

DR. STEVEN STEINLAUF

Please fill out form thoroughly

ACCOUNT # _____

LAST NAME: _____ PRIMARY CARE DR: _____

FIRST NAME: _____ REFERRING DR: _____

ADDRESS: _____ DOB: _____

APT# _____ SEX: _____ MALE _____ FEMALE

CITY: _____ MARITAL STATUS: _____

STATE _____ ZIP: _____ COUNTRY: _____ SOCIAL SECURITY #: _____

HOME #: _____ CELL #: _____

WORK#: _____ EXT: _____ WORK STATUS: FULL TIME/PART TIME/ STUDENT/RETIRED

EMPLOYER: _____ POSITION: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____

RELATION: _____ ADDRESS: _____

PHONE #: _____

INSURANCE NAME: _____ ADDRESS: _____

POLICY HOLDER: _____ DOB: _____ RELATION TO PATIENT: _____

PATIENT'S EMAIL ADDRESS: _____

RACE: AMERICAN INDIAN/BLACK/WHITE/OTHER ETHNICITY: _____ HISPANIC/LATIN _____ NON HISPANIC/NON LATIN

PHARMACY: _____ PHONE#: _____

CITY: _____ OR CROSS ROADS: _____

O.K. TO LEAVE A MESSAGE: _____ HOME _____ CELL _____ WORK

_____ VOICEMAIL _____ TEXT _____ AM _____ PM PRIMARY LANGUAGE: _____ ENGLISH _____ SPANISH

PART OF THE BODY BEING SEEN FOR: _____ RIGHT _____ LEFT

DATE OF ONSET INJURY: _____

WAS ILLNESS OR INJURY DUE IN ANY WAY TO: (PLEASE CHECK ONE)

WORK INJURY: _____ AUTO ACCIDENT: _____ ANY OTHER ACCIDENT: _____ NONE: _____

Current Medication:

_____ MG _____ How do you take it _____

_____ MG _____ How do you take it _____

_____ MG _____ How do you take it _____

_____ MG _____ How do you take it _____

_____ MG _____ How do you take it _____

_____ MG _____ How do you take it _____

Medical History: (Example) High Blood Pressure, Diabetic, etc.

Allergies/intolerances: _____

Surgical History:

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Date: _____ Procedure: _____

Hospitalization non-surgical: (Example-Kidney stones or Pneumonia)

Date: _____ Reason: _____

Date: _____ Reason: _____

Family History	Status (Please circle)	History of: Diabetes	Arthritis	High BP	Heart	Stroke	Cancer
Mother	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Father	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Daughter	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Son	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Paternal Grandfather	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Paternal Grandmother	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Maternal Grandmother	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____
Maternal Grandfather	ALIVE/DECEASED	_____	_____	_____	_____	_____	_____

Social History: Smoke/alcohol use

_____ Currently Smoking _____ Stopped smoking _____ Never smoked

_____ Drink occasionally _____ Recovering alcoholic _____ Weekends only _____ Non drinker

FOR PATIENTS WITH FOOT AND ANKLE PROBLEMS

The doctor will discuss your current problem with you in detail. The following questions are intended to give an overview of how it is affecting you now. Please select the best choice for each item.

Do you have pain?

- None
- Mild, occasional
- Moderate, daily
- Severe, almost always present

What is your activity level?

- No limitation, no support needed
- No limitation of daily activities, limitation of recreational activities – no support needed daily
- Limited daily and recreational activities - cane
- Severe limitation of daily and recreational activities – cane, walker, crutches, wheelchair, or brace needed daily

Footwear requirements:

- Fashionable, conventional shoes – no inserts required
- Comfortable footwear and / or shoe inserts
- Modified shoes or brace

Maximum walking distance:

- Greater than 6 blocks
- 4-6 blocks
- 1-3 blocks
- Less than 1 block

Walking surfaces:

- No difficulty on any surface
- Some difficulty on uneven terrain, stairs, inclines, or ladders
- Severe difficulty on uneven terrain, stairs, inclines, or ladders

Thank you for completing this questionnaire. It will become part of your permanent medical record and will play an important part in understanding your current situation and following you in the future.

Reviewed by: _____

Date: _____

ORTHOPAEDIC

ASSOCIATES OF SOUTH BROWARD, P.A.

(954) 961-3500 Fax: (954) 961-1835

RICHARD E. STRAIN, JR., M.D., F.A.C.S.
WARREN GROSSMAN, M.D., F.A.C.S.
STEVEN D. STEINLAUF, M.D.
CHRISTOPHER WONG, M.D.

Diplomates of the American Board of Orthopaedic Surgery

4700 Sheridan Street
Suite H
Hollywood, Florida 33021

1 S.W. 129th Avenue
Suite #401
Pembroke Pines, Florida 33028

7800 S.W. 87 Avenue
Suite A-110
Miami, Florida 33173

CONSENT FOR MEDICAL CARE: I authorize the patient's doctors to determine what kind of treatment must be done to learn more about the patient's condition. Further, I authorize the personnel of Orthopaedic Associates of South Broward, P.A. to give treatment which I may receive. I understand that medicine is not an exact science and acknowledge that no guarantee or assurance has been made as to the result of treatment, tests, or examinations.

RELEASE OF INFORMATION: I hereby authorize Orthopaedic Associates of South Broward, P.A. to disclose all or part of my records to any person or corporation which is required to pay for all or part of the physician's charge.

ASSIGNMENT OF BENEFITS: I hereby irrevocably assign payment to Orthopaedic Associates of South Broward, P.A., accepting this assignment of all medical benefits applicable and otherwise payable to me. I certify that the information given to me in applying for payment is correct and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for the charges for which the carrier denies payment.

PAYMENT: I understand that it is my responsibility to obtain any needed authorization for treatment according to my individual insurance policy. In the event that I fail to do so I agree to pay any and all fees / costs incurred by Orthopaedic Associates of South Broward, P.A. to enforce this agreement, including but not limited to collection costs, interest / service charges, court costs, and attorney's fees.

Print Patient Name: Last, First, Middle Initial

Patient's Signature

Date

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Policy and procedure for narcotic pain medications

The policy of this office is not to prescribe any narcotic pain medications after normal business hours (9:00 a.m. to 5:00 Monday through Friday). We will attempt to fill appropriate medication request in a timely fashion; however, the office requires at least 48-hours notice to prepare your prescriptions. Therefore, please plan ahead. In addition, any patient who knowingly obtains narcotic pain medications from other treating physicians while under the care of our Drs. without this office's knowledge may lead to dismissal from this practice. It should be noted that this is illegal and will not be tolerated.

In an effort to provide you with the highest level of care and the most appropriate pain relief, I will utilize different medications and pain management techniques. During the course of your treatment you may be prescribed a narcotic analgesic. Please note that these medications are effective in alleviating but not completely eliminating pain. Please also note that they are highly addictive and in the United States prescription opiate overdose is the second leading cause of accidental death, resulting in excess of 12,000 deaths per year. For this reason, I will prescribe narcotic analgesics appropriately but also in a manner fitting the nature of your injury or surgery. In other words, we will do all that we can together to limit the amount of narcotic analgesics that are prescribed.

I have read the above policy and agree to adhere to the conditions set forth.

Printed Name and Date

Patient Signature

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This letter is to inform all patients of Orthopaedic Associates of South Broward, PA that our physicians do participate in a residency training program through the University of Miami. During this course of residency training, the residents are expected to participate in all aspects of patient care. This will include evaluations in the office and in the hospital as well as assisting in surgical procedures.

Considering this, if you agree and give informed consent for the residents to participate in your care, please sign below.

We sincerely thank you for helping further the education of our future generation of orthopedic surgeons.

Printed Name and Date

Patient Signature

In addition, our physicians mentor high school and university students. They are simply observers. If you are willing to allow them to observe, please sign below.

We sincerely thank you for helping further the education of our future generation of orthopaedic surgeons.

Print Name and Date

Patient Signature

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from Orthopaedic Associates of South Broward, P.A.

_____ Date _____
Patient Signature

In lieu of patient signature, I, _____, a staff member of Orthopaedic Associates of South Broward, P.A., state that _____ has been given our current Notice of Privacy Practices

_____ Date _____
Staff Signature

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign this form (Initials _____)
- Communication barriers prohibited obtaining the acknowledgement (Initials _____)
- An emergency situation prevented us from obtaining the acknowledgement (Initials _____)
- Other _____ (Initials _____)

ORTHOPAEDIC FOOT AND ANKLE INSTITUTE OF SOUTH FLORIDA

To All of my Patients,

First and foremost I want to thank you for choosing the Orthopaedic Foot and Ankle Institute of South Florida for your treatment. It is my pleasure to care for you and I will do everything that I can to help you achieve the outcome that you desire. As an orthopedic surgeon and educator, I am active in the research and development of new implants and improved surgical instruments and techniques. As part of this work, I work under contract with orthopedic companies providing consulting services on new products and input on research and development.

Currently, I am a consultant for Smith and Nephew Orthopedics. In this role I have helped to design an implant system made by Smith and Nephew Orthopedics. I do receive royalties from Smith and Nephew Orthopedics. During any surgical procedure that you may undergo, I may or may not use Smith and Nephew implants. I utilize implants that I feel are most suited for the problem that you have. If you have any questions about this, it would be my pleasure to answer these questions. In addition, I give instructional lectures on implants and surgical techniques for other doctors and medical personnel. In return for this time and expertise I am paid a consulting fee by Smith and Nephew Orthopedics. In addition, I am a paid consultant for Don-Joy Orthopedics. This is a company that specializes in multiple products, one being bone growth stimulators. In the course of your treatment, I may prescribe a bone growth stimulator. This may or may not be a Don-Joy product. If you have any questions regarding this issue, please do not hesitate to ask.

I would like to inform you that I have ownership interest in Miramar Surgery Center, you may or may not be scheduled for surgery in this facility.

It should be noted that I am a member of the American Academy of Orthopaedic Surgeons (AAOS), which holds its members to extremely high ethical standards to insure that even the appearance of a conflict of interest does not jeopardize the trust that patients place in our doctors. The American Academy of Orthopaedic Surgeons has adopted standards of professionalism that require orthopedic surgeon members to identify and disclose potential conflicts of interest to their patients, the public, and colleagues. These standards also clearly articulate how and under what circumstances the American Academy of Orthopaedic Surgeons members may work with and be compensated by industry, as well as the penalties for failure to comply. It is important to my practice that you are aware of these relationships with implant manufacturers, that my practice puts the interest of patients first, and that we are available to answer any questions that you may have.

Sincerely,

Steven D. Steinlauf, M.D.

Patient Signature

Date

ORTHOPAEDIC ASSOCIATES OF SOUTH BROWARD, P.A.

Deep Venous Thrombosis / Pulmonary Embolism "Blood Clots"

Dr. Steinlauf or Dr. Wong are providing this information to educate all patients about the potential risks of deep venous thrombosis and pulmonary embolism. These entities are commonly referred to as "Blood Clots." Blood clots can develop in association with orthopedic problems related to the foot, ankle, and lower extremity. The blood clots can form in the veins of a patient's legs and in some instances the blood clots can travel to a patient's lungs, killing the patient. Certain conditions have a higher risk of leading to blood clots. Certain patients may also have risk factors that predispose them to forming blood clots.

Certain medications can be utilized to decrease but not eliminate the risk of forming a blood clot. That being stated, there is no formal recommendation from the American College of Chest Physicians, the American Academy of Orthopedic Surgeons, or the American Foot and Ankle Society for giving patients, with problems related to the foot, ankle, or leg below the knee, medicines to decrease the risk of forming blood clots. Formal recommendations by the American College of Chest Physicians are for patients to mobilize (move) to the best of their ability in an effort to decrease their risk of venous thromboembolism after any type of surgery to the foot, ankle, or lower leg below the knee. Several studies also support not giving patients medications to prevent blood clots after foot, ankle, or lower leg surgery because of the low risk of forming a blood clot.

If there is not a good reason for using powerful medicines to decrease the risk of getting blood clots, there is some evidence that aspirin in the form of one aspirin tablet daily (either baby aspirin or 325 mg aspirin) can be taken to decrease the risk of getting a blood clot. If it is felt that a patient is at higher risk for getting a blood clot, then there may be a reason for giving powerful medicines to decrease the risk of getting a blood clot. With all of this being stated, Dr. Steinlauf or Dr. Wong will discuss with you your own risks of blood clots and whether or not he feels that it is necessary for you to receive any form of medicine or rather to simply mobilization (move more).

It should be known that with powerful medicines such as Coumadin, Lovenox, Arixtra, Fragmin, Xarelto, or any newer medicines there are

significant risks. These risks include, but are not limited to, bleeding into the surgical site leading to significant complications; the risk of sustaining a fall while recovering from any type of orthopedic condition leading to a bleed into your brain or a bleed into another area of the body which could prove deadly; the risk of bleeding into your stomach; the inherent risk in utilization of some of these medicines of forming Heparin induced thrombocytopenia; and other potential complications. The benefits of powerful medicines are potentially lowering the chances of a fatal blood clot. The benefits of aspirin utilization are that in some studies there is a decreased risk of forming a blood clot with fewer risks. That being stated, aspirin itself is not without some potential risk.

Considering that this is a complicated issue, you are encouraged to ask Dr. Steinlauf or Dr. Wong questions about the need for medications to prevent venous thromboembolism, and he will do his best to answer all of your questions. Finally, if at any time throughout your treatment you develop calf pain, calf swelling, chest pain, or shortness of breath, it is recommended that you contact our office but at the same time go to an Emergency Room to be evaluated for a venous thromboembolic disease and to be treated appropriately.

Thank you,

Steven D. Steinlauf, M.D.
Christopher Wong, M.D.

I have read and understand the above material, have asked Dr. Steinlauf or Dr. Wong all of my questions, have had my questions answered to my satisfaction, and have received a copy of this form.

Signature _____ Date _____

dd: 2/20/12
dt: 2/21/12
revised 07/30/2014

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Orthopaedic Associates of South Broward, PA and its Affiliated Providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacies may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Patient Signature and Date

Orthopaedic Associates of South Broward

REVIEW OF SYMPTOMS

Please circle one:

General:

Fever
Yes or No

Chills
Yes or No

Allergies:

Rash
Yes or No

Hives
Yes or No

Ophthalmology:

Blurred vision
Yes or No

Diminished vision
Yes or No

ENT:

Difficulty swallowing
Yes or No

Respiratory :

Wheezing
Yes or No

Short of breath at rest
Yes or No

Cardio:

Chest pain at rest
Yes or No

Difficulty breathing on exertion:
Yes or No

GI:

Blood in stool
Yes or No

Vomiting blood
Yes or No

GU:

Blood in urine
Yes or No

Painful urination
Yes or No

Neuro:

Difficulty Speaking
Yes or No

Seizures
Yes or No

Psych:

Substance abuse
Yes or No

Loss of Appetite
Yes or No