

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.

AUTO 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

DEFERRED PAYMENT AGREEMENT (DPA):

1. Alexander Orthopaedic Associates (hereinafter “Practice”) hereby agrees to provide medically necessary care and treatment to the patient based upon the terms and conditions of this agreement.
2. I _____, (hereinafter referred to as “Patient”) do not currently have health insurance coverage or I do have health insurance coverage, however, I do not want to nor do I currently have the ability to comply with the contractual requirements for the use of those benefits, by timely paying the required out-of-pocket costs, co-pays, deductible, and/or any other forms of patient responsibilities required by my policy. As a result, I have requested and been granted an alternative payment arrangement with the Practice.
3. The Practice agrees to provide the medically necessary medical care and treatment and to bill me at the usual and customary rate. As the patient, I agree to satisfy any/all outstanding balance with the Practice upon the conclusion of my treatment.
4. Based upon this agreement the Practice will defer collection of these medical bills as set out below.
5. I understand and agree that I am personally responsible for any and all medical charges billed by the Practice for my treatment and that if at any time, I default on this obligation, I am subject to a collection action and/or civil litigation instituted by the Practice to recover the above medical debt. My obligations under this Agreement stand alone and are not subject to any other contingency or occurrence.
6. I understand that I have the right to request, in writing (the form will be providing by the practice upon request), an estimate of medical charges to be incurred prior to undergoing any treatment or procedure at the Practice.
7. If I have retained an attorney, I request and direct the Practice to follow my direction that any and all cost estimates for medical care and treatment and/or the actual medical billing for services provided be sent directly to his/her office so that I may consult and seek their counsel through my medical care and treatment.
8. The Practice agrees to defer the collection on any billings provided for 24 months from the date of my first medical treatment without interest.

If my medical debt remains due and owing at the conclusion of that time period, I agree to pay 5% Annual Percentage Rate (hereinafter referred to as “APR”) on the incurred medical debt for the third year the debt is due and owing.

I further agree to pay an additional 5% APR for each additional year the debt remains outstanding up to five years from the date of my first treatment at the Practice or a maximum of 15% interest APR. The above interest shall be compounded annually.

9. I, the Patient, enter into this agreement freely and voluntarily. I have had an opportunity to ask any and all questions of the Practice and I have been provided with satisfactory responses to those questions.
10. Additionally, I have had an opportunity to have this Agreement reviewed by an attorney of my choice prior to signing it.

Patient/Legal Guardian (if patient is a minor):

Practice Representative:

Print Name

Print Name

Signature

Signature

Date: _____

Date: _____

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** 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
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 ASSOCIATES

HISTORY & PHYSICAL

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

TODAY'S DATE: _____

PATIENT NAME: _____ Age: _____ DOB: _____

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

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

PRIMARY CARE _____

PREFERRED LANGUAGE (please circle): ENGLISH SPANISH OTHER _____

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

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

EXACT DATE PAIN BEGAN OR INJURY OCCURRED _____

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

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

HOW LONG HAVE YOUR SYMPTOMS BEEN PRESENT? _____

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

WHAT MAKES YOUR SYMPTOMS WORSE? _____

WHAT MAKES YOUR SYMPTOMS BETTER? _____

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

If yes, explain:

CURRENT MEDICATIONS (name, strength and dose):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

PAST MEDICAL HISTORY: (please check all that apply)

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

PATIENT NAME: _____

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

Reaction: _____

LIST ALL PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES: NONE

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

FAMILY HISTORY

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

- Diabetes _____ High Blood Pressure _____ Rheumatoid Arthritis _____
Difficulty with anesthesia _____ Bleeding Problems _____ None known

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

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

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

REVIEW OF SYSTEMS

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

NONE YEAR Details/Comments

- | | | | | | | |
|-----------------------------|--|--|---|--------------------------|-------|-------|
| 1. GI | <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. CON | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> | _____ | _____ |
| 4. EYE | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Vision Loss | <input type="checkbox"/> | _____ | _____ |
| 5. ENT | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> | _____ | _____ |
| 6. CV | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Palpitations | | <input type="checkbox"/> | _____ | _____ |
| 7. RS | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> | _____ | _____ |
| 8. GU | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> | _____ | _____ |
| 9. SK | <input type="checkbox"/> Frequent Rashes | <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis | <input type="checkbox"/> | _____ | _____ |
| 10. NEU | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness | <input type="checkbox"/> | _____ | _____ |
| 11. PSY | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Drug/Alcohol Addiction | <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> | _____ | _____ |
| 12. HEM | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Anemia | <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 | | | | | |

PHARMACY NAME _____

ADDRESS/CROSS STREETS _____

PHONE# _____

Patient Assessment

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

Please circle the correct answer or fill in the blanks.

1. What is your height _____ weight _____ Prefer not to answer _____
2. Have you had a Bone Density Study (also known as a Dexa scan) for osteoporosis at least once since age 60?
Yes _____ No _____
If yes, in what year did you have the most recent Bone Density Study? _____
3. Have you been on medicine to treat osteoporosis? Yes _____ No _____
If yes, has it been prescribed within 12 months? Yes _____ No _____
What medicine are you taking to treat your osteoporosis? _____
4. Do you take Calcium and Vitamin D? Yes _____ No _____
5. Have you ever had a fracture of your arm, hip, or spine? Yes _____ No _____
6. Have you fallen more than twice or fallen and hurt yourself in the past year? Yes _____ No _____
7. Have you had the influenza vaccination for the current flu season? Yes _____ No _____
8. Have you ever had the pneumococcal vaccine? Yes _____ No _____
9. Do you have an Advanced Care Plan? Yes _____ No _____
10. Have you used or smoked tobacco products in the last 24 months? Yes _____ No _____
If yes, are you a tobacco smoker? Yes _____ No _____
11. Do you consume alcoholic beverages? Yes _____ No _____
If yes, how much per setting? _____ Per week? _____

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

Are you interested in quitting? Yes _____ No _____

Print name: _____

Patient signature: _____

Date: _____

**Alexander Orthopaedic Associates
Minor Paperwork**

If the patient is under the age of 18, please complete the following:

Patient Name: _____ **Date:** _____

Social Security # _____ **Date of Birth:** _____

Please circle: M or F **Race:** _____ **Language** _____ **Ethnicity** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

Mother's Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

Father's Name: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone:** _____

INSURANCE INFORMATION for the Minor:

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 #** _____

I hereby authorize treatment of the above mentioned patient, as the parent or legal guardian. In my absence I authorize the following person's to accompany the patient to his/ her office visits, diagnostic testing, and or physical therapy visits.

Name to accompany minor **Relationship to patient**

Name to accompany minor **Relationship to patient**

Signature **Printed Name**

Relationship to patient **Date:**

Please press the Done button to submit. Thank you! ↓