INSTITUTE FOR NON-SURGICAL ORTHOPEDICS DATE:_____

Referred By: Dr.:_____-Yellow Pages---Patient---Internet---Other_____

Last Name: First: Middle:

Address: City: State: Zip:

Home Phone: Cell: Other:

Date of Birth: Age: Sex:

_____ Marital Status : S M W D SEP
Social Security #

Race: ☐White ☐Black ☐Asian ☐American Indian or Alaska Native ☐Native Hawaiian or Pacific Islander

Ethnicity: ☐Hispanic ☐Non- Hispanic Language: ☐ English ☐French or Creole ☐Other ☐ Spanish

Emergency Contact: Relationship: Phone:

Current Medical Problem: Primary Care Physician:

___Yes ___No Date of Onset/Injury:_____
Was This an Accident?

-Auto- -Work Comp- -Slip/Fall- -Other_____

Responsible Party Name: Address: Phone:

Primary Insurance: ID# Group#

Secondary Insurance: ID# Group#

"Any person who, knowingly and within intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punished as provided in Florida Statute 817.234

Patient Signature: Date:

EMAIL ADDRESS: _____

HEALTH HISTORY

Patient's Name: _____ Birth Date: _____ Date: _____

Chief Complaint: _____

History of Present Illness:

Location: _____ Quality: _____
(where is pain or problem) (example: normal vs. abnormal, color, etc)

Severity: _____ Duration: _____
(how severe is pain on scale 1-5, 5 being the most severe) (how long have you had pain/problem, when did it start?)

Timing: _____ Context: _____
(does pain/problem occur at a specific time) (where were you at the onset of pain/problem)

Associated Symptoms: _____ Modifying Factors: _____

_____ _____
(what other associated problems have you been having) (what makes the pain/problem better or worse)

Past Medical History:
Have you ever had the following: (Circle yes or no, leave blank if uncertain)

Measles	yes no	Anemia	yes no	Back Trouble	yes no	Hepatitis	yes no
Mumps	yes no	Bladder Infection	yes no	High blood pressure	yes no	Ulcer	yes no
Chicken pox	yes no	Epilepsy	yes no	Low blood pressure	yes no	Kidney disease	yes no
Whooping cough	yes no	Migraines	yes no	Hemorrhoids	yes no	Thyroid disease	yes no
Scarlet fever	yes no	Tuberculosis	yes no	Date of last chest x-ray	_____	Bleeding	yes no
Diptheria	yes no	Diabetes	yes no	Asthma	yes no	Any other disease:	
Small pox	yes no	Cancer	yes no	Hives or Eczema	yes no		
Pneumonia	yes no	Polio	yes no	Aids or HIV	yes no	_____	
Rheumatic fever	yes no	Glaucoma	yes no	Infectious mono	yes no		
Heart Disease	yes no	Hernia	yes no	Bronchitis	yes no	_____	
Arthritis	yes no	Blood/Plasma		Mitral valve prolapse	yes no		
Venereal disease	yes no	Transfusion	yes no	Stroke	yes no	_____	

Previous Hospitalizations/Surgeries/Serious Illness: When? Hospital, City, State

_____

_____

ALLERGIES: _____

Medications: (Include non-prescription)
Medication: Dosage: How Taken:

_____

_____

_____

Social History:

Marital Status: Single_____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of alcohol: Never_____ Rarely_____ Moderate_____ Daily_____
Use of tobacco: Never_____ Previous but quit/date_____ Current # of packs per day_____

Family Medical History: Age Disease If Deceased, Cause of death

Father: _____
Mother: _____
Sibling: _____
Sibling : _____
Children: _____
Spouse: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____
Signature of Patient, Parent, or Guardian Date

Review of Systems

General:

Y N Feeling Well
Y N Weight Gain
Y N Weight Loss
Y N Persistent Infections
Y N Anorexia
Y N Appetite Loss
Y N Chills
Y N Dietary Change
Y N Fatigue
Y N Fever
Y N Medication Changes
Y N Night Sweats
Y N Obesity
Y N Significant Weight Change
Y N Weight gain > 10#
Y N Weight loss > 10#

Skin:

Y N Bruising
Y N Change in Wart/ Mole
Y N Clamminess
Y N Cracked Lips
Y N Dryness
Y N Excessive Sweating
Y N Hair Growth
Y N Hair Loss
Y N Hives
Y N Itching
Y N Nail Changes
Y N New Lesions
Y N Rash
Y N Skin color changes
Y N Ulcer
Y N Varicose Veins
Y N Sores

HEENT:

Y N Blurred vision
Y N Headache
Y N Head injury
Y N Wears Glasses/Contacts
Y N Color blindness
Y N Decreased night vision
Y N Double vision
Y N Excessive Tearing
Y N Eye Pain
Y N Eye Redness
Y N Visual Disturbance
Y N Visual Loss
Y N Hearing Loss
Y N Deafness
Y N Decreased Hearing
Y N Ear Discharge
Y N Ear Infection
Y N Ear Pain
Y N Ringing in ears
Y N Spinning sensation
Y N Vertigo
Y N Cold Symptoms
Y N Nose bleed
Y N Frequent colds
Y N Nasal congestion
Y N Seasonal Allergies
Y N Sinus Pain
Y N Bleeding gums
Y N Hoarseness
Y N Oral Ulcers
Y N Sore Throat
Y N Voice Change
Y N Poor Teeth

Neck:

Y N Neck mass
Y N Neck pain
Y N Neck stiffness
Y N Swollen glands

Respiratory:

Y N Chronic cough
Y N Cough
Y N Decreased exercise tolerance
Y N Snoring
Y N Difficulty breathing
Y N Shortness of breath
Y N Sputum production
Y N Wheezing
Y N Bloody sputum
Y N Pneumonia
Y N Asthma

Breast:

Y N Breast mass
Y N Breast pain
Y N Breast swelling
Y N Nipple discharge
Y N Nipple pain
Y N Skin changes

Cardiovascular:

Y N Chest Pain/Angina
Y N Calf Cramps
Y N Claudications
Y N Difficulty breathing on exertion
Y N Fainting/Blacking out
Y N Irregular heartbeat
Y N Low blood pressure
Y N Elevated blood pressure
Y N Night cramps
Y N Difficulty breathing lying down
Y N Palpitations
Y N Rapid heart rate
Y N Air hunger at night
Y N Leg pain/swelling
Y N Phlembitis
Y N Swelling of extremities
Y N Heart murmur

Gastrointestinal:

Y N Excessive gas
Y N Hemorrhoids
Y N Abdominal mass
Y N Abdominal pain
Y N Black, tarry stool
Y N Bloody stool
Y N Change in bowel habits
Y N Constipation
Y N Diarrhea-Chronic/Acute
Y N Difficulty swallowing
Y N Food intolerance
Y N Gastritis
Y N Loss of appetite

Review of Systems

Gastrointestinal continued

Y N Indigestion/Heart burn
Y N Jaundice/Yellow skin
Y N Hepatitis
Y N Nausea
Y N Rectal bleeding
Y N Vomiting
Y N Vomiting blood
Y N Incontinence of stool

Genitourinary:

Y N Contractions, regular
Y N Urinary complaints
Y N Vaginal dryness
Y N Vaginal itching/burning
Y N Vaginal fluid/Discharge
Y N Absence of Menstruation
Y N Kidney Stones
Y N Blood in urine
Y N Change in bladder habits
Y N Change in urinary stream
Y N Penile Lesions
Y N Painful Menstruation
Y N Painful Sex
Y N Painful Urination
Y N Excessive menstrual bleeding
Y N Excessive non-menstrual bleeding
Y N Flank pain
Y N Frequency of urination
Y N Hernia
Y N Hesitancy of urination
Y N Incontinence of urine
Y N Scrotal swelling
Y N Testicular mass/swelling
Y N Pelvic Pain
Y N Polyuria
Y N Urethral discharge
Y N Urgency
Y N Urinary retention
Y N Urinating at night

Musculoskeletal

Y N Leg cramps
Y N Back pain/ backache
Y N Calf pain
Y N Buttock/Leg pain with walking
Y N Decreased range of motion
Y N Disuse
Y N Twitching of muscles
Y N Joint pain
Y N Joint redness
Y N Joint stiffness
Y N Joint swelling
Y N Muscle atrophy
Y N Muscle cramps
Y N Muscle pain
Y N Muscle weakness

Neurological

Y N Numbness
Y N Trouble walking
Y N Auras
Y N Decreased memory
Y N Difficulty speaking
Y N Dizziness
Y N Dysesthesia/Weird sensation
Y N Fasciculations
Y N Fainting/Syncope
Y N Focal neurological symptoms
Y N Headaches
Y N Incontinence stool
Y N Incontinence urine
Y N Incoordination
Y N Loss of consciousness
Y N "Pins and Needles" feeling
Y N Seizures
Y N Spinning sensation
Y N Stroke
Y N Tremor
Y N Unsteadiness
Y N Vertigo
Y N Weakness in general
Y N Weakness in extremities
Y N Migraines
Y N Head injury
Y N Paralysis

Psychiatric

Y N Anxiety/Anxiousness
Y N Change in sleep pattern
Y N Delusions
Y N Depression
Y N Early awakening
Y N Fearful
Y N Hallucinations
Y N Sleeping too much
Y N Inability to concentrate
Y N Mood changes
Y N Insomnia
Y N Panic attacks
Y N Suicidal thoughts
Y N Suicidal planning
Y N Withdrawn
Y N Feels safe at home
Y N Frequent/Excessive crying

Endocrine

Y N Appetite changes
Y N Cold intolerance
Y N Excessive thirst
Y N Excessive urination
Y N Hair changes
Y N Heat intolerance
Y N Libido change
Y N Sexual dysfunction
Y N Thyroid problems

Hematology

Y N Gland problems
Y N Abnormal/Excessive bleeding
Y N Anemia
Y N Blood clots/DVT's
Y N Easy bruising
Y N Enlarged lymph nodes
Y N Pinpoint hemorrhages
Y N Prolonged bleeding
Y N Spontaneous bleeding
Y N Transfusions

INSTITUTE FOR NON-SURGICAL ORTHOPEDICS
Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled substances.

I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and my doctor undertakes to treat me based on this agreement.

I understand that if I break this agreement, my doctor will stop prescribing these pain controlling medications.

In this case, my doctor will taper off the medication's over a period of several days, as necessary, to avoid with-drawl symptoms. Also, a drug-dependence treatment program may be recommended.

I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication helps to relieve the pain.

I will not use any illegal controlled substances, including marijuana, cocaine, etc.

I will not share, sell or trade my medication's with anyone.

I will not attempt to obtain any controlled medication's, including opiod pain medication's, controlled stimulant's, or anti-anxiety medication's from any other doctor.

I will safeguard my medication's from loss or theft. I understand lost or stolen medication's will not be replaced.

I agree that refills for pain medication's will only be made at time of an office visit during regular business hours. No refills will be available during weekends or after normal business hours.

I agree to use _____ Pharmacy

located at _____

telephone number is _____, for filling prescriptions for all of my pain medications.

I authorize the doctor and my pharmacy to cooperate fully with any, city, state or federal law enforcement agency, including this state's Board of Pharmacy in the investigation of my possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respects to these authorizations.

I agree to submit to blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

I agree to use my medication's as directed and understand use greater than as directed may result in being without medication.

I agree to bring unused medications to each office visit.

I agree to follow these guidelines, which have been fully explained to me. I also acknowledge that all of my questions and concerns have been adequately answered and I have received a copy of this agreement.

_____ _____

Patient Signature/Date Physician Signature/Date

_____

Witness/Date

rev.4/2008

FINANCIAL POLICY

The purpose of this form allows Institute for Non-Surgical Orthopedics to treat you, and bill any insurance's you may have, share information with other health care offices/facilities, and collect on your account.

Regarding Insurance: Our office participates with Medicare and many managed care companies, including Auto and Workers Comp. As a courtesy we will bill all insurances. However, Co-payments, Co-insurances, Deductibles, and Non-covered services are the responsibility of the patient/guarantor and expected at the time of service. Any amounts not paid at time of service are subject to additional administrative fees as outlined below.

I authorize treatment by the providers of Non-Surgical Orthopedics. I authorize the release of any information requested by insurance companies or liable third parties and I assign all benefits or injury benefits to Non-Surgical Orthopedics. If the correct insurance is not provided or the proper referral is not obtained, then patient acknowledges full responsibility for the bill.

I acknowledge that I received or read a copy of the Notice of Privacy Practices, which are posted in the waiting room.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay all reasonable Attorney's Fee, Collection Agencies Fee, court costs and any other collection related fees incurred on my account. I also understand that my employer may be contacted to verify employment status.

Special Needs: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise staff prior to receiving treatment. Co-pays are exempt as required by law and your insurance company. You are required to notify us if this is worker's comp or accident to avoid additional financial costs. If you are not covered by any insurance, let us know you are a self-pay and ask about our same day discounts.

Note our Fees for the following:

Returned check fee $30.00.
Any forms such as FMLA, Disability, etc. range from $15.00-$35.00 each.
There may be a $25.00 fee for any appointment not kept without 24-hour notice.
Co-pays, Coinsurance, Deductibles and Non-Covered services not paid at time of service will result in an additional $10.00 monthly service fee.
If a referral is required and not obtained, you will be responsible for payment for those services. Incorrect insurance information provided or changes in policies will be patient responsibility.

Patient/Guardian Signature/Date Relationship to Patient

Authorization for Release of Medical Information

Patient Name: **Patient #:**

Social Security # (last 4 digits): **Date of Birth:**

Please forward copies of requested records to:

Name: Institute for Non Surgical Orthopedics
Address: 4109 N. Federal Highway
City, State, & Zip: Fort Lauderdale, FL 33308

Fax:954-563-7009

Release the following:
_____Entire Health Record
_____Immunization Records Only
_____Specific Dates of Treatment: From_____to_____

_____Other _____

I am requesting that this protected information be released for the following reason: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

o This request is being made because I am transferring care to another primary care provider or leaving the area.

o This authorization shall remain in effect until _____ (up to 6 months) at which time this authorization expires.

o I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and / or substance abuse.

o I also authorize for the release of information regarding diagnosis and or treatment of AIDS or HIV.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Institute for Non Surgical Orthopedics, attention Medical Release Correspondent, at the above address.I hereby authorize Institute for Non Surgical Orthopedics to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

THERE MAY BE A SERVICE CHARGE FOR THE COPYING OF RECORDS

Patient Name: _____
Date:
Patient Signature: _____ _____
Date:
Legal Representative: _____ _____
Relationship:

Witnessed by: _____ **Date:** _____