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:** _____

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

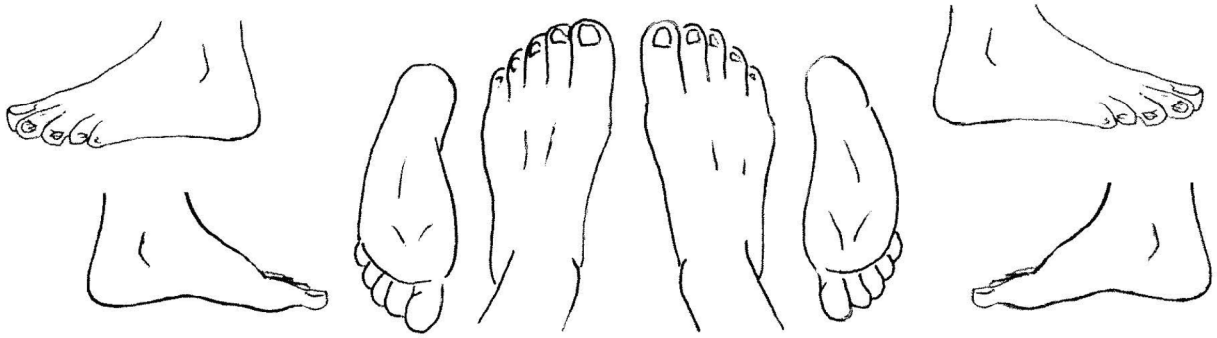
Medication:_____Other: _____

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

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 #_____

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

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.

<u>To be completed by the patient or personal representative:</u>

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: **<u>One Year</u>**

Alexander Orthopaedic Associates
12416 66th Street North, 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

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: _____

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 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.

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
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_____