NORTH FLORIDA SPORTS MEDICINE
& ORTHOPAEDIC CENTER

PATIENT INFORMATION

REFERRING PHYSICIAN_____

LEGAL NAME

PRIMARY PHYSICIAN_____

FIRST_____ MIDDLE _____LAST _____ SUFFIX_____

PREFERRED NAME_____GENDER_____ MARITAL STATUS_____

BIRTHDATE_____ AGE_____SOCIAL SECURITY NUMBER_____ -_____- _____

CONTACT INFORMATION

ADDRESS_____

CITY_____STATE_____ZIP CODE + 4_____+_____

HOME PHONE (_____) _____-_____CELL PHONE (_____) _____- _____

EMPLOYER _____WORK PHONE (_____) _____- _____

EMERGENCY CONTACT INFORMATION

NAME_____ PHONE_____ RELATION_____

INSURANCE INFORMATION

PRIMARY PLAN NAME_____ POLICY OWNER _____

POLICY OWNER SOCIAL SECURITY_____ POLICY NUMBER _____

GROUP NUMBER _____EFFECTIVE DATE_____

SECONDARY INSURANCE_____

WORKERS COMPENSATION INFORMATION DATE OF INJURY_____

WORKERS COMP INSURANCE CARRIER_____

CASE MANAGER / CONTACT PERSON(S)_____

PHONE NUMBER _____

CHART #_____

SIGNATURE AUTHORIZATION FOR ASSIGNED OR UNASSIGNED CLAIMS

I HEARBY AUTORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIERS ANY INFORMAITON NEEDED FOR THIS OR ANY FUTURE MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO THE PARTY WHO ACCEPTS AGREEMENT. I UNDERSTAND THAT I AM REQUIRED TO PAY FOR ANY HEALTH INSURANCE DEDUCTIBLES, CO-INSURANCE, OR ANY OTHER CHARGES INCURRED WHICH ARE NOT PAID BY MY INSURERS OR THIRD PARTY PAYORS. THIS INCLUDES ANY COST INCURRED IN USING A COLLECTIONS SERVICE.

SIGNATURE_____ **DATE:** _____

CONSENT TO DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

The Patient hereby consents to the use or discloser of his/her individually identifiable health information *(Protected Health Information)* by **North Florida Sports Medicine & Orthopaedic Center,** herein after referred to as "FACILITY", in order to carry out treatment, payment, or health care operations. The Patient should review the FACILITIE'S "Notice of Privacy Practices for Protected Health Information" for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing the consent form.

The FACILITY reserves for itself the right to change the terms of its "Notice of Privacy Practices for Protected Health Information" at any time. If FACILITY does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by contacting Privacy Officer, Geri Rickard, at 850-878-2549.

Patient retains the right to request that the FACILITY further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The FACILITY is not required to agree to such requested restrictions; however, if the FACILITY does agree to Patient's requested restriction(s), such restriction(s) are the binding on the FACILITY.

At all times, Patient retains the right to revoke the Consent. Such revocation must be submitted to the FACILTY in writing. The revocation shall be effective except to the extent that the FACILTY has already taken action in reliance on the Consent.

The FACILTY may refuse to treat Patient if he/she (or authorized representative) does not sign the Consent Form (except to the extent that the FACILITY is required by law to treat individuals). If Patient (or authorized representative) signs the Consent Form and then revokes Consent, the FACILITY has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the FACILITY is required by law to treat individuals).

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(CONTINUED FROM PREVIOUS PAGE)

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____ AM/PM

_____
Signature of Patient

_____
Please Print Name

_____
Authorized Representative Signature*

_____
Please Print Name

*Please explain Authorized Representative's Relationship to Patient and include a description of Representative's authority to act on behalf of the Patient:

_____

_____

_____

ORTHOPEDIC EVALUATION

Please list or explain the primary reason for your visit today. (We generally evaluate one problem per appointment.)

_____

_____

MEDICAL HISTORY

(Please circle all that apply)

Cardiovascular Disease

Heart Attack
High Blood Pressure
Artificial Heart Valve
Pacemaker
Coronary Bypass Surgery
Poor Circulation
Heart Murmur
Rheumatic Fever

Lung Disease

Asthma
Emphysema
Cough
Shortness of Breath
Lung Surgery
Sleep Apnea
Snoring
CPAP

Digestive Disease

Ulcers/Reflux
Gall Stones
Chronic Diarrhea
Hepatitis
Stomach Pain
Liver Disease
Abdominal Surgery
Bowel Control Problems

Systemic Disease

Diabetes
Thyroid Disease
Kidney Failure
AIDS / HIV
Recent Weight Loss
Cancer
Night Sweats
MRSA Carrier

Orthopedic Problems

Neck Pain or Surgery
Shoulder Pain or Surgery
Elbow Pain or Surgery
Wrist Pain or Surgery
Hand Pain or Surgery
Scoliosis Surgery
Upper Back Pain
Lower Back Pain
Lumbar Spine Surgery
Hip Pain or Surgery
Knee Pain or Surgery
Ankle Pain or Surgery
Foot Pain or Surgery

Neurological Disease

Epilepsy / Seizure
Stroke / TIA
Multiple Sclerosis
Neuropathy
Nerve Damage

Hematologic Disease

Blood Clots
Anemia
Hemophilia
Leukemia
Coumadin Use
Plavix Use

Psychological

Psychiatric Care
Nervous Problems
Depression / Anxiety
Bipolar Illness
Psychosis
Drug Dependency
Drug Abuse
Alcoholism

Genitourinary Disease

Bladder Control Problems
Bladder Infections
Kidney Infections
Kidney Stones
Sexually Transmitted Disease

Past Surgery

Gallbladder
Appendix
Hysterectomy
Breast Surgery
Thyroid Surgery
Bladder Surgery
Stomach/Bowl Surgery
Kidney Surgery
Other _____

CURRENT AND RECENT MEDICATIONS:

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES:

_____
_____
_____
_____

NAME _____ **CHART #** _____

NORTH FLORIDA SPORTS MEDICINE
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PATIENT: _____ **CHART:** _____
DOB: _____ **ALLERGIES:** _____
_____

MEDICATION LIST

DRUGSTORE _____ **PHONE #** _____

DATE DRUG INTERVAL # RF INT

PETER E. LOEB, MD
R. SPENCER STOETZEL, MD
ALEXANDER E. LOEB, MD

NORTH FLORIDA ORTHOPAEDICS

HISTORY OF PRESENT ILLNESS

Date of Injury_____ Today's Date:_____

Affected body part: _____ How long have you had the pain? _____

How did the injury occur? _____

_____

Have you had any ***previous*** injury/injuries to your affected body part?_____

_____

****Pain Scale 0-10 (***0*** being ***NO*** pain and ***10*** being ***VERY*** painful)****

Rate your pain: ***Worst:***_____ ***Best:***_____

How often does the pain occur: (Circle all that apply)

Constant No Pain

On and Off Worse in Evening

Worse in Morning

Describe the pain: (Circle all that apply)

Aching Burning Deep Boring

Sharp Shooting Stiff

Throbbing

What causes the pain: Normal Daily Activities or Other (Explain):_____

_____

What eases the pain: (Circle all that apply)

Changing Positions Elevation Exercising

Heat Ice Lying Down Massage

Moving About ie.(walking)

Over the Counter Medications

Prescription Medications Rest Stretching

Topical Creams/Ointments

Does the pain radiate? (If YES, explain)

_____

_____

_____

Left or Right Handed: _____ Height:_____Weight:_____

Which pharmacy do you use: _____

Location: _____

NORTH FLORIDA ORTHOPAEDICS

1911 Miccosukee Road • Tallahassee, FL 32308-5321
(850) 878-2549 • Fax (850) 878-9334

PETER E. LOEB, MD, FAAOS, CIME
Board-Certified Orthopaedic Surgeon

Orthopaedic Sports Medicine, Arthroscopic Surgery
Reconstructive Hip, Knee and Shoulder Surgery
General Orthopaedic Surgery
Certified Medical Examinations

R. SPENCER STOETZEL, MD, FAAOS, CIME
Board-Certified Orthopaedic Surgeon

Spine Surgery
Joint Replacement/Arthritis Surgery
General Orthopaedic/Hand Surgery
Certified Medical Examinations

ALEXANDER E. LOEB, MD
Board-Eligible Orthopaedic Surgeon

Complex Knee and Shoulder Reconstruction, Arthroscopic and Minimally Invasive Surgery, Joint Preservation and Robotic/Navigated Joint Replacement, Sports-Related Injuries, General Orthopaedics

NOTICE OF PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD INFROMATION:
Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment means. It is the communication among the many health professionals who contribute to your care. It is also a legal document describing the care you received and is the means by which you or a third-party payer can verify the services billed were actually provided. Your records can also be a tool in education health professionals and a source of data for medical research. It can also be a source of information for public health officials charged with improving the health of the nation, a source of data for facility planning and marketing a tool with which we can assist and continually work to improve the care we render and the outcomes we achieve. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, to better understand who, what, when, where, and why other may access your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS:
Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of the notice of privacy practices upon request. You have the right to inspect and obtain a copy of your health record. You have the right to obtain an accounting of disclosures of your health information. You have the right to request communications of your health information by alternative means or at alternate locations. You may also revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONIBILITES:
This practice is required to maintain the privacy of your health information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to requested restriction, and to accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make new professionals effective for all protected health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:
If you have any questions or would like additional information, you may contact our practice manager at (850) -878-2549. If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information or with the Secretary of Health and Humana Services. There will be no retaliation for filling a complaint.

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RECORDS RELEASE AUTHORIZATION

I,_____HEREBY
(**print patient's name & date of birth**)
AUTHORIZE AND REQUEST YOU TO RELEASE ANY AND ALL MEDICAL RECORDS: X-RAYS, PATHOLOGICAL REPORTS, DIAGNOSTIC REPORTS & SUMMARIES.

_____

Signature of patient or legal representative **Date signed**

PLEASE SEND RECORDS TO:

_____

_____

_____

_____

This authorization allows **North Florida Sports Medicine and Orthopaedic Center** to release a copy of your records to your primary physician, or in the event you would like your records sent to another facility, or if you would like a copy for yourself.