

*FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE
FLORIDA JOINT REPLACEMENT CENTER*

NEW PATIENT INFORMATION FORM

(PLEASE FILL OUT BOTH SIDES OF FORMS)

TODAY'S DATE: ___/___/___

PATIENT NAME _____

(Last, First, MI)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PH. _____ CELL PH _____

EMPLOYERS NAME: _____ WK PH _____

PARENT/LEGAL GUARDIAN: _____

EMAIL ADDRESS: _____

PREFERRED LANGUAGE: _____

EMERGENCY CONTACT: _____

RELATION: _____

FAMILY PHYSICIAN (PCP): _____

REFERRING PHYSICIAN: _____

PHARMACY: _____ LOCATION: _____

PRIMARY INSURANCE TYPE: _____

SECONDARY INSURANCE TYPE: _____

HAVE YOU BEEN INJURED ON THE JOB?

IF YES, IS THIS CURRENT INJURY RELATED?

HAVE YOU BEEN INVOLVED IN AN AUTOMOBILE ACCIDENT?

IF YES, IS THIS CURRENT INJURY RELATED?

IS THIS RELATED TO A SLIP/FALL ACCIDENT? (circle one)

DO YOU PLAN LITIGATION FOR THIS INJURY? (circle one)

ARE YOU IN A NURSING HOME/REHAB CENTER? (circle one)

IF YES, NAME OF FACILITY: _____

WHICH PHYSICIAN / PHYSICIAN ASSISTANT WILL YOU BE SEEING FOR TODAY'S VISIT?

_____ SANG H. CHOI, M.D.

_____ STEVEN C. MIRABELLO, M.D.

_____ JOHN H. SHIM, M.D.

_____ MARK D. TORKE, M.D.

_____ JOYCE GEORGE, P.A.

_____ TOMMY L. RAY, P.A.

_____ MARQUIS D. HOPKINS, P.A.

SS# _____

BIRTH DATE ___/___/___

AGE _____ SEX: M F

RACE: _____

MARITAL STATUS: (Circle One)

S M D W SEP

PHONE#: _____

PHONE# _____

PHONE# _____

PHONE# _____

INSURED NAME _____

INSURED DOB _____

YES NO IF YES, DATE _____

YES NO

YES NO IF YES, DATE _____

YES NO

YES NO IF YES, DATE _____

YES NO IF YES, DATE _____

YES NO

CHIEF COMPLAINT / PROBLEM: _____ DATE OF INJURY/ONSET: _____

East Lake Outpatient Center * 3890 Tampa Road * Suite 202 * Palm Harbor, FL 34684 * (727) 787-5577 * Fax: (727) 781-7757

Baycare Outpatient Center * 12780 Racetrack Road * Suite 200 * Tampa, FL 33626 * (813) 814-9251 * Fax: (813) 814-9261

5243 Hanff Lane * New Port Richey, FL 34652 * (727) 848-4249 * Fax: (727) 841-8934

<http://www.boneshurt.com>

**FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE
FLORIDA JOINT REPLACEMENT CENTER**

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) / Florida Joint Replacement Center(FJRC), 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 I 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.

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 / Florida Joint Replacement Center, 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) / Florida Joint Replacement Center (FJRC) 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 / FJRC 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.

DESIGNATED RELATIVE

I authorize discussion and release of my general medical condition and diagnosis (including treatment, payment and healthcare operations) with relative(s) listed below. Please list 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

HIPAA PRIVACY NOTICE

I have received a copy of Florida Sports, Orthopaedic & Spine Medicine's / Florida Joint Replacement Center's Privacy Notice. Yes _____ No _____

I certify that I have read and understand all above information. I am authorizing treatment and authorizing my insurance to be billed for that treatment. I also certify that the information I have given here is true and correct to the best of my knowledge. I will notify you of any changes in my status or changes in the above information.

Signature: _____ Date: _____
Patient Name (Print): _____ SS#: _____
Witness: _____ Relationship: _____

**FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE / FLORIDA JOINT REPLACEMENT CENTER
CONFIDENTIAL MEDICAL HISTORY**

NAME _____

DATE _____

REVIEW OF SYSTEMS

	Y	N
Chills	___	___
Fever	___	___
Night Sweats	___	___
Sig. weight change	___	___

SKIN

Bruising	___	___
Pallor	___	___
Rash	___	___

HEENT

Headache	___	___
Hearing Loss	___	___
Nose Bleed	___	___

RESPIRATORY

Cough	___	___
Difficulty Breathing	___	___

CARDIOVASCULAR

Calf Cramps	___	___
Chest Pain	___	___
Fainting	___	___
Irregular Heartbeat	___	___
Shortness of Breath	___	___
Swelling of Extremities	___	___

GASTROINTESTINAL

Bloody Stool	___	___
Constipation	___	___
Nausea	___	___
Vomiting	___	___

MALE GENITOURINARY

Frequency	___	___
Hesitancy	___	___
Painful urination	___	___

MUSCULOSKELETAL

Back Pain	___	___
Muscle Weakness	___	___

NEUROLOGY

Loss of Consciousness	___	___
Numbness	___	___
Tingling	___	___
Weak in extremities	___	___

PSYCHIATRIC

Anxiety	___	___
Depression	___	___

HEMATOLOGY

Abnormal Bleeding	___	___
Blood Clots	___	___

MEDICAL HISTORY OF PATIENT

	Y	N
Alcoholism	___	___
Anemia	___	___
Asthma/COPD/Lung Disease	___	___
Bleeding Disorders	___	___
Blood Clots	___	___
Cancer: _____	___	___
Actively being treated?	___	___
Communicable Disease	___	___
If yes: _____		
Depression	___	___
Diabetes	___	___
Fibromyalgia	___	___
Gout	___	___
Heart Trouble	___	___
Hepatitis	___	___
High Blood Pressure	___	___
High Cholesterol	___	___
Irritable Bowel	___	___
Kidney Disease/Stones	___	___
Lupis/Rheumatoid Disease	___	___
Osteoporosis	___	___
Pacemaker	___	___
Phlebitis	___	___
Seizures	___	___
Stomach Ulcers	___	___
Stroke or TIA	___	___
Thyroid Trouble	___	___
Tuberculosis	___	___

ALLERGIES: _____ None

FAMILY HISTORY

	Y	N
Stroke	___	___
Heart Disease	___	___
High Blood Pressure	___	___
Diabetes	___	___
Kidney Disease	___	___
Cancer	___	___
Bleeding Disorder	___	___
Alcoholism	___	___
Osteoporosis	___	___
Explain all "Yes" Answers:		

SOCIAL HISTORY

Occupation _____
 Marital Status: S M D W SEP
 Number of Children: _____
 Number of Pregnancies: _____
 Smoke: _____ Packs Per day: _____
 Alcohol: Never _____ Occasional _____
 Daily _____
 Drug Use: Never _____ Past _____
 Present _____
 Height: _____ Weight: _____

CURRENT MEDICATION &

DOSAGE: _____ None

PAST SURGICAL PROCEDURES:
 _____ None

WOMEN ONLY:

	Y	N
Still Menstruating	___	___
Are you Pregnant	___	___
Chronic Prednisone/ Steroid Use	___	___
Ever had a Bone Density Test? Y N		
When? _____		

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of Patient

*FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE
FLORIDA JOINT REPLACEMENT CENTER*

DOCTOR – PATIENT ARBITRATION AGREEMENT

This agreement is made between Florida Sports, Orthopaedic & Spine Medicine / Florida Joint Replacement Center 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

(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 of 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 _____

Physician (or authorized agent)

Patient Signature

*FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE
FLORIDA JOINT REPLACEMENT CENTER*

In accordance with Florida Statute 458.348(5):

When scheduling your initial (new patient) examination or consultation following such referral (from PCP), the patient may decide to see the physician or any other licensed practitioner supervised by the physician (physician assistant) and, before the initial examination or consultation, shall sign a form indicating the patient's choice of practitioner. The supervising physician must review the medical record of the initial examination or consultation and ensure that a written report of the initial examination or consultation is furnished to the referring practitioner within ten (10) business days following the completion of the initial examination or consultation.

Please circle one: Physician Physician Assistant No preference

Signed:

Print Name:

Date:

FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE / FLORIDA JOINT REPLACEMENT CENTER

PRESCRIPTION DRUG POLICY

Patient # _____

The law requires responsible usage of drugs by doctors and patients. If you accept a prescription from one of our providers at any one of our locations, you are also accepting the responsibility to use the drug for yourself only and only as prescribed. Our responsibility is to prescribe the medications in an appropriate dosage and amounts with clear instructions. We will answer any questions you have about the drug prescribed.

Drugs have the potential for abuse and are regulated closely by state and federal agencies. More closely controlled drugs (narcotic, pain medications, and tranquilizers) require even more responsibility on your part. Pain medications are in the same family of narcotics as stronger more harmful drugs such as morphine or heroin. Actually pain pills can block your perception of pain but when they wear off, you feel the pain more because your own body has not made endorphins (natural pain pills) and the body thinks that the body does not need its own natural remedy. When the pain pills wear off, you may experience worse pain than before. Therefore, we must be careful in the prescribing of these medications to ensure they are medically necessary. We will accept NO excuses for medication loss or theft and will not order replacements. We will not prescribe narcotics if you are using them other than exactly prescribed or receiving them from another source. Any change of pharmacy is your choice and therefore, your responsibility to notify our office.

Many drugs are appropriate for short term use only. Our office policy is to prescribe pain medication only if necessary and in your best interest post surgically for the 90 days following your procedure. If you are not a surgical patient we will prescribe a narcotic pain medication for no more than (30) thirty days from the last visit. Any request past (30) thirty days will require you to come into the office for an appointment to be reassessed as to need. We may also require the consultation of other specialists to help decide on the course of action when we disagree about your continued use of a substance. We may decide not to refill any medication even within the 30 day period if it is deem not medically necessary. Otherwise, we hold to a NO NARCOTIC POLICY.

Our office requires a 24 to 48 hour call in policy for refills of any prescription. Please call for refills before 12:00 PM on Fridays and before 4:00PM on other weekdays. Medications will not be filled after normal business hours or over the weekend.

Failure to follow these policies will force our Practice to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation or the local police.

If you are in agreement with all information stated above, please sign and date on the line below.

Signature of Patient or Patient Guardian

Date

Printed Name of Patient/Guardian

***FLORIDA SPORTS, ORTHOPAEDIC & SPINE MEDICINE
FLORIDA JOINT REPLACEMENT CENTER***

Minor Consent Form

As the parent/legal guardian of _____, a minor child (“Minor”), I hereby authorize Florida Sports, Orthopaedic & Spine Medicine (FSOSM) / Florida Joint Replacement Center (FJRC) to provide routine medical treatment to the Minor in my absence for the injury/condition(s) that is the purpose of today’s appointment. This consent shall expire 90 days from today’s date as set forth below. I understand that this consent is limited to routine medical treatment, not to include surgery, and that I must provide additional consent to surgery.

I understand and acknowledge that this consent does not authorize FSOSM / FJRC to provide routine medical treatment to Minor for any new or unrelated injury/condition(s) that arise in the future. FSOSM / FJRC may only provide routine medical treatment to the Minor for any future unrelated injury/condition(s) if I provide additional consent. Such additional consent may be given by either accompanying the Minor to the appointment or signing an additional consent form applicable to the new injury/condition(s).

I authorize the following person(s) to consent to routine medical treatment of the Minor in my absence, for any injury/condition(s).

_____ (Relationship to Minor)

_____ (Relationship to Minor)

_____ (Relationship to Minor)

I further authorize FSOSM / FJRC to provide emergency medical treatment to the Minor when it is reasonably medically necessary.

Parent Signature / Guardian Signature (Relationship to Minor)

Name (Please Print) Today’s Date

Street City State Zip

Today’s Injury/Condition: _____ **Consent Expires:** _____