SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION

06/2016

Welcome to South Florida Orthopaedics & Sports Medicine

Patient's Last Name:	First Name:	Middle Name:
Social Security #:	Birth Date:	Sex: ☐M ☐F

Primary Street Address:		
City:	State:	Zip:
County:	Primary Care Physician:	Referring Physician:

Alternate Street Address/Northern Address:		
City:	State:	Zip:

Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Religion:	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed		Student: ☐ Yes ☐ No Smoker: ☐ Yes ☐ No	Veteran: ☐ Yes ☐ No

Preferred Method of Contact: ☐ Cell Phone ☐ Primary phone		E-Mail Address:
Primary Phone:	Cell Phone:	Secondary Phone:

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

Patient's Employer Name:		
Employer Street Address:		
Employer City:	Employer State:	Employer Zip:
Employer Phone:	Employer Fax Number (if known):	

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT INFORMATION (continued)

06/2016

Patient Name:	Date of Birth:

EMERGENCY CONTACT:	Relationship to Patient:
Emergency Contact Phone Number:	

REASON FOR TODAY'S VISIT:

- ☐ **OTHER (not an Accident or Injury)**
- ☐ **INJURY**
- ☐ **WORKERS COMPENSATION ACCIDENT**
- ☐ **AUTO ACCIDENT**
- ☐ **OTHER TYPE OF ACCIDENT:** _____

If INJURY or ACCIDENT:

WHEN did it occur? Date: Time:	WHERE did it occur?
Was a POLICE REPORT filed? ☐ NO ☐ YES, Police Department Name:	
Do you have ATTORNEY REPRESENTATION for this Injury or Accident? ☐ NO ☐ YES, Attorney Name:	Attorney Phone Number:
Do you have a WORKERS' COMPENSATION ADJUSTER regarding this Injury or Accident? ☐ NO ☐ YES, Adjuster Name:	Adjuster Phone Number:

IF PATIENT IS A MINOR:

Parent's or Legal Guardian's Last Name:	Parent's or Legal Guardian's First Name:	
Relationship to Patient		
Primary Street Address:		
City:	State:	Zip:
County:		
Race:	Language Spoken: ☐ English ☐ Spanish ☐ Other -	Ethnicity: ☐ Non Hispanic/Non-Latino ☐ Hispanic / Latino
Preferred Method of Contact: ☐Cell Phone ☐Email ☐Home phone ☐Work phone	E-Mail Address:	
Home Phone:	Day (Work) Phone:	Cell Phone:

By my signature below, I affirm the above information is current and accurate to the best of my knowledge.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
HIPAA CONSENT FORM

06/2016

Patient Name:	Date of Birth:

This consent form allows South Florida Orthopaedics & Sports Medicine to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

South Florida Orthopaedics & Sports Medicine has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at South Florida Orthopaedics & Sports Medicine.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. ☐ cell phone ☐ e-mail ☐ home phone ☐ work phone

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that South Florida Orthopaedics & Sports Medicine may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that South Florida Orthopaedics & Sports Medicine services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that South Florida Orthopaedics & Sports Medicine may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while South Florida Orthopaedics & Sports Medicine is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that South Florida Orthopaedics & Sports Medicine may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

PATIENT ASSIGNMENT OF BENEFITS

06/2016

Patient Name:	Date of Birth:

ASSIGNMENT OF BENEFITS, LIEN, & AUTHORIZATION

I hereby authorize and direct you (my insurance company, liability insurance adjuster, and/or attorney) to pay directly to South Florida Orthopaedics & Sports Medicine ("office"), such as may be due and owing this office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any insurance benefits obligated to reimburse me or from any settlement, judgment, or verdict on my behalf as may be necessary to adequately protect said office. I hereby further give a lien to said office against any and all insurance benefits named herein. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

If I have a Medigap policy, I request that payment of authorized Medigap benefits be made either to me or on my behalf to South Florida Orthopaedics & Sports Medicine for any services furnished to me by a provider in the group. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

In the event my insurance company obligated to make payments to me upon the charges made by this office for services rendered refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company any authorize this office to prosecute said cause of action either in my name or in the office's name. I further authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as it sees fit.

If my claims are related to an automobile accident, I hereby authorize South Florida Orthopaedics & Sports Medicine to obtain my PIP log showing all payments made by my automobile insurance.

I understand that I remain personally responsible for the total amounts due the office for services rendered. I further understand and agree that this Irrevocable Assignment, Lien, & Authorization does not constitute any consideration for the office to await payments; the office may demand payments from me immediately upon rendering services, at its option. Such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I agree to pay all costs of collection of any balance due this office, including agency fees and reasonable attorney's fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this Irrevocable Assignment, Lien, & Authorization. I agree that the above-mentioned office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill. I, individually, and/or my successors hereby waive any statute of limitation, defense of the time for claims to be filed, any argument of estoppels, or other defenses to the timely filing of a claim by South Florida Orthopaedics & Sports Medicine as they pertain to any claim filed against me beyond any statutory period applicable to any proceeding after services were rendered. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature _____ Date: _____

Witness Signature _____ Date: _____

For Internal Use Only:

SOUTH FLORIDA ORTHOPAEDICS & SPORTS MEDICINE

NEW PATIENT QUESTIONNAIRE
Center for Spine Care

Rev. Sept. 2014

Name: _____ Date of Visit: _____

Male O Female O Date of Birth: _____

Height: _____ Weight: _____ Age Today: _____

**Please note this is a multi-part questionnaire. When you are done, please take a moment to go over the questionnaire to be sure you have not missed any pages or questions. Thank you for your help.*

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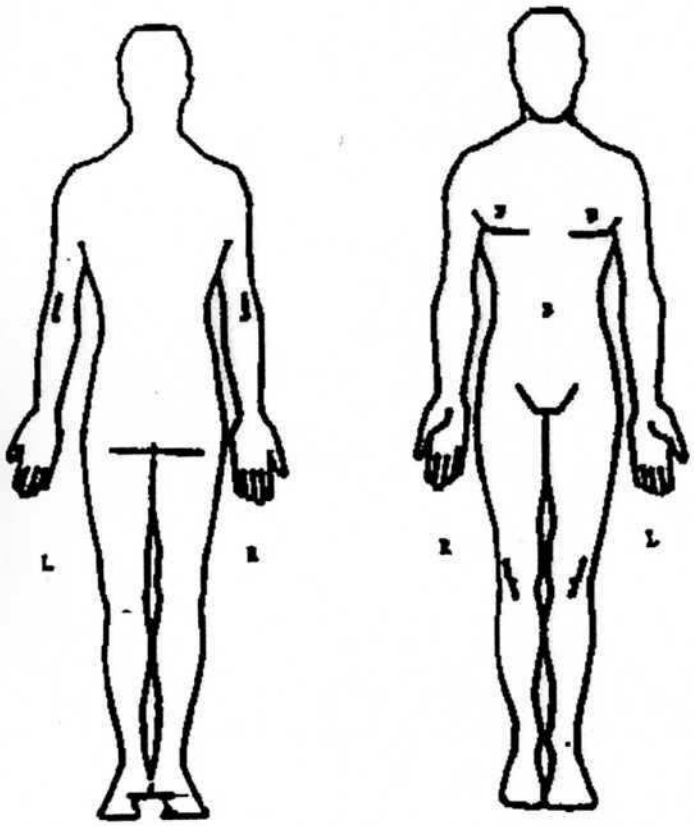
1. Pain Drawing: Mark these drawings using the symbol that best describes your pain quality

Numbness = = = = Ache ^ ^ ^ ^ Stabbing //////
Burning XXXX Cramping ++++ Pins & Needles OOOO



2. Which area is most painful?

O Low back and/or legs O Neck and/or arms O Both are equal

O **Pelvis / Buttock Pain**

O **Hip / Groin Pain**

3. If you have BACK pain…

_____% back pain + _____% leg pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Back

	0	1	2	3	4	5	6	7	8	9	10	
None	O	O	O	O	O	O	O	O	O	O	O	Worst Pain

Circle one: occasional | intermittent | frequent | constant

Leg

	0	1	2	3	4	5	6	7	8	9	10	
None	O	O	O	O	O	O	O	O	O	O	O	Worst Pain

Circle one: occasional | intermittent | frequent | constant

4. If you have NECK pain…

_____% neck pain + _____% arm pain = 100%

On a scale of 0 to 10, mark your level of current pain discomfort, with 0 being none and 10 being the worst pain you can imagine.

Neck

	0	1	2	3	4	5	6	7	8	9	10	
None	O	O	O	O	O	O	O	O	O	O	O	Worst Pain

Circle one: occasional | intermittent | frequent | constant

Arm

	0	1	2	3	4	5	6	7	8	9	10	
None	O	O	O	O	O	O	O	O	O	O	O	Worst Pain

6. **What is the primary reason for your visit?**
   - O Evaluation/ Diagnosis/ Treatment
   - O Second opinion
   - O Education/ information
   - O Surgical planning

7. **How did your current symptoms begin?**
   - O Suddenly Date: _____
   - O Gradually

   Please describe: _____

   _____

   _____

8. **How long ago did your current symptoms begin?**
   - O Less than 2 weeks ago
   - O 3 months to less than 6 months ago
   - O 2 weeks to less than 8 weeks ago
   - O 6 to 12 months ago
   - O 8 weeks to less than 3 months ago
   - O More than 12 months ago

9. **Is this a work-related injury?**
   - O Yes O No

10. **Have you ever filed a Worker's Compensation claim for your back/ neck symptoms in the past?**
    - O Yes O No

    If yes, Date: _____

11. **Did your pain begin after a car accident?**
    - O Yes O No (skip to question #12)

    If you were injured in a car accident please carefully fill out the questions below.

    Date of Accident: _____

    Briefly describe the details of the accident:

    _____

    _____

    Describe the pattern of symptoms over the first 1-4 weeks:

When did you first notice symptoms?

O Immediately	O 1-2 weeks
O 24-28 hours	O 2-4 weeks
O 3-7days	O > 1 month

When did you first report these to a doctor?

_____

If there was a delay between the symptoms starting and your first report, please explain:

_____

Did you suffer any other injuries when you hurt your spine?

O Yes O No

If yes, please list:

_____

12. Have you ever been involved in a previous car accident?

O Yes O No

If yes, approximate date: _____

Was your back or neck injured?

O Yes O No

If yes, did the injury resolve?

O Yes O No

If that injury did NOT resolve, what treatment, if any, did you require on an ongoing basis?

Explain:_____

_____

13. Is your pain due to an injury not covered in the questions above?

O Yes O No

If yes, Date of injury: _____

Describe injury:_____

_____

14. Have you ever had previous back or neck surgery? O Yes O No If yes, how many surgeries? _____

Date of Spine surgery	Type of surgery	% Improvement	How long did the improvement last?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ DOB:_____

18. Modified Oswestry Disability Index: This questionnaire has been designed to give your doctor information as to how your pain as affected your ability to manage in everyday life. Please answer every question marking the ONE box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but *please mark only the box that most closely describes your current condition.*

Pain Intensity
- O I can tolerate the pain I have without having to use pain medication.
- O The pain is bad, but I can manage without having to take pain medication.
- O Pain medication provides me with complete relief from pain.
- O Pain medication provides me with moderate relief from pain.
- O Pain medication provides me with little relief from pain.
- O Pain medication has no effect on my pain.

Personal Care (e.g., Washing, Dressing)
- O I can take care of myself normally without causing increased pain.
- O I can take care of myself normally, but it increases my pain.
- O It is painful to take care of myself, and I am slow and careful.
- O I need help, but I am able to manage most of my personal care.
- O I need help every day in most aspects of my care.
- O I do not get dressed, I wash with difficulty, and I stay in bed.

Lifting
- O I can lift heavy weights without increased pain.
- O I can lift heavy weights, but it causes increased pain.
- O Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- O Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- O I can lift only very light weights.
- O I cannot lift or carry anything at all.

Walking
- O Pain does not prevent me from walking any distance.
- O Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km).
- O Pain prevents me from walking more than 1/2 mile.
- O Pain prevents me from walking more than 1/4 mile.
- O I can walk only with crutches or a cane.
- O I am in bed most of the time and have to crawl to the toilet.

Sitting
- O I can sit in any chair as long as I like.
- O I can only sit in my favorite chair as long as I like.
- O Pain prevents me from sitting for more than 1 hour.
- O Pain prevents me from sitting for more than 1/2 hour.
- O Pain prevents me from sitting for more than 10 minutes.
- O Pain prevents me from sitting at all.

Standing
- O I can stand as long as I want without increased pain.
- O I can stand as long as I want, but it increases my pain.
- O Pain prevents me from standing for more than 1 hour.
- O Pain prevents me from standing for more than 1/2 hour.
- O Pain prevents me from standing for more than 10 minutes.
- O Pain prevents me from standing at all.

Sleeping
- O Pain does not prevent me from sleeping well.
- O I can sleep well only by using pain medication.
- O Even when I take medication, I sleep less than 6 hours.
- O Even when I take medication, I sleep less than 4 hours.
- O Even when I take medication, I sleep less than 2 hours.
- O Pain prevents me from sleeping at all.

Social Life
- O My social life is normal and does not increase my pain.
- O My social life is normal, but it increases my level of pain.
- O Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- O Pain prevents me form going out very often.
- O Pain has restricted my social life to my home.
- O I have hardly any social life because of my pain.

Traveling
- O I can travel anywhere without increased pain.
- O I can travel anywhere, but it increases my pain.
- O My pain restricts my travel over 2 hours.
- O My pain restricts my travel over 1 hour.
- O My pain restricts my travel to short necessary journeys under 1/2 hour.
- O My pain prevents all travel except for visits to the physician/ therapist or hospital.

Employment / Homemaking
- O My normal homemaking / job activities do not cause pain.
- O My normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- O I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
- O Pain prevents me from doing anything but light duties.
- O Pain prevents me from doing even light duties.
- O Pain prevents me from performing any job or homemaking chores

Patient Name: _____ DOB:_____

To insure that your medical report is sent to the individual(s) that you request, please provide us with the information below, *including FAX number(s).* Without all of this information, we *cannot* send the report.

I authorize the Group to release my medical reports to the individual(s) as specified below. By signing below understand that this information will not be sent unless requested by myself.

ATTORNEY's Name:_____ Phone:_____

Address:_____

ATTORNEY's FAX Number:_____

PRIMARY and/or
REFERRING CARE PHYSICIAN:_____ Phone:_____

Address:_____

PRIMARY and/or REFERRING CARE PHYSICIAN FAX Number:_____

OTHER:_____ Phone:_____

Address:_____

OTHER FAX Number:_____

Patient's Signature: _____

Please *Print* Name: _____

Patient Number: