ORTHOPÆDIC
ASSOCIATES OF SOUTH BROWARD, P.A.

DR.WARREN GROSSMAN

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: ________

Have you ever been in a work related accident________ Auto accident__________ Any other accident_____

If so, what part of your body was injured____

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____________________

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

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 _____)

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

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