte del cuerpo se lesionó?*
_____

Which side? / *¿Cuál lado?*
Left ___ *Izquierdo* Right ___ *Derecho*

Mark problem areas of pain/ Marque la(s) parte(s) del cuerpo que le duele(n) y el tipo de dolor
*XXX=aching (dolor) | - - - = burning (ardor) | *** = pins & needles (alfileres & agujas)| >>> = shooting (sensación de disparo) | / / = stabbing (sensación de puñalada) | 000 = throbbing (sensación de palpitación)*



RT **LT** **RT** **RT** **LT** **LT**

How did you injure yourself?/ ¿Cómo se lesionó?
□ **No Injury** □**Fall** □ **MotorVehicle Accident** □**Work/Job** □**Sports**

Please briefly describe injury/ Por favor describa cómo se lesionó: _____
_____

Date of Injury/ ***Fecha de la lesión:*** **_____**

Is this case involved or will it be involved in litigation? / ¿Está este caso relacionado con una demanda o va a estar en una demanda? □ Yes / Sí □ No / No

New and Updated Patient Form

How long have you been experiencing these symptoms? / *¿Cuánto hace que experimenta estos síntomas?*
_____Days/Días _____Months/Meses _____Years/Años

What previous treatments have you tried?/ *¿Qué tipo de tratamientos ha seguido?*
□ Medications □ Therapy □ Injections □Other_____

Any previous surgery for this problem?/ *¿Lo/ La han operado por esta condición médica?*
Please list type and Dates/ *Por favor, escriba el tipo de operación y la fecha*:

_____

Check the symptoms that best describe your problem / *Seleccione el sintoma(s) que describa su problema*
□ Stiffness / *Rigidez* □ Pain / *Dolor* □ Instability / *Inestabilidad* □Numbness / Adormecimiento
□ Swelling / *Inflamación* □ Other / *Otro*_____

How severe is the pain? (0 = none/ 10=severe/*severo*)
At Rest /*Al descansar* 0 1 2 3 4 5 6 7 8 9 10
At its worst/ *A lo máximo* 0 1 2 3 4 5 6 7 8 9 10
Do you have pain at night? /*¿Siente dolor de noche?* □Yes □No
Does it wake you from sleep? / *¿Lo/ La despierta?* □Yes □ No

What makes your problem better? / *¿Qué mejora sus síntomas?*_____
What makes it worse? / *¿Qué empeora sus síntomas?*_____
What are you current limitations? / *¿Cuáles son sus limitaciones?*_____

Are you currently working/*¿Está usted trabajando?* □ Yes/Sí □ No/No □ □Retired/*Retirado*
If yes, at full capacity? *¿Trabajo de tiempo completo?* □ Yes/Sí □ No/No

Past Medical History: Do you have or are you being treated for, any of the following:
Historia Médica: ¿Tiene o ha sido tratada(o) por lo siguiente?

Medical History/ *Historia Médica*	Yes	No	Please Describe
Arthritis/ *Artritis*			
Bleeding,clotting disorder/*Sangramiento*			
Cancer			
Diabetes			
Heartburn; reflux; ulcers/ *Indigestión-acidez*			
Heart problems /*Problemas del corazón*			
Hepatitis___ (please specify type)			
High Blood Pressure/*Presión alta*			
Kidney Disease/*Enfermedad de los riñones*			
Lung disease;Asthma;emphysema/ *Pulmones;asma*			
Stroke/*Derrame*			
Thyroid disease/ *Tiroides*			
Other (specify)/ *Otro*			
Are you pregnanat?/ *¿Está usted embarazada?*			
Are you HIV positive?/ *¿Está usted con VIH?*			

Current Medications/ *Medicamentos actuales*
_____
_____
_____
_____

New and Updated Patient Form

Allergies: □ No Known Drug Allergies □ Penicillin □ Sulfa □ Iodine □ Radiologic Dyes □ Latex □ Soy □ Shellfish
□ Other:_____

Consent for Orthopedic Associates, USA to obtain your medical history and to use ePrescribing as the means to send certain medication to the pharmacy of your choice.

ePrescribing is defined as a physician's ability to electronically send and accurate, error free, and understandable prescription directly to a pharmacy from the point of care.
The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefic transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with the information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notifications** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Orthopedic Associates, USA can request and use your prescription medication history from third party pharmacy benefit payors for treatment purposes.
Understanding all of the above, I hereby provide informed consent to Orthopedic Associates, USA to enroll me in the ePRescribe Program.

I consent for OAUSA to obtain up to 13 months of my medication history. ____Yes ____No

Patient name (PRINT): _____
Pharmacy name and phone number: _____
Signature of patient or guardian: _____ Date: _____
Previous Surgeries: □ NONE
□Yes/Sí (please list): _____
_____
_____

Have you or a family member had complications from anaesthesia? □ No □Yes (explain):_____

Family History: (Check all that apply)
□ Heart Disease □ Stroke/TIA □ Diabetes □ Gout □ Arthritis (type):_____Cancer(type):_____
□**Other**_____

Do you have any children? / ¿*Tiene hijos?* □ Yes / *Sí* □ No / *No* **How many?** / ¿*Cuántos?*_____

Do you smoke or use tobacco? / ¿Fuma? □ No / *No* □ Cigarettes_____ □ Cigars □ Pipe □ Chewing Tobacco
If Yes, **How many a day? /** ¿*Cuántos por día?* **____How many years /** ¿Cuántos años? **_____ Quit on_____**

Do you drink alcoholic beverages?/ ¿*Bebe alcohol***?** □ **No** □ **Yes**
If yes, then: □ Socially □ Rarely □ Daily _____drinks per week)

Do you use recreational drugs? / ¿*Usa otras drogas?* □ **No** □ **Yes**
If yes, what kind?/ ¿*Qué tipo?* **_____**

New and Updated Patient Form
Review of Systems/ *Revisión de sistemas*

Do you have or have you had any of the following symptoms?/ *¿Tiene o ha tenido usted alguno de los siguientes síntomas?*

	Yes	No		Yes	No
Constitutional/ *Síntomas generales:* Fever/ *Fiebre* Chills/ *Escalofríos* Headache/ *Dolor de cabeza* Other/ *Otro:*			**Integumentary**/ ***Cardiovascular***: Skin Rash/ *Erupción de la piel* Boils/ *Ampollas* Presistent Itch/ *Picazón persistente* Other/ *Otro*		
Eyes/ *Ojos*: Blurred Vision/ *Visión nublada* Double Vision/ *Visión doble* Pain/ *Dolor* Other/ *Otro:*			**Muscular Skeletal/ *Esquelético muscular:*** Joint Pain/ *Dolor articular* Neck Pain/ *Dolor de cuello* Back Pain/ *Dolor de espalda* Other/ *Otro:*		
Allergic/ *Alergias:* Hay Fever/ *Fiebre del heno* Drug Allergies/*Alergias a ciertos medicamentos* Other/ *Otro:*			**Ear/Nose/Throat/Mouth/ *Oído/Nariz/Garganta/Boca*:** Ear Infection/ *Infección de oído* Sore Throat/ *Dolor de garganta* Sinus Problem/ *Sinusitis* Other/ *Otro:*		
Neurological/ *Neurológico:* Tremors/ *Temblores* Dizzy Spells/ *Mareos* Numbness-Tingling/ Ador*mecimiento-hormigueo* Other/ *Otro:*			**Genitourinary/ *Genitourinario:*** Urine retention/ *Retención de orina* Painful Urination/ *Orina dolorosa* Urinary Frequency/ *Orina frecuentemente* Other/ *Otro:*		
Cardiovascular/ *Cardiovascular:* Chest Pain/ *Dolor de pecho* Varicose Veins/ *Venas varicosas* High Blood Pressure/ *Presión alta*			**Respiratory/ *Respiratorio:*** Wheezing/ *Silbidos en el pecho* Frequent Cough/ *Tos frecuente* Shortness of breath/ *Falta de aire* Other/ *Otro:*		
Endocrine/ *Endocrina:* Excessive thirst/ *Sed excesiva* Too Hot-Cold/ *Mucho frío-calor* Tired-Sluggish/ *Cansancio* Other/ *Otro:*			**Hematologic/ Lymphatic/ *Hematológico/ Linfático:*** Swollen Glands/ *Glándulas inflamadas* Blood Clotting Problem/ *Coágulos sanguíneos* Other/ *Otro:*		

Orthopaedic Associates USA
350 N Pine Island Rd. Suite 200
Plantation, FL 33324

Authorization for Release of Medical Records/Payment Authorization/Practice Policies

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Not to be released to anyone

[ ] Physician Name/Office: _____

Check information requested and how to be sent. X-rays incur a cost of $10.00

_____ Entire Record _____ X-Ray _____ Email _____Fax _____US Mail

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number
If unable to reach me: [ ] you may leave a detailed message [ ] please leave a message asking me to return your call

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released by this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the authorization. This authorization is valid for one year from date of signature if not specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules. I also understand that although the practice makes its best efforts, the transmission of information via email or text between the practice and myself may not be encrypted and secure. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at (954) 476-8800.

Assignment of Insurance Benefits: I hereby authorize payment directly to Orthopaedic Associates USA ("OAUSA") and assign to them any and all rights and benefits that I or the patient may have under and policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to OAUSA. I understand that I am financially responsible to OAUSA for charges not covered by this assignment.

Consent to Medical and Surgical Treatment: The undersigned hereby consents to all medical care and services, surgical treatments. Examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostics

procedures and tests, anesthesia, which a physician, their employees, nurses, associates, assistants, or designees may deem advisable to the undersigned patient during this treatment.

Payment Guarantee: The undersigned patient and guarantor, if any, hereby agree to OAUSA charges to OAUSA in accordance with the regular rates and terms of OAUSA and agree to pay for any charges not covered by any third party payer. The medical practice files insurance as a courtesy to the patient, but the patient is ultimately responsible for the payment of the total incurred charges. The undersigned agrees that if the account is turned over to a collection agency or attorney, that the undersigned patient shall be obligated to pay the outstanding balance plus all court, collection, and attorney costs. The undersigned agrees that any overpayment collected on this account may be applied to any delinquent account for which the undersigned patient is legally responsible.

Referral Policy: The purpose of this notice is to inform you of our office policy regarding referrals. If your plan requires that you obtain a referral for specialist services, it is your responsibility to do so. We do not contact the primary care physician (PCP) for referrals. If you present to the office without a referral you have the option of paying out of pocket or rescheduling your appointment until you have obtained a referral.
For your convenience, we will accept faxed referrals. However, it is the patient/parent/guardian's responsibility to ensure that the referral is received in the office prior to the appointment. Please feel free to call our office to verify that they referral has been received before arriving to our office if the referral is being faxed. We will not be responsible for referrals that are expired or otherwise invalid. Please request a copy of your referral if one has not been provided to you to enable you to track when a referral is needed. Please advise our office immediately of any changes in your insurance policy as this may void any referrals on file and may result in unnecessary out of pocket expenses to you. If you need assistance in understanding your insurance policy, please see one of our administrative staff members or management and we will gladly assist you.

Controlled Substances Policy: I am responsible for my controlled substance and all prescription medications. If the prescription or medication is lost, misplaced or stolen or I use it sooner than prescribed, I understand that it will not be replaced. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from Orthopaedic Associates U.S.A. The exception would be if I were hospitalized and under the care of another physician. I understand that if I violate any of the above conditions, my relationship with Orthopaedic Associates U.S.A. may be terminated. I understand that, I may be reported to the Drug Enforcement Authorities, other physicians and local medical facilities.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/___/_____