Alexander Orthopaedic Associates

MVA / Pedestrian Accident Form

Please complete this form in addition to principle intake if your visit is in relation to an accident.

Patient Name: _____

Today's Date: ____ / ____ / ____

DOB: ____ / ____ / ____ Date of Accident: ____ / ____ / ____

Please complete all fields. If it does not apply, please mark N/A

Were you the: driver / passenger / pedestrian

Were you struck from: behind / front / drivers side / passenger side / other

Did another car stike yours? Yes / No Did your car strike another car? Yes / No

Were you wearing your seatbelt? Yes / No Was a citation issued to you? Yes / No

Did airbags deploy? Yes / No Did you go to the hospital? Yes / No

By Ambulance? Yes / No / N/A Did you lose consciousness? Yes / No / I don't recall

---

What part of the body did you injure? (Please specify right or left)

_____

_____

Please circle the symptoms you've been experiencing since this accident.

Headache	Tingling in Arms	Buzzing in Ears
Neck Pain	Tingling in Legs	Loss of Balance
Neck Stiffness	Numbness in Toes	Fainting
Dizziness	Numbness in Fingers	Diarrhea
Back Pain	Shortness of Breath	Stomach Upset
Back Stiffness	Fatigue	Constipation
Nervousness	Light Sensitivity	Cold Sweats
Chest Pain	Loss of Memory	Fever
Sleep Disruption	Ringing Ears	Other

What is your chief complaint today?

_____

Have you been treated for this accident? Yes / No

If yes, by whom? (list all doctors, physical therapists, Hospital ER, etc.)

_____

_____

Are you taking any medications for this injury? Please list.

_____

Have you had any diagnostic testing for this injury? (MRI, CT, X-Ray) Please indicate facility and date.

_____

_____

Rate your pain by circling the number that best describes your pain at it's worst

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

Rate your pain by circling the number that best describes your pain on average

No pain - 0 1 2 3 4 5 6 7 8 9 10 - Pain as bad as you can imagine

What makes your pain better?

_____

What makes your pain worse?

_____

Have you missed work? Please list dates

_____

Is your condition preventing you from participating in certain activities? Yes / No - Please list.

_____

_____

Have you had any previous injuries not related to this accident? (Previous auto accidents, fractures, surgeries, etc.) Please list the year.

_____

INSURANCE COMPANY:_____

For and in consideration of the above-mentioned provided agreeing to pursue my insurance provider for payment of benefits due me and not requiring prepayment for services. I hereby irrevocably assign to the aforementioned medical provided (Alexander Medical Group, PLLC) any Personal Injury Protection benefits I may have in accordance with Florida Statue 627.756(5). This in includes any benefits from my insurance company or any other entity that may be responsible for expenses incurred, and I authorize the provider to prosecute said action and collect legal expenses as they see fit. This DOCUMENT CONSTITUES AN ASSIGNMENT OF BENEFITS. I hereby further give a lien to the Provider against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict, which may be paid to me as a result of the injuries or illness for which the Provider has treated me. This is to act as an irrevocable assignment of my rights and benefits to the extent of the services provided. I agree to cooperate with the Provider and any attorney that the Provider chooses and to do all things reasonable to effect payment of the bills by the insurance company to the Provider including, but not limited to, disclosing patient's medical condition and treatment. This assignment concerns only the bills for the Provider and those costs (including, but not limited to attorney's fees, court costs and interest) necessary in procuring payment form the above named insurance company, etc. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deduction or co-payment not covered by the PIP insurance coverage. I understand that this is a benefit and convenience to me in that the Provider will pursue collection against the insurance company on my behalf. I hereby instruct and direct my insurance company to pay my benefits by check, made payable to and mailed to the Provider at the address listed above. If my current policy prohibits direct payment to doctors, then I hereby instruct and direct my insurance company to make the check payable to me and mail it to the Provider at the address listed above. Furthermore, I hereby give the Provider limited power of attorney to endorse/sign my name on any and all checks for payment to the Provider. This agreement is intended to serve as an assignment of the patient's rights and benefits under his/her aforementioned insurance policy in favor of the Provider, if any language within this agreement has the effect of invalidating this assignment, that language shall be deemed void and the assignment shall remain in full force and effect. A photocopy of this assignment shall be considered as effective and valid as the original.

_____
PRINTED NAME

_____ _____
PATIENT SIGNATURE DATE

_____ _____
WITNESS SIGNATURE DATE

Alexander Orthopaedic Associates

12416 66th Street North, Suite A. Largo, Fl. 33773
2438 Dr. ML King Jr Street North St Petersburg, FL 33704
1532 Oakfield Dr. Brandon, FL 33511
(P) 727-547-4700 (F) 727-394-8661

MEDICAL RECORDS RELEASE AGREEMENT AND HEALTH INSURANCE DISCLOSURE

Patient Name: _____

Date of Injury: _____

I hereby authorize Alexander Orthopaedic Associates (AOA) to furnish my attorney of record, with a full report of my examination, diagnosis, imaging, treatment, prognosis, etc. concerning the injury/illness for which I am treated.

A photocopy of this document shall be sufficient to authorize any person having medical treatment, services, or supplies pertaining to me, to release copies of the same to Alexander Orthopaedic Associates (AOA) or any insurer providing coverage in connections with processing any claim pertaining to payment for care. A photocopy of this document shall be as binding as an original signature page.

If I currently do not have an attorney, but retain an attorney in the future, or change my attorney of record, I understand I am responsible for communicating that change to AOA as soon as possible.

I constitute and appoint AOA to endorse any checks, drafts, or money orders written in both our names where such check is in payment for services regarding my injury. Furthermore, I allow AOA to sign any document that will be necessary to enhance, expedite, and / or allow payment to said provider. This may include insurance forms and other statements.

I understand that I may have health insurance or be a member of an HMO and that I may be a third party beneficiary of an agreement between my health insurer. After careful consideration, it is my decision to decline benefits available through my personal or group health insurance. I understand the reason for this is related to properly pre-approving care, timely filing limits of claims, and other such standards and rules pertaining to health insurance payments. By signing this acknowledgement, I knowingly waive any rights I may have as a third party beneficiary to any agreements my healthcare provider may have with any insurance company.

If I have Medicare Insurance and I am treating for a liability related injury, I understand that the provider has a choice of billing the liability insurer, filing a lien against the court settlement, or billing Medicare. I authorize AOA to release to the Centers of Medicare (CMS) any information needed to determine these benefits, or benefits payable to related services. I agree to pay any portion of my charges that my Medicare carrier deems my responsibility.

I am also fully aware that in the event of an unfavorable judgment in my personal injury matter, I am responsible for all charges incurred for my care at AOA.

Today's Date: _____

Patient Printed Name: _____

Patient Signature: _____

11/13/17

Alexander Orthopaedic Associates

12416 66th Street North, Suite A. Largo, Fl. 33773
2438 Dr. ML King Jr Street North St Petersburg, FL 33704
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PATIENT FINANCIAL AGREEMENT
& AUTHORIZATION FOR LIEN ON SERVICES

_____
Patient Name

_____
Date of Accident

In the event that I, _____ recover funds from a settlement of my claim relating to the accident dates above, I direct my attorney to withhold from my settlement sufficient funds to pay for all medical care provided by Alexander Medical Group, LLC dba Alexander Orthopaedic Associates FEIN#16-1626040, up to the lesser of a.) funds received from the recovery of the above named patient / client or b.) the balance of the account, unless otherwise approved.

My attorney will use his / her best efforts to request a confirmation of my account balance when the recovery is imminent.

If the net recovery of settlement is less than the total outstanding charges owes to all healthcare providers covered by a letter of protection or any other lien holder, excluding Medicare or Medicaid, Alexander Orthopaedic Associates has priority to have the account balance paid first, after attorney fees and costs.

In the event that I am no longer represented by an attorney, I authorize any and all lien holders to pay Alexander Orthopedic Associates directly, for all funds due on my account related to the above accident.

I understand that if I object to the amount of the bill, my attorney or any other lien holder will withhold an amount sufficient to pay my bill in a trust account. My attorney or any other lien holder will not thereafter pay any portion of the funds withheld, either to the doctor or myself, until a written agreement is made by all parties involved. The only exception is an Order of Court competent jurisdiction directing that such funds be paid to either myself, or Alexander Orthopaedic Associates.

By signing below, I have read and understand the above written statements. I authorize my attorney to protect my bills for the treatment outlined above. I also understand and agree that I am ultimately responsible to Alexander Orthopaedic Associates for the payment of all services rendered for my benefit.

_____ _____
Name of Representing Attorney **Signature of Patient** **Date**

OFFICE USE ONLY

_____ **Patient given copy of Financial Agreement / Lien on Services**

_____ **Copy faxed to Representing Attorney**

Alexander Orthopaedic Associates

New Patient Information:

Patient Name: _____ **Date:** _____
Social Security #_____ **Date of Birth:** _____
Please circle: M or F **Race:** _____ **Language** _____
Ethnicity _____ Single Married Divorced Widowed
Primary Home Address: _____
City: _____ **State**: _____ **Zip Code**: _____
Occupation: _____ Employer: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Secondary Home Address: -_____
City: _____ **State**: _____ **Zip Code:** _____

Primary Care Physician: _____ **Phone#:**_____

EMERGENCY CONTACTS:

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
If you have a spouse:
Name: _____ Date of Birth: _____
Social Security #_____ Employer: _____
Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone # _____
Name of Insured: _____Relationship to patient: _____
ID #_____ Group #_____
Subscribers SS#:_____ Subscribers DOB: _____
Please Circle: **HMO** **PPO** **Other**

Secondary Insurance: _____Effective Date: _____

Address: _____
City: _____ State: _____ Zip Code: _____
Telephone # _____
Name of Insured: _____Relationship to patient: _____
ID #_____ Group #_____
Subscribers SS#:_____ Subscribers DOB: _____
Please Circle: **HMO** **PPO** **Other**

Did your injury occur at work? (Please circle) **Yes** **No** if yes, Date of injury_____
Is your injury from an auto accident? (Please circle) **Yes** **No** if yes, Date of injury_____
Are you being represented by an attorney? (Please circle) **Yes** **No**
if yes, Name of attorney_____ Phone #_____

MRI REFERRAL DISCLOSURE

In the course of your treatment, an x-ray, MRI, CT, bone scan, bone density scan, or other ancillary studies may be necessary and ordered. Alexander Medical Group, LLC, dba Alexander Orthopaedic Associates in accordance with the Patient Protection and Affordable Care Act, as modified by the Health Care and Education Reconciliation Act of 2010, ("PPACA") Section 6003, informs you that it is your choice to have the study done at our facility or at the facility of your preference.

A written list of such facilities in the area is provided below.

Advanced Medical Imaging	**727-398-5999**	**Palms of Pasadena**	**727-341-7890**
Bardmoor Imaging	**727-461-8555**	**Pinellas High Field Imaging**	**727-347-4674**
Central MRI	**727-381-4674**	**Rose Radiology**	**727-531-5444**
Largo Medical Center	**727-588-5850**	**St. Petersburg General**	**727-341-4808**
National PET Scan	**727-471-1000**	**Tampa Bay Imaging (TBI)**	**727-545-9674**
Gateway	**727-525-2121**	**Westcoast Radiology**	**727-446-6760**

Please print and sign your name below to acknowledge your understanding of the above statements.

Print Name	Signature	Date

ALEXANDERORTHOPAEDICASSOC.

Alexander Orthopaedic Associates Disclosure of Policies

Financial Policy:

Alexander Orthopaedic Associates participates with many forms of health insurance, such as HMO's, PPO's, Workman's Compensation and Medicare. However, few insurance carriers cover all medical costs and a balance on your account may result from co-payments, co-insurance, deductibles, or non-covered services. The patient is responsible for full payment of any and all balances deemed "patient responsibility" by their insurance carrier. We will file medical insurance claims as a courtesy to our patients.

Motor Vehicle and Worker's Compensation: In order for our office to submit your claims for you, you must provide us with the following information: insurance company name, address and telephone number, as well as your claim number, date of accident and claims adjuster's name. In the event that your insurance denies or terminates your benefits, you will be responsible for full payment for services rendered. Please note for all Workers' Compensation patients, your initial appointment must be scheduled by your nurse case manager or Worker's Compensation adjustor. Authorization must be received prior to the initial office visit. Motor Vehicle patients, please note prior to your initial office visit your auto benefits must be confirmed and verified by our office.

Payment Policy:

All co-payments, co-insurance, and deductibles are paid at the time of service to help control costs of medical care. Payments may be made by cash, check, Visa, MasterCard, American Express, and Discover. For larger amounts, such as surgical fees not covered by insurance, AOA will work with you to arrange a payment plan. Self pay patients and Surgical Pre-pay patient's payments will only be accepted via credit card, cash payment, and/or money orders.

Treatment of Patients:

Throughout your treatment at AOA, the medical providers may order diagnostic testing to help determine your diagnosis or create a better treatment plan for you, the patient. These tests include lab work, x-rays, MRI's, CT scans, Bone Scan's, etc. Failure to schedule or obtain the recommended diagnostic studies in a timely manner or to schedule a follow up appointment to review the diagnostic tests in a timely manner; will constitute as a breech of our recommendations and is Against Medical Advice (AMA). Therefore, AOA employees and medical providers will not be held responsible for lack of patient responsibility and purposeful disregard of our medical recommendations. Non- compliance may result in an adverse complication to the patient's medical result/ outcome.

Alexander Orthopaedic Associates notifies you that our providers may be involved in education, research, development and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore the providers may benefit directly or indirectly from such educational, research, development and/ or consulting relationships. This will not conflict with the best interest of the patient and/or their medical condition/ diagnoses.

Alexander Orthopaedic Associates notifies you that some or all providers may or may not carry Medical Malpractice Insurance.

AUTHORIZATION FOR
RELEASE OF
CONFIDENTIAL INFORMATION
(PURSUANT TO 45.C.F.R.164.508)
(T) 727-547-4700 (F) 727-394-8661

Patient Name: _____ DOB:_____
Last 4 digits of Social Security Number: _____ MR#: _____
Patient Phone Number: _____ (Personnel to Fill out)

I authorize to release **medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorder information** or any other medical records of a sensitive nature:(Pursuant to 42.C.F.R.2.31)

This will authorize:_____(Name of facility/entity to provide records)

To Release To: **To Release To:**

Alexander Orthopaedic Associates
12416 66th Street No Suite A
Largo, FL. 33773

For the purpose of_____

Please disclose the exact information selected below:
Entire Medical Record, excluding _____
Date(s) of Service:

Check all that apply:

_____ Laboratory Reports	**_____ Medication Sheets**	**_____ Operative Reports**
_____ Radiology Reports	**_____ Facesheet**	**_____ Pathology**
_____ Progress Notes	**_____ History and Physical**	**_____ Emergency Report**
_____ Physician Orders	**_____ Discharge Summary**	**_____ EKG Report**
_____ Nurses Notes	**_____ Consultations**	**_____ Other (Specify):**

Note: X-ray films must be obtained from Radiology Dept.

To be completed by the patient or personal representative:

I hereby authorize the use or disclosure of my protected health information as described above.

This authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign the form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.

I understand that I have a right to revoke this authorization by sending written notifications to:

Alexander Orthopaedic Associates 12416 66th Street No Suite A Largo, FL. 33773

Any revocation will not affect disclosures made prior to Alexander Orthopaedic Associates receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

Signature of patient or patient's representative/Power of Attorney_____

Printed name of patient's representative/Power of Attorney_____

Relationship to the patient:

Date: _____ Expiration Date of this Authorization: **One Year**

Alexander Orthopaedic Associates
Patient Authorization Form

HIPPA Privacy Notice

I have received and read a copy of Alexander Orthopaedic Associates Notice of Privacy Practices (Notice).

*By initialing I have read and understand the above*_____

Authorization to Release Information

I consent to the use or disclosure of my protected health information by Alexander Orthopaedic Associates (AOA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my Health care bills or to conduct health care operations of AOA. As mentioned in (*sections I, II, III, V*) of the Notice.

*By initialing I have read and understand the above*_____

AOA Disclosures

I acknowledge that I have been notified that some or all of the providers at AOA may or may not carry Medical Malpractice Insurance. I also acknowledge that I have been notified that the providers at AOA may be involved in education, research, development, and/ or consulting with regards to Orthopaedic products and the Orthopaedic industry; therefore, the providers may benefit directly or indirectly from such educational, research, development, and or consulting relationships. The above does not conflict with my best interest as a patient at AOA. I desire to enter into a doctor-patient relationship with a provider at AOA. As mentioned in (*section VI*) the Notice.

*By initialing I have read and understand the above*_____

Financial Agreement & Payment Policy

I understand that I am financially responsible for services rendered by AOA providers.
I also understand that few insurance carriers cover all costs for services rendered. AOA will submit claims to your insurance carrier. I will be responsible for the balance on my account that my insurance company does not cover. I will pay any co-payments, co-insurance, and deductibles at the time of service at AOA. As mentioned in (*section VII, VIII*) in the Notice.

*By initialing I have read and understand the above*_____

Authorization for treatment

Throughout your treatment at AOA the medical providers may order diagnostic testing (lab work, bone scan's, x-rays, MRI's, CT scans… etc) that will help determine your diagnosis and future treatment. Failure to schedule or obtain the recommended diagnostic studies or failure to schedule a follow up visit in a timely manner to review the diagnostic studies and discuss the results will constitute as a breech of our recommendations. AOA employees and medical providers will not be held accountable for your lack of responsibility and purposeful disregard of our medical recommendations. As mentioned in (section IX) in the Notice.

*By initialing I have read and understand the above*_____

I hereby authorize the medical staff of AOA to render medical services and treatments as deemed necessary. I understand that failure to comply with our medical recommendations is against medical advice. (AMA)

*By initialing I have read and understand the above*_____

By signing, I have read, understand and agree to comply with AOA policies so noted in the Notice of Privacy Practices (Notice).

Signature _____Date _____

Printed Name_____

If patient is a minor (under 18):

Minor's Name_____ Guardian's Name (printed) _____

Signature_____ Relationship _____ Date_____

Consent for the Release of Protected Health Information to Personal Representatives

I, _____, give my written consent for Alexander Orthopaedic Associates to share information regarding my protected health information and care to the following listed persons: I understand that these persons will be treated as personal representatives of myself.

Personal Representatives that Alexander Orthopaedic Associates may share my Protected Health Information with:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____Do not discuss my Protected Health Information with anyone other than myself at any time.

Alexander Orthopaedic Associates may leave a message:

At Home _____ At Work _____

Patients' Signature _____ Date: _____

Alexander Orthopaedic Associates
Form Fee Agreement

Please note: The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs, especially when multiplied over the large number of patients our practice serves. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of the forms as follows:

NO Charge:

- Workers Compensation requested Disability and Work Status forms
- Auto Insurance Carrier requests for Work Status and Treatment Plans

$15.00:

- Disabled Parking Applications

$35.00/ form:

- Credit Card deferment forms
- Private Disability Insurance Forms
- School Educational Disability or Limitation Forms

$35.00/form

- Family Medical Leave Act (FMLA) forms

$150.00- $300.00

- For completion of any dictated letter describing medical care and limitations
- For any narrative report detailing diagnosis, treatment, and future medical care including work capacity statements. Functional Capacity Evaluation testing may be necessary prior to, or in addition to the narrative report. The fee for the FCE test is determined by the facility that the testing is completed at.

I have read and understand the above. By signing I agree to comply with the Form Fee policy of AOA. Fees subject to change without notice.

_____ _____ _____

Patient Name (printed) Signature Date

Revise 9/7/10

ALEXANDER ORTHOPAEDIC ASSOCIATES
HISTORY & PHYSICAL

Room # _____
Provider _____
X-ray taken _____
XR/MRI brought yes no
Facility _____
(for office use only)

TODAY'S DATE: _____

PATIENT NAME: _____ **Age:** _____ **DOB**: _____

(please circle): **M** **F** Right handed Left handed **HEIGHT:**_____ **WEIGHT:** _____ **BLOOD PRESSURE:**_____

RACE/ETHNICITY (please circle): **WHITE** **HISPANIC** **AFRICAN AMERICAN** **PACIFIC ISLANDER** **OTHER** _____

PRIMARY CARE_____

PREFERRED LANGUAGE (please circle): **ENGLISH** **SPANISH** **OTHER** _____

TODAYS CHIEF COMPLAINT (what body part are you seeking treatment for) _____ ☐ right ☐ left

HISTORY OF PRESENT ILLNESS OR INJURY (when and how did it happen):

EXACT DATE PAIN BEGAN OR INJURY OCCURRED _____

HOW WERE YOU INJURED? ☐ IN A SPORT ☐ ACCIDENT ☐ AUTO ACCIDENT ☐ NEITHER

WERE YOU INJURED AT WORK? ☐ YES ☐ NO **IF YES, WHAT DATE WERE YOU INJURED?**_____

HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT? _____

ON A SCALE OF 1-10, HOW SEVERE IS YOUR PAIN? _____

WHAT MAKES YOUR SYMPTOMS WORSE? _____

WHAT MAKES YOUR SYMPTOMS BETTER? _____

PREVIOUS INJURY TO THIS AREA: (please circle) **Y** **N**

If yes, explain:

CURRENT MEDICATIONS (name, strength and dose):

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

7._____ **8.**_____ **9.**_____

PAST MEDICAL HISTORY: (please check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders/Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Diabetes
- ☐ GERD
- ☐ GI Disorders
- ☐ Heart Attack
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Other
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Stroke
- ☐ Thyroid Disease

PATIENT NAME: _____

ALLERGIES (please circle): **Aspirin Codeine Latex Penicillin Sulfa None Other:** _____
Reaction: _____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: ☐ NONE

1. _____ YEAR _____
2. _____ YEAR _____
3. _____ YEAR _____
4. _____ YEAR _____
5. _____ YEAR _____

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative
☐Diabetes _____ ☐High Blood Pressure _____ ☐Rheumatoid Arthritis _____
☐Difficulty with anesthesia_____ ☐Bleeding Problems_____ ☐None known

SOCIAL HISTORY (please circle): **Smoking** Qty_____ **Drinking** Qty_____ **Drugs** Type/Qty_____

MARITAL STATUS (please circle): **Single Married Divorced Widow Separated Student**

EMPLOYMENT STATUS (please circle): **Employed Unemployed Disabled Retired Occupation _____**

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE				**NONE**	**YEAR**	**Details/Comments**
1. GI	☐Heartburn, Ulcers	☐Nausea, Vomiting	☐Blood in Stool	☐	____	_____
2. ENDO	☐Thyroid Disease	☐Heat or Cold Intolerance		☐	____	_____
3. CON	☐Weight Loss	☐Loss of Appetite	☐Fatigue	☐	____	_____
4. EYE	☐Blurred Vision	☐Double Vision	☐Vision Loss	☐	____	_____
5. ENT	☐Hearing Loss	☐Hoarseness	☐Trouble Swallowing	☐	____	_____
6. CV	☐Chest Pain	☐Palpitations		☐	____	_____
7. RS	☐Chronic Cough	☐Pneumonia	☐Shortness of Breath	☐	____	_____
8. GU	☐Painful Urination	☐Blood in Urine	☐Kidney Problems	☐	____	_____
9. SK	☐Frequent Rashes	☐Skin Ulcers	☐Lumps ☐Psoriasis	☐	____	_____
10. NEU	☐Headaches	☐Dizziness	☐Seizures ☐Numbness	☐	____	_____
11. PSY	☐Depression/Anxiety	☐Drug/Alcohol Addiction	☐Sleep Disorder	☐	____	_____
12. HEM	☐Easy Bleeding	☐Easy Bruising	☐Anemia	☐	____	_____

13. Are you HIV Positive? ☐Yes ☐No
Have you ever had Hepatitis A, B, or C? ☐Yes ☐No If yes what type? _____
14. Are you pregnant? ☐Yes ☐No
15. Are you Claustrophobic? ☐Yes ☐No

PHARMACY NAME _____
ADDRESS/CROSS STREETS _____
PHONE# _____

Patient Assessment

The physicians at Alexander Orthopaedic Associates are concerned about your orthopaedic health and want to make sure that we are evaluating those factors which may impact your orthopaedic wellbeing. The following questions are intended to give the physicians at Alexander Orthopaedic Associates information about your general health.

Please circle the correct answer or fill in the blanks.

1. What is your height _____ weight _____ Prefer not to answer _____

2. Have you had a Bone Density Study (also known as a Dexa scan) for osteoporosis at least once since age 60?
   Yes _____ No _____
   If yes, in what year did you have the most recent Bone Density Study? _____

3. Have you been on medicine to treat osteoporosis? **Yes _____ No _____**
   If yes, has it been prescribed within 12 months? **Yes _____ No _____**
   What medicine are you taking to treat your osteoporosis? _____

4. Do you take Calcium and Vitamin D? **Yes _____ No _____**

5. Have you ever had a fracture of your arm, hip, or spine? **Yes _____ No _____**

6. Have you fallen more than twice or fallen and hurt yourself in the past year? **Yes _____ No _____**

7. Have you had the influenza vaccination for the current flu season? **Yes _____ No _____**

8. Have you ever had the pneumococcal vaccine? **Yes _____ No _____**

9. Do you have an Advanced Care Plan? **Yes _____ No _____**

10. Have you used or smoked tobacco products in the last 24 months? **Yes _____ No _____**
    If yes, are you a tobacco smoker? **Yes _____ No _____**

11. Do you consume alcoholic beverages? **Yes _____ No _____**
    If yes, how much per setting? _____ Per week? _____

Please understand that smoking and consuming alcoholic beverages can impair your general health as well as your orthopaedic health.

Are you interested in quitting? **Yes _____ No _____**

Print name: _____

Patient signature: _____

Date: _____