

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

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PATIENT INFORMATION

PATIENT'S NAME _____ DATE _____

HAVE YOU EVER BEEN TREATED BY THESE DOCTORS? Yes No If so, what doctor? _____

CELL PHONE _____ HOME PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

MALE FEMALE MARITAL STATUS: Married Single Divorced Widow

ETHNICITY: Hispanic or Latino Not Hispanic or Latino

SPOKEN LANGUAGE English Spanish Other, specify _____

RACE Black or African American White Asian American Indian or Alaska Native Other _____

PRIMARY DOCTOR: Dr. _____ Address _____

=====

EMPLOYER'S NAME & ADDRESS _____

EMPLOYER'S PHONE # _____ OCCUPATION _____

NAME OF SPOUSE/ PARENT _____

SPOUSE/PARENT ADDRESS _____

SPOUSE/PARENT SOCIAL SECURITY #/ _____

SPOUSE/PARENT EMPLOYER'S NAME _____

SPOUSE/PARENT EMPLOYER'S PHONE _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT _____

=====

PRIMARY INSURANCE COMPANY NAME _____

PRIMARY INSURANCE COMPANY ADDRESS _____

GROUP # _____ POLICY # _____ SUBSCRIBER NAME _____

SUBSCRIBER DATE OF BIRTH _____ SUBSCRIBER SOCIAL SECURITY # _____

=====

SECONDARY INSURANCE COMPANY NAME _____

SECONDARY INSURANCE COMPANY ADDRESS _____

GROUP # _____ POLICY # _____ SUBSCRIBER NAME _____

SUBSCRIBER DATE OF BIRTH _____ SUBSCRIBER SOCIAL SECURITY # _____

=====

PHARMACY NAME _____ LOCATION _____ PHONE _____

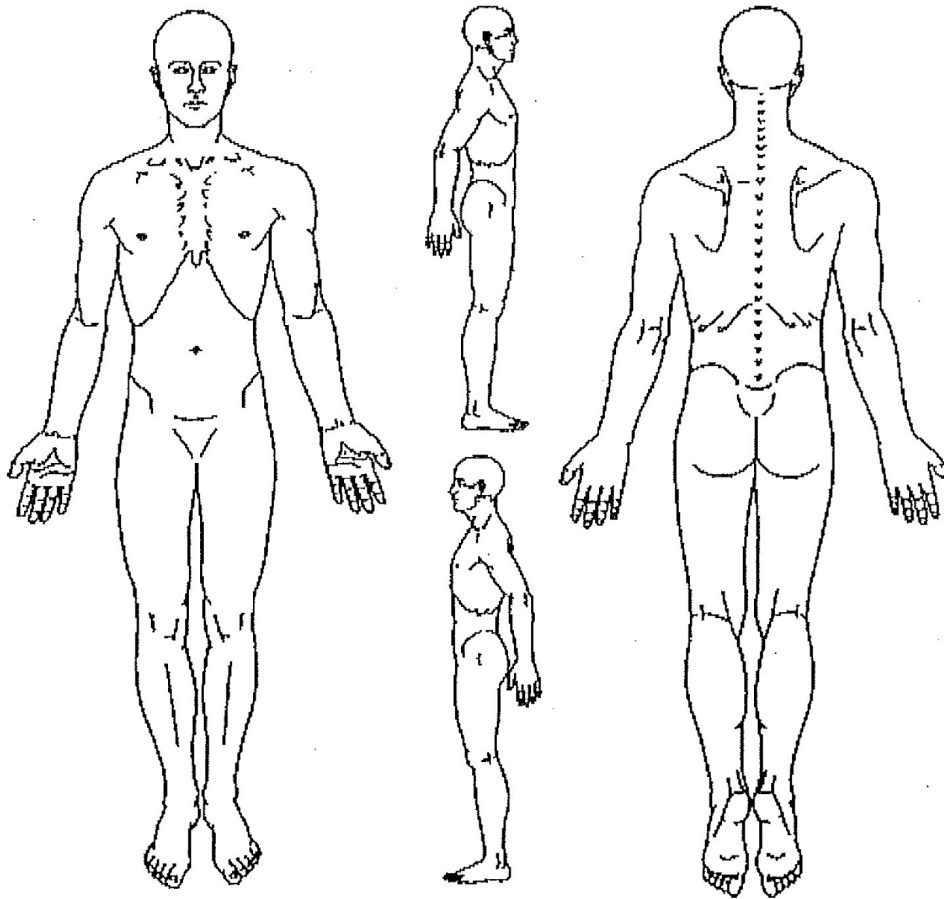
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COMPLAINT DIAGRAM

PATIENT'S NAME: _____ DATE: _____

How long have you had pain _____ Weeks _____ Months _____ Years

On the diagram below, please indicate where you are currently experiencing pain or other symptoms.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

E = ELECTRICAL

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

MEDICAL HISTORY & INTAKE FORM

Patient's Name: _____ Date: _____

PATIENT HISTORY:

Reason for visit: _____ Patient Age: _____

For how long has this been bothering you? _____

If Upper Extremity Involved, What is Your Dominant Hand Right Left

Pain at Rest or Pain That Awakens From Sleep? _____

Severity (Mild/Moderate/Severe) _____

What Makes Symptoms Better? _____

What Makes Symptoms Worse? _____

Describe Any Prior Treatment (Surgery/Therapy/Injections/Medications)

PAST MEDICAL HISTORY, OTHER MEDICAL PROBLEMS:

PRIOR SURGERIES AND HOSPITALIZATIONS:

FAMILY HISTORY: MARK IF FAMILY MEMBER HAS ANY OF THE FOLLOWING:

Arthritis Hypertension Heart Disease Diabetes Endocrine or Glandular Problems Muscular Disease

MEMBER	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

SOCIAL HISTORY:

Patient Education (in years) _____ Employment Description _____

Marital Status Single Married Number of Children _____ Children(s) Ages _____

Living Situation _____ Alcohol Use (amount & type) _____

Drug Use (amount & type) _____ Tobacco Use (# of packs/cigarettes daily) _____

ALLERGIES:

MEDICATIONS (INCLUDING VITAMINS AND SUPPLEMENTS):

REVIEW OF SYSTEMS - Are you currently having or have you had problems with:

CIRCLE ALL THAT APPLY

- | NO | YES |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis Swelling of Joints Osteoporosis Fibromyalgia Fractures Muscle Atrophy |
| <input type="checkbox"/> | <input type="checkbox"/> Rashes Masses or Lumps Problems with Scars Itching |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches Stroke Seizures Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> Depression Sleep Disorders Hallucinations Anxiety Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes Thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising or Bleeding Anemia Swollen Glands or Lymph Nodes |
| <input type="checkbox"/> | <input type="checkbox"/> Dermatitis Latex Allergy Food Allergy Environmental Allergy |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma Wheezing Cough COPD Coughing up Blood |
| <input type="checkbox"/> | <input type="checkbox"/> Nausea Vomiting Stomach Pain Bloody Stools Diarrhea Constipation Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty with Urination Pain or Burning on Urination Blood in Urine Incontinence Menstrual Problems |
| | Prostate Problems Erectile Dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> Fever Night Sweats Chills Weight Loss Tiredness Malaise |
| <input type="checkbox"/> | <input type="checkbox"/> Visual Problems Glasses |
| <input type="checkbox"/> | <input type="checkbox"/> Hearing Problems Sinus Problems Vertigo Dizziness Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle Swelling High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Chest Pain Shortness of Breath Abnormal Heart Beat |

For all questions answered YES, explain: _____

***IF VISIT TODAY IS FOR PAIN OR INJURIES SUSTAINED IN AN ACCIDENT (AUTOMOBILE, WORK PLACE, OR OTHER), ANSWER THE FOLLOWING QUESTIONS. OTHERWISE SKIP TO LAST PAGE AND SIGN)**

1. Nature of illness/injury/accident:

Auto _____

Work _____

Other _____

2. Name and address of attorneys involved in this case, if applicable:

3. Accident Date _____

4. Accident Location _____

5. Accident Time _____

Please describe the circumstances _____

***IF AUTO ACCIDENT, CONTINUE ANSWERING QUESTIONS, OTHERWISE SKIP TO QUESTION 20**

6. What kind of car were you in? _____

7. Where were you seated?

____ Driver ____ Front Passenger ____ Rear Driver side ____ Rear Passenger side

8. Were you going?

____ North ____ South ____ East ____ West

9. Were you moving or stopped? ____ Moving ____ Stopped

10. What was the approximate speed of your vehicle? _____ mph

11. Where on your vehicle were you hit:

____ In the front (head on) ____ In the front (left side) ____ In the front (right side)
____ In the rear ____ In the rear (left side) ____ In the rear (right side) OR Other (list) _____

12. At the time of impact I was looking:

____ Straight ahead ____ To the left ____ To the right

13. Were you wearing your seatbelt? ____ Yes ____ No

14. Were there airbags in your vehicle: ____ Yes ____ No

If so, did they deploy? ____ Yes ____ No

15. I was thrown after impact:

____ Forward ____ Backward ____ Side-to-side

16. I struck:

____ Dashboard ____ Headrest ____ Windshield ____ Rear view mirror ____ Door ____ Seat belt
____ Side window ____ Steering wheel ____ Other (list) _____

17. What part of your body did you strike?
 Head Chest Face Knees Arms Shoulder
 Other (list) _____

18. I had:
 Cuts Bruises OR Both
on my: _____

19. I was I was NOT unconscious at the scene of the accident.

20. Was there:
 Momentary Deafness Loss of Balance Nausea Ringing in Ears
 Blurred vision Immediate Pain Dizziness

21. I was taken from the scene of the accident by:
 Ambulance Friend Parents Mother Other (list) _____
 To Hospital Home Other (list) _____

22. When did you first seek medical attention for this accident? _____
Who did you see? _____

23. At (hospital name) _____
I was examined by _____

24. Were you admitted? Yes No

25. I was examined and given:
 X-Rays Medication Neck Collar Brace Stitches
 Other (list) _____

26. After your release, what did you do?
 Return Home to Bed Return to Work
 Other (list) _____

27. Work:
Have you lost any time from work since the accident?: Yes No
1. Are you still off work? Yes No
2. If not, date returned to work _____

28. Give names of all other doctors that treated you for injuries from your accident:
A. Name _____ Date _____
What did he/she do? _____
What did he/she say was wrong? _____

B. Name _____ Date _____

What did he/she do? _____

What did he/she say was wrong? _____

29. Check symptoms you have noticed since the accident:

- | | |
|---|---|
| A _____ Mid back (pain, stiffness) | L _____ Neck pain, stiffness upon arising |
| B _____ Low back (pain; stiffness)/ | M _____ Low back pain, stiffness on arising |
| C _____ Swelling?
Where? _____ | N _____ Pain radiating into:
_____ Arm _____ Leg |
| D _____ Restriction of neck motion | O _____ Difficulty in lifting:
_____ Light _____ Moderate
_____ After lifting a few times |
| E _____ Upper back pain and stiffness/ | P _____ Pain radiating into:
_____ Neck
_____ Base of skull
_____ Arms
_____ Hips
_____ Legs |
| F _____ Pins & needles in:
_____ Arms _____ Legs | |
| G _____ Numbness in:
_____ Fingers _____ Arms _____ Legs | |
| H _____ Headache | |
| I _____ Neck pain | |
| K _____ Difficulty in excessive
_____ Standing _____ Walking
_____ Riding _____ Bending | |

30. I have pain in the following areas (most severe first, list all of them):

- A. _____
- B. _____
- C. _____
- D. _____
- E. _____

31. My symptoms are aggravated by:

- _____ Walking _____ Standing _____ Lifting _____ Turning _____ Working
_____ Sitting _____ Playing sports _____ Lying down _____ Exercise
_____ Other (list) _____

32. My symptoms are helped by:

- _____ Resting _____ Medication _____ Bed rest _____ Ice packs _____ Hot shower _____ Aspirin
_____ Other (list) _____

33. Medication presently taking related to the injury (list all):

- | | |
|----------|----------|
| A. _____ | D. _____ |
| B. _____ | E. _____ |
| C. _____ | F. _____ |

34. Have you had prior injuries or received treatment to the areas that are currently injured? If yes:

Date _____ Name of doctor _____
Address of Doctor _____

35. ____ I have or ____ I have NOT been able to work since the accident. If you have not, list dates unable to work:
From _____ To _____ Other _____

36. What activities have changed since the accident?

- A. Employment: ____ No change ____ Cannot do work ____ Hurts to work
- B. Exercise: ____ Can still exercise ____ Cannot exercise ____ Hurts to exercise
- C. Housework: ____ Can still do housework ____ Can do limited housework
____ Hurts to do housework ____ Cannot do housework
- D. Sports: ____ Can still do sports ____ Can do limited sports
____ Hurts to do sports ____ Cannot do sports
- E. Lifting: ____ Can still lift ____ Can do limited lifting ____ Hurts to lift ____ Cannot lift
- F. Other: _____

37. ____ I have OR ____ I have NOT been involved in other auto accidents.
If so, give date(s) and describe _____

38. ____ I have ____ OR ____ I have NOT been involved in ANY type of prior accident.
If so, give date(s) and describe _____

39. Do you have any type of disability or have you ever been given an impairment rating?
____ Yes ____ No. If yes, explain _____

PATIENT'S SIGNATURE

DATE

FOR OFFICE USE ONLY:
Liens and Cover letter sent out _____
Lien returned _____
Report fee paid _____

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

PATIENT'S REQUEST TO RELEASE HEALTH INFORMATION

I request and authorize South Florida International Orthopaedics, P.A. to provide a copy of the specific health and medical information as described below.

Patient Name _____ Date _____

The request applies to the following information to be provided one time, as soon as possible. Select only **ONE** of the following:

All health information pertaining to any medical history, mental or physical condition and treatment received. [**OPTIONAL**]
Except _____

Only the following records or types of health information (including any dates)

The designated information should be sent to:

Name _____

Address _____

Telephone _____ Fax _____

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Patient Signature _____ Witness Signature _____

OR CIRCLE ONE: Representative Spouse Financially Responsible Party

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or an employee benefit plan.

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

ASSIGNMENT OF BENEFITS/POLICY RIGHTS

The undersigned patient hereby assigns the rights and benefits of the applicable Personal Injury Protection (PIP), medical payments, and/or other insurance to **South Florida International Orthopaedics, P.A.**, for services and/or supplies rendered by it for diagnosis and/or treatment of personal injuries sustained in the incident of (date of occurrence)_____ to the undersigned patient, which services are covered by Personal Injury Protection (PIP) or other insurance coverage inuring to the benefit of the undersigned patient, in accordance with Florida Statute 627.736(5). The undersigned patient agrees to pay any applicable deductible or co-payment not covered by the PIP or other insurance coverage.

This assignment includes, but not limited to, all rights to collect benefits directly from the Insurance Company obligated to provide benefits, in any action including legal suit, if for any reason the Insurance Company fails to make payment of benefits to which the undersigned is entitled. Specifically, this assignment includes the right to collect payment for reasonable costs connected with photocopying and mailing records to the insurer at the insured's request, in accordance with F.S. ' 627.736(5). This assignment also includes the right to recover attorney's fees and costs for any action brought by the provider as patient's assignee. I agree that **South Florida International Orthopaedics, P.A.**, may select any attorney it wishes to enforce the rights assigned herein, and I understand and agree that the attorney selected by **South Florida International Orthopaedics, P.A.**, may be different from the attorney handling my personal injury/bodily injury claim or case.

As part of this assignment of rights and benefits, I hereby instruct the insurance carrier, in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **South Florida International Orthopaedics, P.A.**, is to be set aside and not disbursed until the dispute is resolved. As part of this assignment of rights and benefits, I further instruct the insurance carrier to notify the provider immediately of any dispute as to payments so that it may exercise its legal rights. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true and correct to the best of my knowledge and belief.

If it is necessary for **South Florida International Orthopaedics, P.A.**, to use a collection agency and /or attorney to collect its bill, I will also be responsible for all their fees and costs incurred in the collection of my bill. I will be responsible for any other costs involved in the collection of my bill including court costs. I will be responsible for a late charge of 1.5% monthly on any unpaid portion of my bill beginning 60 days after the date of service.

INFORMATION RELEASE: I hereby authorize **South Florida International Orthopaedics, P.A.**, to release any or all portions of my medical records and/or X-rays, including records of diagnosis, examination, and any treatment rendered to me to insurers as needed for processing of medical claims for care, and to other treating physicians and hospital personnel as my physician deems necessary.

_____ **I am NOT a Medicare patient.**

_____ **I am a Medicare Patients (HMO Disclaimer):** I hereby declare that I am not a member of any **HMO** or **PPO**. If Medicare benefits are denied because I am a member of an **HMO** or **PPO**, I agree that I will be personally responsible for my bill to **South Florida International Orthopaedics, P.A.** If it is necessary for **South Florida International Orthopaedics P.A.**, to use a collection agency and/or attorney to collect its bill, I will also be responsible for all their fees and costs incurred in the collection of my bill. I will be responsible for any other costs involved in the collection of my bill including court costs. I will be responsible for a late charge of 1.5% monthly on any unpaid portion of my bill beginning 60 days after the date of service.

PATIENT'S SIGNATURE _____ **Date** _____

Witness _____

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.
(ASSIGNMENT OF BENEFITS/POLICY RIGHTS page two)

PATIENT'S NAME _____ DATE _____

CHECK OFF ONE OF THE FOLLOWING:

_____ I am pregnant.

_____ I am not pregnant at this time. If I am given any medication by Dr. Evans, Pell, Gombosh, Torregrosa and/or APRN Mauricio Aragon Caceres, and become pregnant while taking it, I will immediately notify my obstetrician that I am taking this medication.

_____ The above questions do not apply to me.

PROVIDER

South Florida International Orthopaedics, P.A. hereby accepts assignment of the insurance rights and benefits for services to the patient listed above to be paid directly to **South Florida International Orthopaedics, P.A.** This includes Personal Injury Protection (PIP) or other insurance coverage as listed above, in accordance with F.S.627.736 (5).

South Florida International Orthopaedics, P.A.

E.I.N. # 27-3378728

By _____
Authorized Agent/Representative

Date

By _____
Patient's Signature

Date

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: _____ Date: _____
(LAST) (FIRST) (M.I.)

Address: _____

Telephone: _____ Date of Birth: _____

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _____

Address: _____

Telephone: _____

What relationship is this person to you? _____

This person is to be afforded all of the privileges that would be afforded to me with respect to my protected health information.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to South Florida International Orthopaedics, P.A. I further understand that any such revocation does not apply if that person or persons authorized to use or disclose my protected health information have already taken action on my behalf.

Patient's Signature _____ Date: _____

I hereby revoke this designation of a personal representative.

Patient's Signature: _____ Date: _____

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

Financial Arrangements and Medical Insurance

We are committed to providing you the best possible care. If you have medical insurance, we would like to help you receive your maximum amount of benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. We ask that you provide us with the necessary information to verify your insurance benefits. Once this has been done, the insurance secretary will explain to you what you are responsible for at the time services are rendered. We do accept MasterCard, Visa, American Express, Discover Card, Care Credit and personal checks.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. U.C.R is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. DEDUCTIBLES AND COPAYMENTS WILL BE DUE AT TIME OF SERVICE.
4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You will be responsible for these fees.

We must emphasize that as the health care providers, our relationship is with you, not with your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding coverage, PLEASE do not hesitate to ask us. We are here to help.

SOUTH FLORIDA INTERNATIONAL ORTHOPAEDICS, P.A.

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT******

I have received a copy of this Office's Notice of Privacy Practices:

Patient Name _____

Patient's Signature _____

Date _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other _____