

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.



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered**. This means that those services have **already been provided**.

H&P, X-rays, A&P

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (*PRINT or TYPE*)

Signature

Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (*Signature by his/ her own hand*):

Name (*PRINT or TYPE*)

Signature

Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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 CONSTITUTES 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 9th Street North, Ste A St. Petersburg, FL 33704

2114 Seven Springs Blvd. New Port Richey, FL 34655

1325 Belcher Road Palm Harbor, FL 34683

(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: _____

Alexander Orthopaedic Associates

12416 66th Street North, Suite A. Largo, Fl. 33773
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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



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

HIPAA 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

Alexander Orthopaedic Associates

12416 66th Street North, Largo, FL 33773
2438 9th Street North, Ste. A St. Petersburg, FL 33704
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CONSENT FOR TRANSFER OF BIOLOGICAL SPECIMEN

Florida law (Section 817.5655, Florida Statutes) prohibits the sale or transfer of a person's biological specimen from which DNA can be extracted to a third party without the express consent of such person.

During the course of your care at Alexander Orthopaedic Associates, it may be medically necessary to obtain a blood, urine, stool, tissue or other type of biological specimen for analysis. This analysis **will not** involve the examination of your DNA to identify the presence and composition of genes in your body. After the analysis has been performed and the sample is no longer needed, it will be stored as medical waste and then transferred to a third party for disposal in accordance with all local, state and federal requirements.

It may also be the case that a biological specimen (such as blood, urine, hair, bodily fluids, etc.) from you may be deposited on medical instruments, bedding, clothing or other objects. These objects may then be transferred to a third party for cleaning or disposal.

By signing this document, you affirmatively state that it is your intentional decision to consent to the transfer of any and all biological specimens collected by or deposited with Alexander Orthopaedic Associates to a third party as set forth above. This consent does not authorize the sale or transfer of a biological specimen for the purpose of DNA analysis.

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

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: _____

**ALEXANDER ORTHOPAEDIC ASSOCIATES
SPINE 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** _____

PLEASE CIRCLE THE PROBLEM YOU ARE SEEKING TREATMENT FOR TODAY:

- | | | |
|--------------------------|---------------------|-------------------------|
| Neck Pain | Arm Pain (R or L) | Arm Numbness (R or L) |
| Low Back or buttock pain | Leg Pain (R or L) | Leg Numbness (R or L) |
| Difficulty Walking | | |

HAVE YOU EVER HAD PROBLEMS WITH THIS AREA IN THE PAST? (please circle): **Yes** **No**

BRIEFLY DESCRIBE WHAT CAUSED YOUR SYMPTOMS

YOUR PAIN IS BEST DESCRIBED AS: (please circle)

Dull ache **Sharp** **Burning** **Electric Shock**

ONSET OF PAIN: How did you current symptoms start?

Injury (at work) _____ **exact date of injury**

Injury (not at work) _____ **exact date of injury**

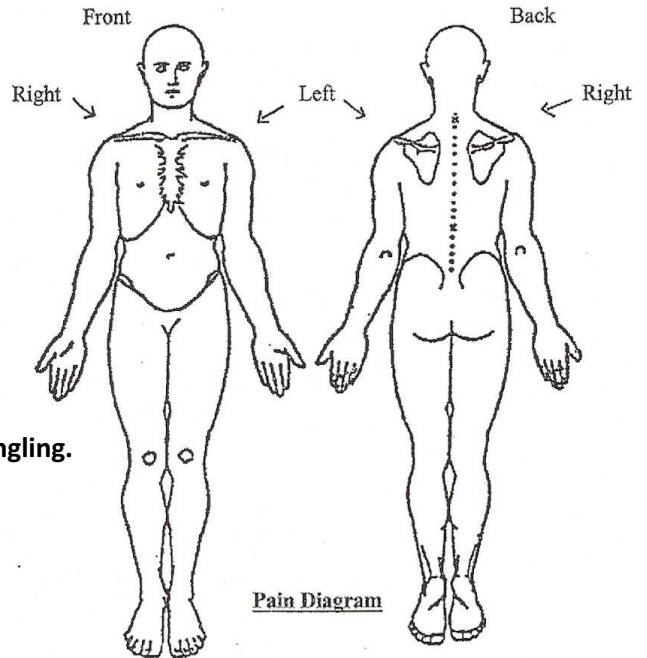
Motor Vehicle Accident _____ **exact date of accident**

Undetermined Other _____

WHERE IS YOUR PAIN NOW? (Use the diagram to the right)

Place an X in the area(s) you feel the most pain.

Place an O on the body diagram where you feel numbness/tingling.



WHAT IS THE PERCENTAGE OF YOUR PAIN? (totaling 100%)

Neck _____ + **Arm(s)** _____ = 100%

Back _____ + **Leg(s)** _____ = 100%

SEVERITY OF PAIN:

-In general, what is the intensity of your pain (circle one)?

NO PAIN **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **WORSE POSSIBLE PAIN**

-In general, how is this problem affecting your life (circle one)?

Nuisance **Minor Problem** **Major Problem** **Catastrophe**

TIMING OF PAIN: How often do you have your pain (circle one)?

Occasionally (less than 30% of the time) **Nearly constantly** (60-95% of the time)

Intermittently (30-60% of the time) **Constantly** (100% of the time)

PATIENT NAME: _____

PHARMACY NAME: _____

ADDRESS: _____

PHONE#: _____

RELIEVING AND AGGRAVATING FACTORS: How do the following affect your pain (please check one for each item):

	IMPROVES PAIN	NO CHANGE	WORSENS PAIN
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

Have you had any **recent** change in bowel or bladder habits? (please circle)

No **Yes** (please describe) _____

Have you experienced any of the following? (please circle)

Clumsiness in your hands difficulty with buttons changes in handwriting
Changes in the way you walk unsteadiness

ACTIVITIES AND YOUR PAIN: (please circle)

-How many blocks can you walk?

Less than a block 1-2 blocks 2-5 blocks 5-10 blocks Greater than 10 blocks

-To assist walking, I use a:

Cane Walker Wheelchair No assistance device

-How long can you stand for?

5 minutes 10 minutes 30 minutes 1 hour 1 hour +

-How often during the day do you lie down because of pain?

Never Seldom Sometimes Often Constantly

-I am NOT able to perform the following activities of daily living (please circle all that apply)

Doing yard work or shopping Performing household chores Going to work

Socializing with friends Participating in recreational activities Exercising

TREATMENTS FOR YOUR SPINE TO DATE: (please circle all that apply)

Physical Therapy

Tens Unit

Facet Blocks

Back Injections

Epidural Steroid Injections

Chiropractor

Medications

Spine Surgery (describe below)

Date of Spine Surgery	Title of Spine Operation	Hospital

PATIENT NAME: _____

PREVIOUS SURGERIES:

PAST MEDICAL HISTORY: (please check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GI Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding Disorders/Blood | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Renal Disease |
| <input type="checkbox"/> Clots | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Neurological Disorders | |

ALLERGIES: (circle all that apply) **Aspirin** **Codeine** **Latex** **Penicillin** **Sulfa** **None** **Other:** _____

Reaction: _____

CURRENT MEDICATIONS (name, strength and dose):

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

REVIEW OF SYSTEMS

Have you ever had any of these symptoms? If no, mark NONE

NONE YEAR **Details/Comments**

- | | | | | | |
|------------------------------------|--|--|---|--------------------------|-------|
| 1. GI | <input type="checkbox"/> Heartburn, Ulcers | <input type="checkbox"/> Nausea, Vomiting | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> | _____ |
| 2. ENDO | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heat or Cold Intolerance | | <input type="checkbox"/> | _____ |
| 3. EYE | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Loss | <input type="checkbox"/> | _____ |
| 4. ENT | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> | _____ |
| 5. CV | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | | <input type="checkbox"/> | _____ |
| 6. RS | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | _____ |
| 7. GU | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | _____ |
| 8. SK | <input type="checkbox"/> Frequent Rashes | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis | <input type="checkbox"/> | _____ |
| 9. NEU | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness | <input type="checkbox"/> | _____ |
| 10. PSY | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> | _____ |
| 11. HEM | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Anemia | <input type="checkbox"/> | _____ |
| 12. CON | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> | _____ |
| 13. Are you HIV Positive? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | Have you ever had Hepatitis A, B, or C? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes what type? _____ | | |
| 14. Are you pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 15. Are you Claustrophobic? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

FAMILY HISTORY

Have any direct relatives had any of the following disorders? If so, list your relative

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ |
| <input type="checkbox"/> Difficulty with anesthesia _____ | <input type="checkbox"/> Bleeding Problems _____ | <input type="checkbox"/> None known |

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

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

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

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.

Please understand that smoking can impair your general health as well as your orthopaedic health.

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

Print name: _____

Patient signature: _____

Date: _____