ORTHOPÆDIC
ASSOCIATES OF SOUTH BROWARD, P.A.

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.
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DR. **Strain**

NEW PATIENT INFORMATION, ADULT

PATIENT'S NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH AGE		TODAY'S DATE
LOCAL ADDRESS	APT. #	CITY	ZIP CODE	PHONE #
OUT OF STATE ADDRESS	APT. #	CITY STATE	ZIP CODE	CELL #
PATIENT'S SOC. SEC. #	PATIENT'S EMPLOYER			OCCUPATION
ADDRESS OF EMPLOYER		CITY	ZIP CODE	PHONE #
NAME & ADDRESS OF GROUP HEALTH BENEFIT CARRIER				PHONE #
SPOUSE'S FULL NAME	SPOUSE'S SOC. SEC. #			SPOUSE'S DATE OF BIRTH
EMPLOYER OF SPOUSE				OCCUPATION
ADDRESS OF EMPLOYER		CITY	ZIP CODE	WORK PHONE #
REFERRING DOCTOR:				PHONE #
NAME OF PRIMARY DOCTOR:				WHAT MEDICATION IS PATIENT ALLERGIC TO?
ADDRESS				
DR. TELEPHONE NO.	PATIENT BEEP:	PATIENT E-MAIL:		
DATE OF ONSET OF ILLNESS OR INJURY		AREA OF BODY TO BE EXAMINED		

WAS ILLNESS OR INJURY DUE IN ANY WAY:		REMARKS (If claim is due to an accident, state when, where, and how it occurred)
a. To a Worker's Comp. accident	☐ Yes ☐ No	
b. To an automobile accident	☐ Yes ☐ No	
c. Any other type of accident	☐ Yes ☐ No	
If any of the above are answered "yes", give details in " Remarks"		

HEALTH INSURANCE	NAME & ADDRESS OF PRIMARY HEALTH INSURANCE COMPANY	POLICY # OR MEDICARE #
AUTO INSURANCE (If auto accident)	NAME & ADDRESS OF AUTO INSURANCE COMPANY	POLICY #

HOW ARE YOU PAYING TODAY? ☐ CHECK ☐ CREDIT CARD ☐ CASH

IN CASE OF EMERGENCY NOTIFY:

PLEASE READ CAREFULLY AND SIGN. THANK YOU!

A service charge of 1% per month will be added on any account not paid within 60 days after the initial billing. If the undersigned fails to make payment when due, the undersigned promises to pay all collection fees and costs incurred to the extent permitted by law.

I authorise the release of any payment and medical information necessary to process this claim

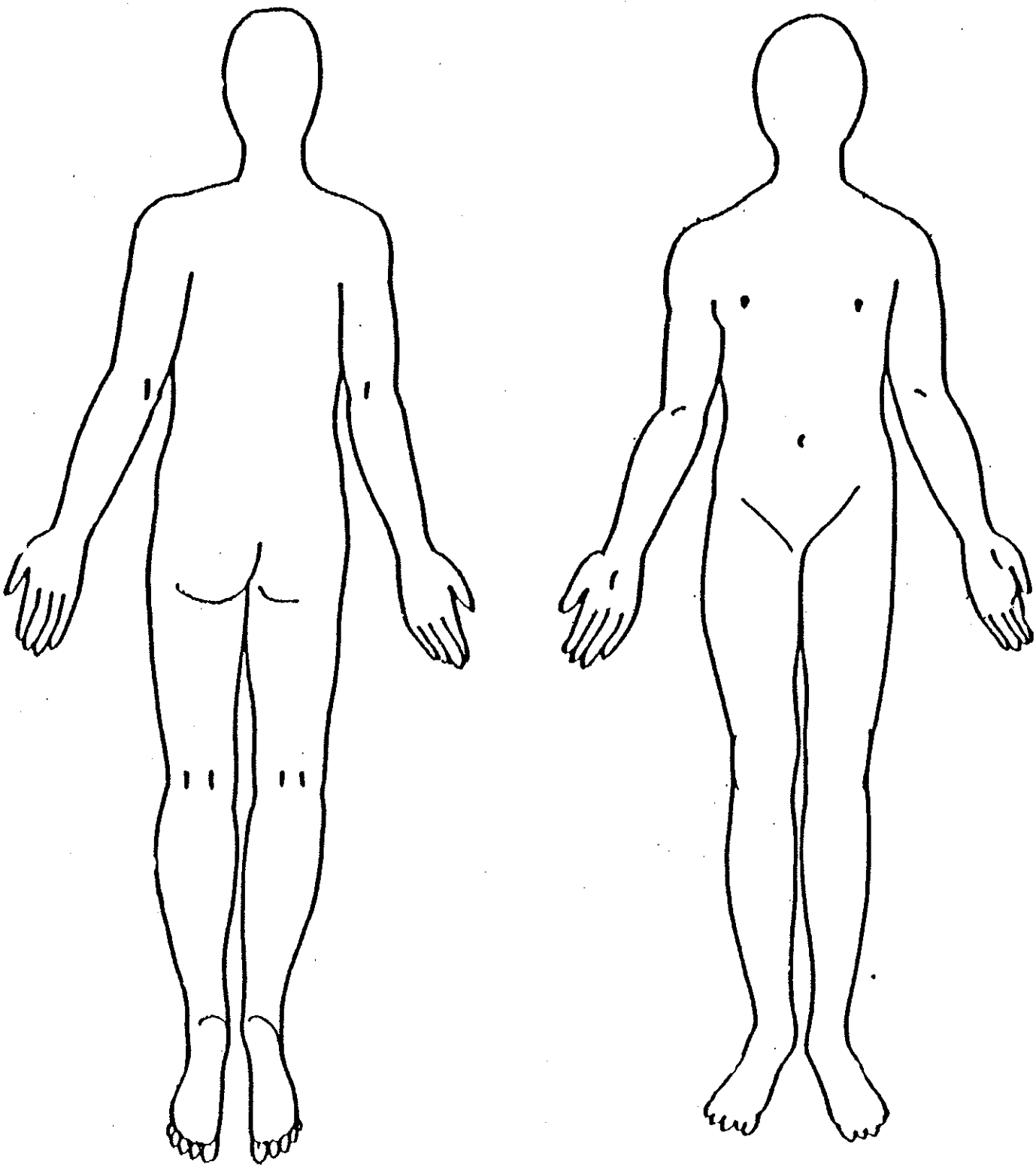
_____
Signature of person responsible for paying bill

Signed _____

NAME:_____ DATE:_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation, include all affected area.

	****		OOOO		XXXX		////
NUMBNESS	****	PINS & NEEDLES	OOOO	BURNING	XXXX	STABBING	////
	****		OOOO		XXXX		////



ORTHOPÆDIC
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Richard E. Strain, M.D.
Warren Grossman, M.D.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ SSN: _____

Reason for Today's Visit: _____

Current problem is the result of a (check all that apply):

❑ Car accident ❑ Work accident ❑ Other accident ❑ Other _____

Current Medication	Dose	Reason for Medication	Side Effects

Allergies: _____

Are all your immunizations up to date? ❑ Yes ❑ No – If no, which ones? _____

Review of Systems

Are you currently having problems or have had problems with (describe all "yes" responses) –

Eyes	❑ No	❑ Yes	_____
Ears, Nose, Throat	❑ No	❑ Yes	_____
Lungs / breathing	❑ No	❑ Yes	_____
Digestion	❑ No	❑ Yes	_____
Bowel movements	❑ No	❑ Yes	_____
Bladder problems	❑ No	❑ Yes	_____
Diabetes	❑ No	❑ Yes	_____
High blood pressure	❑ No	❑ Yes	_____
Bleeding problems	❑ No	❑ Yes	_____
Balance problems	❑ No	❑ Yes	_____
Numbness / tingling	❑ No	❑ Yes	_____
Blackouts / fainting	❑ No	❑ Yes	_____
Psychological issues	❑ No	❑ Yes	_____
Tired or weak	❑ No	❑ Yes	_____
General health	❑ No	❑ Yes	_____

Reviewed by: _____ Date: _____

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Warren Grossman, M.D.

Past Medical History

Check all of the medical problems you have had in the past (even if currently resolved)

- ❑ I have no known medical problems
- ❑ High blood pressure
- ❑ Coronary artery disease
- ❑ Peripheral vascular disease
- ❑ Heart attack -- Dates _____
- ❑ Adult onset diabetes
- ❑ Childhood onset diabetes
- ❑ Asthma
- ❑ COPD
- ❑ Ulcers
- ❑ Hepatitis
- ❑ Liver disease
- ❑ Cancer -- Type _____
- ❑ Immune disorder
- ❑ Tuberculosis
- ❑ Overweight
- ❑ Arthritis -- Type / location _____
- ❑ Other - _____

Prior Medications

_____

_____

_____

Past Surgeries / Hospital	**Year**	**Complications**

Have you ever been diagnosed with - ❑ HIV ❑ Cancer ❑ Polio ❑ TB ❑ Epilepsy ❑ Arthritis ?

Have you ever had general anesthesia? ❑ No ❑ Yes

Have you ever had problems with anesthesia? ❑ No ❑ Yes _____

Reviewed by: _____ Date: _____

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Family History

Member	Alive	Deceased	Health Status / Cause of Death
Father	❑	❑	_____
Mother	❑	❑	_____
Grandfather (mom)	❑	❑	_____
Grandmother (mom)	❑	❑	_____
Grandfather (dad)	❑	❑	_____
Grandmother (dad)	❑	❑	_____
Sister / brother	❑	❑	_____
Sister / brother	❑	❑	_____
Sister / brother	❑	❑	_____

Social History

❑ Student ❑ Housewife ❑ Retired ❑ Employed full time ❑ Employed part time
❑ Unemployed ❑ Disabled (since _____) Employer - _____

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Do you live: ❑ Alone ❑ With spouse ❑ With family ❑ With friends ❑ Other
Exercise: ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never
What type of exercise? _____
Children? ❑ No ❑ Yes – ages _____
History of substance abuse? ❑ No ❑ Yes – type _____
Smoke currently? ❑ No ❑ Yes - _____ packs daily for _____ years
Quit smoking? ❑ This year ❑ >1 year ❑ >5 years ❑ >10 years
Previously smoked - _____ packs per day for _____ years
Drink alcohol? ❑ Daily ❑ 1-2x / week ❑ 1-2x / month ❑ 1-2x / year

Reviewed by: _____ Date: _____

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Joint Pain Questionnaire

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____

Occupation: _____

Hobbies / Sports: _____

Problem Joint(s): _____

Do you currently use: ❑ Cane ❑ Crutches ❑ Walker ❑ Wheelchair

Do you have difficulty with stairs? ❑ Yes (explain) _____

❑ No

Do you need arm support to arise from a chair? ❑ Yes

❑ No

Are you able to cut your toenails? ❑ Yes

❑ No

Are you able to tie your shoes? ❑ Yes

❑ No

Current or previous pain medications: 1) _____

2) _____

3) _____

Arthritis medications: _____

Other medications: _____

Have you had previous orthopaedic operations? ❑ Yes ❑ No

If yes – please list: _____

Other previous operations: _____

Do you have any medical problems? ❑ Yes ❑ No

If yes – please list: _____

Allergies: _____

Name of primary care physician: _____

Reviewed by: _____ Date: _____

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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 Assocaites 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 _____)

AUTOMATIC APPOINTMENT REMINDERS

How would you like to be contacted for your next appointment reminder?

Please choose from the following:

Voice message at home_____

or

Voice message on cell_____

or

Text message_____

Phone number:_____

Preferred language: English_____ Spanish_____

Preferred time to be called: morning_____ afternoon_____ evening_____

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

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Suite #2
Miami, Florida 33136
(305) 873-6800

Please fill out the information below.

PHARMACY NAME: _____

ADDRESS:

_____

_____

_____

_____

PHONE: (_____)_____-_____

FAX: (_____)_____-_____

IF ADDRESS IS UNKNOWN PLEASE GIVE US THE CITY NAME AND THE TWO CROSSROADS OF THE LOCATION OF YOUR PREFERRED PHARMACY:

_____

_____

_____