



Adam D Perler, DPM, FACFAS

Podiatric Medicine
Foot and Ankle Reconstructive Surgery

Room # _____
X-ray taken _____
XR/MRI brought yes no
Facility _____

PATIENT HISTORY- Please print and fill out completely

Name: _____ Date of Birth: _____ Today's Date: _____
Age: ____ Height: _____ Weight: _____ Shoe Size: _____ Hand Dominance: Right Left
Primary Care Physician: _____ Doctors Phone/Fax #: _____
Email: _____
Pharmacy name, address and phone number: _____

HISTORY OF CURRENT CONDITION

Why are you here for an evaluation today? (It is important to fill out this section to the best of your ability)

Is the condition the result of an injury? Yes No If yes, what was the date of the injury? _____

The injury occurred during: sports injury motor vehicle accident work other _____

Please describe how the injury occurred: _____

How do you rate your pain? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Is the pain: Constant Occasional Sharp Dull Aching Burning Throbbing Stabbing
 worse in the am worse at pm present in bed worse with the first few steps out of bed worse with walking/standing

What symptoms are you experiencing? Burning Tingling Numbness Popping Giving Way Grinding

How long have you had this problem? (#) _____ Days Weeks Months Years

Have you experienced this problem in the past? Yes No

What makes your symptoms better? _____

What makes your symptoms worse? _____

What treatments have you tried? Rest Ice/heat Bracing/Arch Supports Injections Physical Therapy

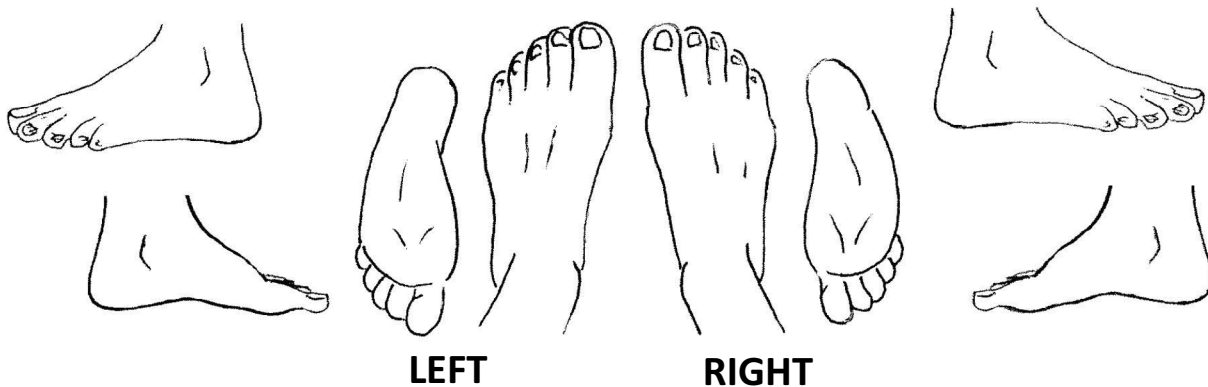
Medication: _____ Other: _____

Have you had any of the following tests? X-Rays MRI Scan CT Scan EMG/NCV Blood Test

Have you seen another foot/ankle doctor for this problem? No Yes Who: _____

Do you have any history of any prior foot/ankle injuries? No Yes: _____

Please mark the site of your pain/problem with an "X":



PAST MEDICAL HISTORY (please check all that apply)

- | | | | |
|----------------------------------------------|-----------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Hepatitis: A B C | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Arthritis: Gen or | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker/Stimulator | <input type="checkbox"/> Bladder Disorder | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes: __years | <input type="checkbox"/> Bone/Joint Disorder | <input type="checkbox"/> Keloid Formation |
| <input type="checkbox"/> Rheumatic Fever | o Diet-controlled | <input type="checkbox"/> Low Back Problems | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Stroke | o Oral Medication | <input type="checkbox"/> Gout | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Poor Circulation | o Insulin Dependent | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Pregnancy # _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Neurological Condition | <input type="checkbox"/> Births # _____ |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> History of Blood Clots | <input type="checkbox"/> Other _____ |

MEDICATIONS (Please include any supplements and vitamins)

Current Medications (name, strength and dose):

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

ALLERGIES (please also list any drug intolerances)

Are you allergic to any medications? **NO** **YES** Sulfa Latex Penicillin Tape Codeine Other: _____

Please specify the type of reaction you had to the above medication(s): _____

LIST ALL PREVIOUS HOSPITALIZATIONS/SURGERIES

None

<u>Procedure</u>	<u>Complications</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any complications with anesthesia in the past? Yes No **If yes, what type?**

FAMILY HISTORY (check all that apply and circle any involved family members)

DISEASE:

- Heart Disease Mother Father Sibling Child
- High Blood Pressure Mother Father Sibling Child
- Rheumatoid Arthritis Mother Father Sibling Child
- Diabetes Mother Father Sibling Child
- Cancer/Tumor Mother Father Sibling Child

FAMILY MEMBER:

DISEASE:

- Blood Clots Mother Father Sibling Child
- Stroke Mother Father Sibling Child
- Anesthesia Reaction Mother Father Sibling Child
- Similar Foot Problems Mother Father Sibling Child

FAMILY MEMBER:

SOCIAL HISTORY

What kind of work do you do? (Example: Student, secretarial, construction, teaching) _____

What kinds of physical demands do you have on your feet due work, school, or other activities? _____

What type of shoes do you typically wear? _____

Does your problem limit your work or activities? Yes No If yes, how much? _____

How would you describe your daily activity level prior to your injury? Active Moderately Active Not Active

Do you exercise regularly? Yes No If yes, what type of activity and how often? _____

Are you on a special diet? Yes No If yes, restrictions? _____

Do you smoke? Yes No Quit If yes, how many packs per day? _____ For how long? _____

Do you drink? Yes No Quit If yes, how often? (Number) _____

When was the Date of last physical examination? _____ Performed by: _____

REVIEW OF SYMPTOMS (these are symptoms you are currently experiencing)

GENERAL

- Fatigue
- Fever
- Weight Loss >10

SKIN

- Nail Changes
- New Lesions/ulcers
- Frequent Rashes
- Skin Color Changes

ENT

- Double Vision
- Loss of Vision
- Decreased Hearing
- Earache
- Nose Bleeds
- Dry Mouth
- Hoarseness
- Sore Throat

NECK

- Neck Pain
- Swollen Glands

RESPIRATORY

- Chronic Cough
- Decreased Exercise Tolerance
- Difficulty Breathing
- Coughing Up Blood
- Sputum Production
- Wheezing

CARDIOVASCULAR

- Chest Pain
- Leg Pains with walking
- Leg Swelling
- Night Awakening due to trouble Breathing
- Palpitations
- Shortness of Breath

GASTROINTESTINAL

- Abdominal Pain
- Change in Bowel Habits
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Heartburn/Ulcers
- Difficulty Swallowing

GENITOURINARY

- Vaginal Discharge
- Painful Urination
- Change in Urinary Stream
- Increased Frequency
- Blood in Urine
- Loss of Bladder Control
- Urinary Retention

MUSCULOSKELETAL

- Decreased Motion
- Joint Pain
- Joint Redness
- Joint Swelling
- Joint Stiffness
- Muscle Wasting
- Muscle Weakness
- Muscle Aches/Pains

NEUROLOGICAL

- Dizziness/Vertigo
- Headaches
- Numbness/Tingling
- Passing Out
- Seizures
- Tremor

PSYCHIATRIC

- Anxiety/Depression
- Change in Sleep Pattern
- Hallucinations
- Suicidal Thoughts

ENDOCRINE

- Appetite Changes
- Cold Intolerance
- Increased Thirst
- Increased Urination
- Hair Changes
- Sexual Dysfunction

HEMATOLOGY

- Easy Bruising
- Enlarged Lymph Nodes
- Prolonged Bleeding

Are You Pregnant

- Yes No

Are you claustrophobic

- Yes No

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 _____ and weight _____ Prefer not to answer
2. Have you had a Bone Density Study (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 or Dexa scan? Year: _____
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

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

10. Have you used or smoked tobacco products in the last 24 months? Yes No
 - If yes, are you a tobacco smoker? Yes No
 - Are you interested in quitting? Yes No
11. Do you consume alcoholic beverages? Yes No
 - If yes, how much per setting? _____ Per week? _____

Print name: _____

Date: _____

Patient signature: _____

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.

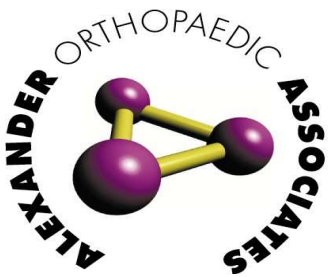
Advanced Medical Imaging	727-398-5999	Palms of Pasadena	727-341-7890
Bardmoor Imaging	727-461-8555	Pinellas High Field Imaging	727-347-4674
Central MRI	727-381-4674	Rose Radiology	727-531-5444
Largo Medical Center	727-588-5850	St. Petersburg General	727-341-4808
National PET Scan	727-471-1000	Tampa Bay 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



ALEXANDER **ORTHOPAEDIC** ASSOC.

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 breach 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:

<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Medication Sheets	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Facesheet	<input type="checkbox"/> Pathology
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Emergency Report
<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> EKG Report
<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Consultations	<input type="checkbox"/> 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 breach 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