

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

PATIENT UPDATE INFORMATION AND AUTH FORM

DATE _____ CHIEF COMPLAINT /PROBLEM _____

NAME (Last) _____ (First) _____ (Middle) _____ DOB _____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

HOME # _____ CELL# _____ SS# _____

EMERGENCY CONTACT _____ RELATION _____ PHONE# _____

FAMILY PHYSICIAN: _____ PHONE# _____

PHARMACY: _____ LOCATION: _____ PHONE# _____

EMAIL ADDRESS: _____ RACE: _____ PREFERRED LANGUAGE: _____

IF YOU ARE IN A REHAB/NURSING HOME, PLEASE INDICATE NAME OF FACILITY _____

PRIMARY INSURANCE _____ INSURED NAME _____ DOB _____

SECONDARY INSURANCE _____ INSURED NAME _____ DOB _____

Have you been injured on the job? YES NO

If yes, is this current problem related? YES NO

Have you been involved in an Automobile Accident? YES NO

If Yes, is this current injury Auto related? YES NO

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

Do you plan litigation for this injury? YES NO

RIGHT TO SHARE PERSONAL HEALTH INFORMATION:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

AUTHORIZATION AND ASSIGNMENT //PERMISSION TO TREAT: I, the undersigned, consent to medical care/diagnostic/ and or minor surgical treatment by the provider at FL Sports Orthopaedic and Spine Medicine / FL Joint Replacement Center deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that no guarantees have been made to me as to the result of treatment or exam in the office. I also request that the payment of authorized Medicare/Medigap Benefits and/or Commercial Benefits be made to me on my behalf for any services furnished by FL Sports, Orthopaedic and Spine Medicine / FL Joint Replacement Center. I authorized any holder of medical information about me to release to the CMS and its agents/Insurance carriers, any information needed to determine these benefits for related services. I authorize payment and assign my insurance carrier(s)/CMS to make payment directly to FL Sports, Orthopaedic and Spine Medicine / FL Joint Replacement Center for the services rendered in my behalf.

I agree to pay all charges for myself and for members of my family as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to e correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon. In the event that legal action should become necessary to collect unpaid balance due, I agree to pay reasonable attorney fees and other such costs as the Court determine proper.

Patient /Beneficiary Signature

Date

03/15/2012

**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 03/15/12

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