

ORTHOPAEDIC ASSOCIATES OF SOUTH BROWARD, P.A.

WARREN GROSSMAN, M.D. Account#

LAST NAME _____ PCP _____

FIRST NAME: _____ REFERRING DR: _____

ADDRESS #1 _____ DOB: _____

APT# _____ MALE /FEMALE

CITY: _____ MARITAL STATUS: _____

STATE: _____ Zip: _____

Home#: _____ Cell#: _____ Employer: _____

Work#: _____ Ext# _____ Full Time/ Part time/ Student/Retired

Insurance Name: _____ Policy holder: _____

Policy number: _____

Emergency Contact Name: _____

Relation: _____ Phone# _____

Patient email address: _____

Race: __American Indian__ Black _____ White _____ Other _____ Ethnic: Latin/ Non Latin

Pharmacy Name: _____ Phone #: _____

Cross roads: _____ Preferred Language _____ English _____ Spanish

Part of the body being seen: _____ ___ 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 seen previously for: _____ Work injury _____ Auto Accident _____ Other _____

Explain when and what 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 _____

_____ 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: _____ What _____

Date: _____ What _____

Date: _____ What _____

Hospitalization;(Example-Kidney stones or Pneumonia)

Date: _____ What: _____

Date: _____ What: _____

Family History:

Mother ALIVE / DECEASED

Father ALIVE / DECEASED

Daughter ALIVE / DECEASED

Son ALIVE / DECEASED

Paternal Grand Father ALIVE/ DECEASED

Paternal Grandmother ALIVE / DECEASED

Maternal Grandmother ALIVE / DECEASED

Maternal Grandfather ALIVE / DECEASED

Social History: Smoking _____ No _____ Yes

____ Drink occasionally Recovering _____ Weekends only ____ Non Drinker

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.
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	