B/C

ORTHOPÆDIC
ASSOCIATES OF SOUTH BROWARD, P.A.

DR.CHRISTOPHER WONG

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 recreactional 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: ____________________

ORTHOPÆDIC
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 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 _____)

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.
Chirstopher 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

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

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 Rx Hub 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 Date