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 ina **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.

OIR-B1-1571
Pub. 1/2004

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 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: _____

11/13/17

Alexander Orthopaedic Associates

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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

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 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

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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: _____

Adam D Perler, DPM, FACFAS

Podiatric Medicine
Foot and Ankle Reconstructive Surgery

PATIENT HISTORY- Please print and fill out completely

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

Name:_____ **Date of Birth:**_____ **Today's Date:** 09/07/2022

Age: ____ **Height:**_____ **Weight:**_____ **Shoe Size**:_____ **Hand Dominance:** □ Right □ Left

Primary Care Physician:_____ **Doctors Phone/Fax #s:** _____

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

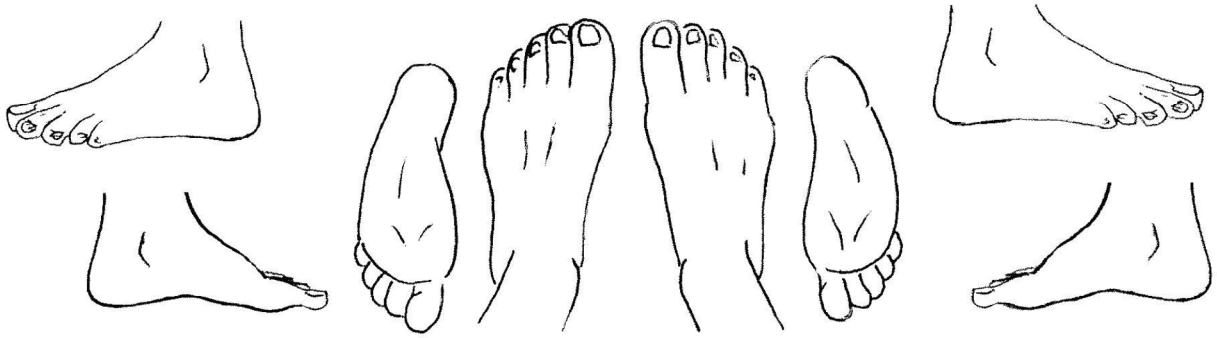
Medication:_____ Other: _____

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":



LEFT **RIGHT**

PAST MEDICAL HISTORY (please check all that apply)

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

Procedure	**Complications**	**Year**

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:	FAMILY MEMBER:
☐ **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
☐ **Blood Clots**	Mother Father Sibling Child
☐ **Stroke**	Mother Father Sibling Child
☐ **Anesthesia Reaction**	Mother Father Sibling Child
☐ **Similar Foot Problems**	Mother Father Sibling Child

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: _____