

# Florida Sports, Orthopaedic & Spine Medicine

## PATIENT UPDATE

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Patient #** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

(Last, First, MI)

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home # \_\_\_\_\_ Cell# \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work# \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

.....  
**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

In the last 6 months, have you been injured on the job? YES NO

If yes, is this current injury related? YES NO

In the last 6 months, have you been involved in Auto Accident? YES NO

If yes, is this current injury related? YES NO

Is this related to a slip/fall accident? YES NO

Do you plan litigation for this injury? YES NO

Are you in a nursing home/rehab center? YES NO

If yes, name of facility: \_\_\_\_\_

CHIEF COMPLAINT/PROBLEM:

**FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE**  
**Confidential Medical History**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**HEALTH HISTORY OF THE PATIENT**

	YES	NO
Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease / Stones	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/COPD/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Lupus/Rheumatoid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

**Surgical Procedures (Include approx dates)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:**       NONE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medications and Dosages:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS**

Have you recently had or have now?

	YES	NO
Chills or Fever	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart or chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Leaky heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>
Tingling or numbness	<input type="checkbox"/>	<input type="checkbox"/>
Blackout	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Frequent constipation	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty starting urination	<input type="checkbox"/>	<input type="checkbox"/>
Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Non-healing wounds	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>

YES      NO

**WOMEN ONLY:**

Still menstruating           

Irregular periods           

Are you pregnant? No  Yes  Unsure

\_\_\_\_\_

Chronic Prednisone / Steroid use? No  Yes

Ever have a Bone Density Study? No  Yes

If Yes, when? \_\_\_\_\_

**FAMILY HISTORY**

	YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease / Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

Explain all "Yes" answers:

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

**Occupation:** \_\_\_\_\_

**Married**     **Single**     **Divorced**   
**Widowed**

Number of Children Living: \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_

**Smoke:** \_\_\_\_\_ Packs per day

**Alcohol:** Never  Occasional   
Daily

**Drug Use:** Never  Past  Present

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

*I certify that the above information is correct to the best of my knowledge.*

X \_\_\_\_\_



# FLORIDA SPORTS ORTHOPAEDIC & SPINE MEDICINE

## PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Florida Sports, Orthopaedic & Spine Medicine (FSOSM), deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any prior healthcare providers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Florida Sports, Orthopaedic & Spine Medicine, I authorize any holder of medical information about me to release to CMS/Insurance carriers and its agents any information needed to determine these benefits or benefits related to services. I hereby authorize Florida Sports, Orthopaedic & Spine Medicine (FSOFM) to furnish information to CMS/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier(s)/CMS to make payment directly to FSOSM for medical/diagnostic/surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that CMS and/or other insurance carriers do not cover all office services/procedures. **I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services rendered.** I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or changes in the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## DESIGNATED RELATIVE

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with  Spouse  Children  Other \_\_\_\_\_

Please list the family members or significant others, if any, whom we may inform about your medical condition, and/or in case of an emergency. I also specifically authorize the persons listed below to pick up prescriptions or radiology films for me if I am not able to do so. This authorization will remain in effect until revoked in writing.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Messages may be left on my answering machine regarding my health & appointment made:  Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA PRIVACY NOTICE

I have received a copy of Florida Sports, Orthopaedic & Spine Medicine's Privacy Notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_ SS#: \_\_\_\_\_

Witness: \_\_\_\_\_ Relationship: \_\_\_\_\_



## FLORIDA SPORTS ORTHOPAEDIC & SPINE MEDICINE

### DOCTOR – PATIENT ARBITRATION AGREEMENT

This agreement is made between Florida Sports, Orthopaedic & Spine Medicine to include; Sang H. Choi, M.D., Steven C. Mirabello, M.D., John H. Shim, M.D. and Mark D. Torke, M.D., their agents Physician Assistants, employees, servants or any of the foregoing, referred to hereinafter as “Physician” and

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(Patient’s Name)

referred to hereinafter as the “Patient”. It is the intention of the parties of this agreement to bind not only themselves, but also their heirs, personal representatives, guardians or any persons deriving their claims through or on behalf of the Patient.

It is understood by the Patient that he or she is not required to use the aforesaid Physician or any of the physicians named for orthopaedic care, treatment and surgery and that numerous other physicians in the state of Florida and West Central Florida are qualified to perform orthopaedic care, treatment and surgery.

It is further understood that in the event of any controversy or dispute which might arise between the physician and patient, regardless of whether the dispute concerns the medical care rendered, payment of surgical fees or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 62, Florida Statutes. This arbitration shall be binding and shall be in lieu of and instead of any trial by judge or jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for Rules 1.280-1.390, Florida Rules of Civil Procedure. The panel or arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court or competent jurisdiction in and for Pinellas County, Florida.

This agreement shall remain in effect for all treatment and surgery provided the patient presently and at any future date.

In witness whereof, I (we) have set our hand this date \_\_\_\_\_

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Physician (or authorized agent)

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Patient Signature