ALL-PRO

Orthopedics and Sports Medicine

Dr. Jesse Shaw
17779 SW 2nd Str.
Pembroke Pines, FL 33029

2013 PATIENT INFORMATION

Name(First) _____ (M) _____ (Last) _____ Marital Status: _____

Address: _____ Apt No: _____

City _____ State _____ Zip _____

HomePhone _____ Cell Phone _____ Email: _____

DOB: _____ Age _____ Sex _____ Social Security No: _____ Occupation: _____

Language: English Race: _____ Ethnicity: _____

Employer/School _____ Business Phone: _____

Pharmacy Name _____ Pharmacy Phone: _____

If patient is a minor: Parent/Guardian name _____ DOB: _____

Who may we thank for referring you to us? _____

Primary care physican _____ Phone _____

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name: _____ Relationship: _____ Phone: _____

Address: _____ Apt No: _____ City: _____ State _____ Zip _____

PRIMARY INSURANCE

Insurance Company: _____

ID#: _____ Group# _____

Insured's full name: _____ Insured SS# _____ Insured DOB _____

Relationship to Insured (self, spouse, child, other) _____

SECOND INSURANCE

Insurance Company: _____

ID#: _____ Group# _____

Insured's full name: _____ Insured SS# _____ Insured DOB _____

Relationship to Insured (self, spouse, child, other) _____

SIGNATURE OF PATIENT, PARENT OF LEGAL GUARDIAN: _____ DATE: 12/25/2018

ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

INSURANCE AUTHORIZATION AND ASSIGNMENT OF DENEFITS

I bereby authorize payment of insurance benefits to be made directly to All-Pro Orthopedics ans Sports Medicine for services provided to me by All-Pro Orthopedics. I understand that i am financially responsible to All-Pro Orthopedics and Sports Medicine for charges not covered by this assignment. I authorize All-Pro Orthopedics and Sports Medicine to refund overpayment of insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. This is authorization will remain in effect until revoked in writting by the undersigned

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Patient Signature: _____ Date 12/25/2018 :

PATIENT CONSENT TO TREATMENT AT ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

I give my consent for evaluation and treatment to All-Pro Orthopedics and Sports Medicine, and its staff members. I unerstand I may rescind this consent at any time, formally in writing, and then will not permit or receive further treatment. As regards the treatments which may be rendered to me at All-Pro, these may include the following:

Initial examination, follow up examination, radiographs, injections, fluid drainage, medications for pain, muscle spasm or inflammation. This will be at the discretion and judgment of me and my medical physician.

Patient Signature: _____ Date 12/25/2018 :

Witness name & signature: _____ Date 12/25/2018 :

Jesse Shaw, Orthopedic Surgeon www.AllProOrthopedics.com

17779 SW 2nd Street, Pembroke Pines, FL 33029
Phone 954-322-1110 fax 954-322-1099

All-Pro Orthopedics & Sports Medicine P.A
17779 SW 2nd Street
Pembroke Pines, FL 33029
Phone: (954) 322-1110
Fax: (954) 322-1099

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. to use health information about you for treatment, payment, and health care operations perposes.

NOTICE OF PRIVACY PRACTICES: ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may abtain a revised notice by submittings a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: 17779 SW 2nd St, Pembroke Pines, FL 33029 Tel: 954-322-1110/Fax:954-322-1099

Acknowledgement and Consent

I have received the Notice of Privacy Practices for ALL-PRO ORTHOPEDICS AND SPORTS MEDI P.A..
They are authorized to use health information about (please print patient's name)
for treatment, payment, and healthcare operations purposes consident with its Notice of Privacy Practices.

Signature of Patient 12/25/2018 Date Account #

Personal representative information (if applicable):

Name of Personal Representative Relationship to Patient

IDENTITY OF RECIPENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: YES _____ No No _____
____Daytime Phone@# _____
____On My Home Answering Machine Phone@# _____
____On My Voicemail@#_____
____With My Designated and Authorized Person(s) Named Below:

ALL-PRO ORTHOPEDICS

NEW PATIENT MEDICAL HISTORY FORM

Patient name: _____ Height: _____ Weight _____

Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ other _____

Preferred Parmacy: _____

Preferred Source: Doctor (Name): _____ Other (ex. Google Search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Sysptoms: (select only ONEprimary sysptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness ○ Other

Shoulder	○ Right ○ Left	Pelvis	○ Right ○ Left	Neck	○
Upper Arm	○ Right ○ Left	Hip	○ Right ○ Left	Upper back	○
Elbow	○ Right ○ Left	Thigh	○ Right ○ Left		
Forearm	○ Right ○ Left	Knee	○ Right ○ Left	Mid Back	○
Wrist	○ Right ○ Left	Lower Leg	○ Right ○ Left	Low Back	○
Hand	○ Right ○ Left	Ankle	○ Right ○ Left	Buttocks	○
Thumb	○ Right ○ Left	Foot	○ Right ○ Left	Tail Bone	○
Index	○ Right ○ Left	Great Toe	○ Right ○ Left		
Middle	○ Right ○ Left	2nd Digit	○ Right ○ Left		
Third	○ Right ○ Left	3rd Digit	○ Right ○ Left		
Little	○ Right ○ Left	4th Digit	○ Right ○ Left		
		4th Digit	○ Right ○ Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the sysptoms been present (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (> 3 months)

Onset date: (mm/dd/yyyy) _____

2. Are you represented by an attorney ○ Yes ○ No

Attorney Name _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

4. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

Patient Name: _____

History of Present Illness (continued)

5. Race the pain (10 being the most pain):

○ 1○ 2○ 3○ 4○ 5○ 6○ 7○ 8○ 9○ 10

6. Do the symptoms wake you from sleep?

○ Yes○ No

7. Please describe the symptoms:

○ Sharp○ Dull○ Stabbing○ Throbbing○ Aching○ Burning○ Shooting

8. What is the timing of the symptoms?

○ Constant○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better○ Getting worse○ Unchanged

10. What makes the symptoms worse?

○ Squatting○ Kneeling○ Sitting○ Bending○ Stairs○ Twisting○ Moving○ Lying in bed○ Running○ Walking○ Athletics○ Standing○ Gripping○ Lifting○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness○ Bruising○ Swelling○ Numbness○ Stiffness○ Limping○ Clicking○ Locking○ Popping○ Tingling○ Weakness○ Giving way

Prior Testing / Treatment

How you had any prior tests? ○ None○ X-rays○ MRI○ CT Scan○ Never Test (EMG/NCV)○ Bone Scan

How you had any prior treatment for this problem? ○ Yes○ No

Type of treatment	Status of symptoms after treatment (select only those that Date of treatment apply)
Ice	○ Improved○ Worsened○ Unchanged
Heat	○ Improved○ Worsened○ Unchanged
Rest	○ Improved○ Worsened○ Unchanged
NSAIDs	○ Improved○ Worsened○ Unchanged
Muscle Relaxers	○ Improved○ Worsened○ Unchanged
Chiropractor	○ Improved○ Worsened○ Unchanged
Physical Therapy	○ Improved○ Worsened○ Unchanged
HomeExerciseProgram	○ Improved○ Worsened○ Unchanged
Surgery	○ Improved○ Worsened○ Unchanged
Injections	○ Improved○ Worsened○ Unchanged
Bracing	○ Improved○ Worsened○ Unchanged
TENS unit	○ Improved○ Worsened○ Unchanged
Other/Comments	

Patient Name: _____

Select all previous Hospitalizationa/surgeries: ☐ None

☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass / Vascular Surgery
☐ Appendectomy
☐ Cataract (Eye) Surgery
☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ LAP Band/Gastric Bypass Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy/Cancer
☐ Stents

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○
Spinal Surgery - Indicate Level:	_____	

Other Surgery

Other Orthopedic Surgery

_____

Medical Questions

Mark all that currently apply:

○ Meta in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you talking blood thinners: ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None of all

	None	Comment
1. GI ○Heartburn, Ulcers ○Nausea, Vomiting ○Blood in Stool		
2. ENDO ○Fever ○HeatorColdIntolerance ○Night Sweats		
3. CON ○Weight Loss ○Loss of Appetite ○Fatigue		
4. EYE ○Blurred Vision ○Double Vision ○Vision Loss		
5. ENT ○Hearing Loss ○Hoarseness ○Trouble Swallowing		
6. CV ○Chest Pain ○Palpitations		
7. RS ○Chronic Cough ○Pneumonia ○Shortness of Breath		
8. GU ○Painful Urination ○Blood in Urine ○Kidney Problems		
9. SK ○Frequent Rashes ○Skin Ulcers ○Lumps ○Psoriasis		
10. NEU ○Frequent Falls ○Loss of Coordination ○Numbness ○ Change in Bowel ○Change in Bladder ○Dizziness		
11. PSY ○Depresion/Anxiety ○Drug/AlcoholAddiction ○Sleep Disorder		
12. HEM ○Easy Bleeding ○Easy Bruising ○Anemia		

Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father

○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ Stroke	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Mother

○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ Stroke	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Sibling

○ Bleeding Problems	○ Diabetes	○ Heart Disease	○ Hypertension
○ Stroke	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer

Comments (ex. Cancer type) _____

Social History

Do you use tobacco? ○ Daily○ Occasionally○ Former smoker○ Never○ Unknown

Do you drink alcohol? ○ Daily○ Occasionally○ Rarely○ Never

Marital Status: ○ Married○ Single○ Divorced○ Windowed○ Domestic Partnership

Are you currently working? ○ Yes○ No○ Retired○ Disabled If no, what date did you last work?

Please list work restriction, if any:

Occupation Employer ○ Student

Patient Name: _____

Pain Diagram

Do you have any allergies? ○ Yes○ No If Yes, Please list below:

Medication, Relevant Food, or "Seasonal" Reaction

_____

Latex allergy? ○ Yes○ No

Please list all medications you take on a regular basis: ○ None

Medication Dosage and Frequency (e.g. 20 mg, once/day)

_____ _____

Do you have a personal history of any of the following? ☐ None

☐ AneurysmWhere:
☐ Angina (Chest Pain)
☐ ArthritisType:
☐ Asthma
☐ Bone or Joint Infections
☐ Cancer Type:
☐ Chemotherapy / Radiation
☐ COPD
☐ Congestive Heart Failure
☐ Diabetes Type:
☐ Emphysema
☐ Epilepsy
☐ Heart Attack
☐ Hepatitis Type:
☐ HIV / AIDS
☐ High Cholesterol
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Last A1C:
☐ Kidney Disease
☐ Kidney Stones
☐ MRSA Infection
☐ Pacemaker
☐ Phlebitis (Blood Clots)
☐ Pulmonary Embolism
☐ Reaction to Anesthesia Type:
☐ Seizures
☐ Stomach Ulcers
☐ Stroke / TIA
☐ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____ 12/25/2018

Signature Date