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.
CHRISTOPHER WONG, M.D.
MARC IALENTI, 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

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, PA to give treatment which I may receive. I understand that medicine is not an exact science, and acknowledge that no guarantee or assurance had been made to as to the results of treatment, test or examinations.

RELEASE OF INFORMATION: I hereby authorize Orthopaedic Associates of South Broward, PA 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, PA, accepting this assignment, of all medical benefits applicable and other wise 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, 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, PA to enforce this agreement.

_____
Print Patient Name: Last, First, 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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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____ have received the notice of privacy practices from Orthopaedic Associates of South Broward, PA

_____ _____

Patient Signature Date

In lieu of patient signature, I _____ a staff member of Orthopaedic Associates of South Broward,PA, state that _____ has been given the opportunity to obtain our current Notice of Privacy Practices

_____ _____

Staff Signature Date

**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 form

_____Communication barriers prohibited obtaining acknowledgement

_____Emergency situation prevented us from obtaining acknowledgement

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

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 Orthopaedic Associates of South Broward, P.A., 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 Orthopaedic Associates of South Broward, P.A. 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	
Personal Representative	
Date	