ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

DATE: _____

Please use BLACK INK when completing this form

ACCOUNT #: _____

PATIENT INFORMATION

PLEASE PRINT CAREFULLY

PATIENT'S NAME (Last Name, First Name, Middle Name)

SOCIAL SECURITY NUMBER

PATIENT'S ADDRESS

DATE OF BIRTH
_____
MM DD YYYY

GENDER
☐ MALE ☐ FEMALE

CITY

EMPLOYER

STATE

ZIP CODE

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ OTHER

TELEPHONE (Include Area Code)
HOME WORK

PATIENT RELATIONSHIP TO PRIMARY INSURED
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SPOUSE: _____

SPOUSE'S EMPLOYER: _____

PHONE: _____

EMERGENCY CONTACT: _____
(not living in household)

RELATIONSHIP: _____

PHONE: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE PHYSICIAN: _____

IS PATIENT'S CONDITION RELATED TO:

☐ YES ☐ NO EMPLOYMENT INJURY DATE _____

☐ YES ☐ NO AUTO ACCIDENT INJURY DATE _____

☐ YES ☐ NO OTHER ACCIDENT INJURY DATE _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____

EMPLOYER'S TELEPHONE: (____) _____

IF FULL-TIME STUDENT – SCHOOL: _____

CHIEF MEDICAL PROBLEM TODAY: _____ LEFT / RIGHT (INDICATE WHICH SIDE)

DATE SYMPTOMS BEGAN: _____

PLACE OF ACCIDENT: _____

HOW DID INJURY HAPPEN: _____

PRIOR TREATMENT FOR COMPLAINT: DATE: _____ PLACE & TREATING PHYSICIAN: _____

PRIOR X-RAYS FOR THIS PROBLEM: DATE: _____ PLACE: _____

INSURANCE INFORMATION

Your insurance cards will be requested for the registration process.

☐ PRIMARY INSURANCE

INSURED'S NAME _____
(Last, First, MI)

SOCIAL SECURITY #: _____

INSURED'S EMPLOYER _____

INSURED'S DATE OF BIRTH _____

☐ SECONDARY INSURANCE

INSURED'S NAME _____
(Last, First, MI)

SOCIAL SECURITY #: _____

INSURED'S EMPLOYER _____

INSURED'S DATE OF BIRTH _____

IF PATIENT IS A MINOR

FATHER'S NAME: _____

DATE OF BIRTH: _____ SS#: _____

FATHER'S EMPLOYER: _____

WORK PHONE: _____

MOTHER'S NAME: _____

DATE OF BIRTH: _____ SS#: _____

MOTHER'S EMPLOYER: _____

WORK PHONE: _____

ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

Please use BLACK INK when completing this form

ASSIGNMENT OF BENEFITS AND DIRECTION FOR PAYMENT

Patient: _____ Insurance Co: _____ (Primary)

Account #: _____ Insurance Co: _____ (Secondary)

I hereby instruct and direct the above named insurance company to pay by check made payable to:

INTERNATIONAL ORTHOPAEDIC SPECIALISTS
2260 NE 123RD STREET
N. MIAMI, FLORIDA 33181

The medical and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the Services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Orthopaedic Specialists of Miami Beach and I have agreed to pay, in a current manner, any balance of said service charges over and above this insurance payment except to the extent my liability for any such balance is limited by agreement or law applicable to the Orthopaedic Specialists of Miami Beach.

A photocopy of this assignment shall be considered as effective and as valid as the original. I also authorize the release of any information acquired in the course of my treatment to any insurance company, adjuster or attorney involved in this case.

DATE _____

_____ _____
SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

ASSIGNMENT AND LIEN FOR MEDICAL SERVICES RENDERED

If I, _____, receive or become entitled to receive any monies from any source whatsoever for my injuries, either through a lawsuit, settlement of a lawsuit or claim, award by a court or arbitrator(s), jury verdict or payment of insurance proceeds, I hereby assign and agree to pay said funds to:

INTERNATIONAL ORTHOPAEDIC SPECIALISTS
2260 NE 123RD STREET
N. MIAMI, FLORIDA 33181

to the extent of any outstanding amounts then owed by me to the Orthopaedic Specialists of Miami Beach for medical services before any other fees, costs, or expenses are disbursed from any said funds. I further agree that the fee for the services to be performed by the Orthopaedic Specialists of Miami Beach depends on the treatment rendered and that any amount that I owe to the Orthopaedic Specialists of Miami Beach shall constitute a lien on any claim or lawsuit I may have as a result of my injuries and any settlement, award, jury verdict or insurance proceeds that I receive or become entitled to receive as a result of my injuries.

This Assignment and Lien shall be placed in my chart and a copy thereof shall constitute actual notice to my attorney, or any other person, that my medical bills to the Orthopaedic Specialists of Miami Beach shall be paid first from the proceeds of any such lawsuit, settlement, award, jury verdict or insurance. This authorization cannot be modified unless it is in writing and signed by both parties.

I hereby appoint the Orthopaedic Specialists of Miami Beach or its designee as my attorney-in-fact to sign my name to and file a financing statement under the Uniform Commercial Code to evidence this lien.

I understand that I remain personally responsible for the payment of all fees owed by me to the Orthopaedic Specialists of Miami Beach and that notwithstanding this Assignment and Lien, the Orthopaedic Specialists of Miami Beach is not required to look to any other person or entity for payment.

I will instruct my attorney to pay the Orthopaedic Specialists of Miami Beach as provided above from any monies received by him/her described above. These instructions are irrevocable and may not be changed without the written agreement of the Orthopaedic Specialists of Miami Beach. I have given authorization to the Orthopaedic Specialists of Miami Beach to forward this document to my attorney.

DATE _____

_____ _____
SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE*) PRINT NAME OF PATIENT (OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

JERRY SHER, M.D.

SOPHIA DEBEN, M.D.

MALPRACTICE COVERAGE

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who failed to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law. Florida Statutes 458.320 7(b)(II) 5.

_____

Signature

_____

Name

_____

Date

INTERNATIONAL ORTHOPAEDIC SPECIALISTS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ DOB: _____

I hereby authorize _____
(PLEASE PRINT NAME OF DOCTOR/FACILITY TO RELEASE YOUR RECORDS)

To release my medical records information including any labs, diagnostic images, operative reports and office notes to:

INTERNATIONAL ORTHOPAEDIC SPECIALISTS
2260 NE 123rd STREET
NORTH MIAMI, FL 33181
(305) 674-5956 P
(786) 703-7872 F

By authorizing the release of the above mentioned records, I understand that the medical records are confidential and cannot be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I further understand that once released, the records custodian, or its employees have no responsibility or liability that may arise regarding and aspect of this authorization.

PATIENT SIGNATURE: _____

WITNESS: _____ **DATE:** _____

APPOINTMENT POLICY

I understand that I will be charged a fee for appointments not cancelled within 24 hours. This includes cancelled appointments, rescheduled appointments, and missed appointments ("no shows").

The fee is $ 50.00 but is subject to change at the discretion of INTERNATIONAL ORTHOPAEDIC SPECIALISTS.

PATIENT SIGNATURE: _____ **DATE:** _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

Please Print

I, _____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

_____

_____

_____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ___/___/___

Name: _____
Please Print

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient refused to sign (date of refusal) ___/___/___.
- ☐ Communications barriers prohibited obtaining an acknowledgment.
- ☐ An emergency situation prevented us from obtaining an acknowledgment.
- ☐ Other _____

Attempt was made by: _____ Date: ___/___/___

PATIENT MEDICAL HISTORY

Name: _____ Email address: _____

Age: _____ Height: ___' ___" Wt: _____lbs. Sex: ☐M ☐F

Are you? ☐ Right-handed ☐ Left-handed

CC / Reason for today's visit? _____

Date of Injury or Onset of Symptoms: _____

Were you sent to our office by a physician? ☐ Yes ☐ No Is this work related? ☐ Yes ☐ No

If so, please provide:
Requesting Physician's Name: _____ Phone #: _____
Physician's Address: _____ City/State: _____

PREFERRED PHARMACY (*name, address, phone number*):

_____

MEDICATIONS: *Include non-prescription & herbal supplements*

Drug Name	Dosage	Frequency

ALLERGIES: ☐ Yes ☐No *(If yes, please list below)*

Medication	Reaction

Tape Allergy ☐Yes ☐No Latex Allergy ☐Yes ☐N o

PAST MEDICAL HISTORY: Have you ever had any of the following or received treatment? *Please check all pertinent boxes:*

☐AIDS or HIV	☐Bronchitis	☐Hepatitis	☐Mumps	☐Thyroid Disease
☐Anemia	☐Chicken Pox	☐High Blood Pressure	☐Pneumonia	☐Tuberculosis
☐Arthritis	☐Diabetes	☐Infectious Mono	☐Polio	☐Ulcer
☐Asthma	☐Diphtheria	☐Kidney Disease	☐Rheumatic Fever	☐Venereal Disease
☐Back Trouble	☐Epilepsy/Seizures	☐Low Blood Pressure	☐Scarlet Fever	☐Whooping Cough
☐Bladder Infections	☐Glaucoma	☐Measles	☐Sleep Apnea	☐Other (please list)
☐Bleeding Tendency	☐Heart Disease	☐Migraine Headaches	☐Smallpox	_____
☐Blood Transfusions	☐Hemorrhoids	☐Mitral Valve Prolapse	☐Stroke	_____

PAST SURGICAL/Hospitalization HISTORY:

Date	Surgery/Illness	Doctor	Hospital, City/State

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

PATIENT MEDICAL HISTORY

Patient Social History:

Marital Status	Living Situation	Use of Tobacco	Use of Alcohol
☐Single	☐With Family	☐Never	☐Never
☐Married	☐With Friends	☐Previously, but quit	☐Rarely
☐Divorced	☐Alone	☐Currently	☐Moderate
☐Widowed	☐Other	____Packs per day	☐Daily
☐ Separated			

***OCCUPATION: *** _____

Review of Systems: Please indicate any personal history below: *(Please circle all that apply)*

Musculoskeletal		Genitourinary		Psychiatric	
Joint Pain	No Yes	Frequent urination	No Yes	Memory loss or confusion	No Yes
Joint Stiffness or swelling	No Yes	Burning or painful urination	No Yes	Nervousness	No Yes
Weakness of muscles or joints	No Yes	Blood in urine	No Yes	Depression	No Yes
Muscle pain or cramps	No Yes	Incontinence or dribbling	No Yes	Insomnia	No Yes
Back pain	No Yes	Female – number pregnancies	_____		
Cold extremities	No Yes	Female – number of deliveries	_____	Gastrointestinal	
Difficulty in walking	No Yes			Loss of appetite	No Yes
		Integumentary (skin, breasts)		Nausea or vomiting	No Yes
Constitutional Symptoms		Rash or itching	No Yes	Frequent diarrhea	No Yes
Bad general health lately	No Yes	Changes in skin color	No Yes	Constipation	No Yes
Recent weight change	No Yes	Varicose veins	No Yes	Rectal bleeding, blood in stool	No Yes
Fever	No Yes	Breast pain	No Yes	Abdominal pain	No Yes
Fatigue	No Yes	Breast lump	No Yes		
Headaches	No Yes			Respiratory	
		Neurological		Chronic or frequent coughs	No Yes
Ears/Nose/Mouth/Throat		Lightheaded or dizzy	No Yes	Spitting up blood	No Yes
Hearing loss or ringing	No Yes	Numbness or tingling sensation	No Yes	Shortness of breath	No Yes
Earaches or drainage	No Yes	Tremors	No Yes	Wheezing	No Yes
Chronic sinus problems	No Yes	Paralysis	No Yes		
Nose bleeds	No Yes			Eyes	
Bleeding gums	No Yes	Endocrine		Eye disease or injury	No Yes
Sore throat or voice change	No Yes	Excessive thirst or urination	No Yes	Wear glasses/contact lenses	No Yes
Swollen glands in neck	No Yes	Heart or cold intolerance	No Yes	Blurred or double vision	No Yes
		Skin becoming drier	No Yes		
Cardiovascular				Women:	
Heart Trouble	No Yes	Hematologic/Lymphatic		Irregular periods	No Yes
Chest pain or angina pectoris	No Yes	Slow to heal after cuts	No Yes	Frequent spotting	No Yes
Palpitation	No Yes	Bleeding or bruising tendency	No Yes	Are you pregnant?	No Yes
Shortness of breath (walking)	No Yes	Anemia	No Yes	(If over age 18)	
Swelling of feet, ankles or hands	No Yes	Enlarged glands	No Yes	Are you nursing?	No Yes

Have you ever experienced any prior injury or symptoms regarding this body part? ☐Yes ☐ No

If so, please provide details: _____

Please list any sports/hobbies you enjoy: _____

LEGAL INFORMATION:

Is there any current or pending litigation involving this problem for which we are seeing you today? ☐Yes ☐No

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

Signature of Patient or Parent of Minor Date Signature of Physician Date

ORTHOPAEDIC SPECIALISTS
SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Date _____
Update _____
Update _____
Update _____

NAME _____

HAVE YOU EVER RECEIVED TREATMENT FOR?			IF YES, EXPLAIN
Mental Illness	☐ Yes	☐ No	_____
HIV Positive / AIDS	☐ Yes	☐ No	_____
Sexually Transmitted Disease(s)	☐ Yes	☐ No	_____
Alcohol Abuse	☐ Yes	☐ No	_____
Illicit Drug Use	☐ Yes	☐ No	_____
Are you currently Pregnant and under age of 18?	☐ Yes	☐ No	_____

If you have answered *Yes* to any of the above, ***please initial*** the corresponding categories listed below which will authorize Orthopaedic Specialists to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law.

Initials: _____ Mental Illness Information

Initials: _____ HIV / AIDS Information

Initials: _____ Sexually Transmitted Disease(s) Information

Initials: _____ Alcohol Abuse Information

Initials: _____ Illicit Drug Use Information

Initials: _____ Pregnancy Information, If patient is under the age of eighteen (18)

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

By signing below, I acknowledge and agree to the above conditions. DATE _____

_____ _____
SIGNATURE OF PATIENT
(OR AUTHORIZED REPRESENTATIVE*)

PRINT NAME OF PATIENT
(OR AUTHORIZED REPRESENTATIVE*)

*Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

_____

_____

_____
Physician Signature

_____
Date