THE CENTER FOR BONE & JOINT DISEASE

MR#__________________ (OFFICE USE ONLY)

MEDICAL HISTORY FORM

Name: ____ Date: ____________________

D.O.B:____________ Age: ________ Hand dominant: Right/Left/Ambidextrous *"Both"* (please circle)

Occupation: __________________ Weight: __________lb Height: __________

Primary Care Doctor:______________________________ Phone#:____________________________

Pain Management Doctor:______________________________Phone#______________________

Who referred you to us:____

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Describe present symptoms/complaints:____

____

____

When did this problem begin:__________ Is this a work injury: *Yes or No* Motor Vehicle : *Yes or No*

How did this problem/injury occur:____

____

Do you have an Attorney for this injury: *Yes or No* If yes who:_______________________________

Previous injury to this body part: *Yes or No* if yes when: ______________________________________

Does anything make the problem worse?: ____

Does anything make the problem better?:____

Did you bring X-rays and/or MRI with you? *Yes or No* where/when: ___________________________

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Smoking/Tobacco History: ☐ Chews ☐ Current Smoker ___ pack per day ☐ Former ☐ Never Smoked ☐ E-cigarettes

Recreational Drugs: Yes/ No (please circle) What type:_____________________________________

Alcohol History: ☐ Never ☐ Former ☐ Seldom ☐ Occasionally ☐ Moderate ☐ Heavy

Marital Status: ☐ Single Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living Presently Alone: Yes/ No (Please circle) Number of Children: ______________

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Past/Present Medical History: (PLEASE CHECK ALL THAT MAY APPLY TO YOU AND WRITE ANY OTHERS)

☐ Hypertension (High Blood Pressure) ☐ Hypotension (Low Blood Pressure) ☐ A-Fib/Angina Pectoris

☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ HIV ☐ AIDs ☐ Hepatitis: A__ B ___ C___ ☐ Prostate Disorder

☐ Cancer what kind: ________________________________Remission: Yes/ No (please circle)

☐ Rheumatoid Arthritis ☐ MS ☐ Lupus ☐ Thyroid ☐ Fibromyalgia ☐ Diabetes: Type: ______________

☐ Esophageal Reflux/Acid Reflux ☐ Blood Clots/Thrombophlebitis ☐ GOUT ☐ Rosacea ☐ MRSA

☐ High cholesterol (Hyperlipidemia) ☐ Depression ☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Epilepsy/Seizure

☐ Alzheimer's/Dementia ☐ Heart Attack ☐ Stroke Other ______________________

____

☐ NO KNOWN PAST MEDICAL HISTORY ______________________

Past Surgical History/ Hospitalizations: (PLEASE CHECK ALL SURGERIES THAT MAY APPLY TO YOU AND WRITE ANY OTHERS)

☐ Hysterectomy ☐ Tubal Ligation ☐ C-Section x_____ ☐ Cholecystectomy(Gallbladder) ☐ Appendix removed

☐ Tonsillectomy ☐ Adenoidectomy ☐ Carpal Tunnel Right/ Left/Both ☐ Stent Placement How Many_______

☐ Pacemaker ☐ CABG(Coronary Artery Bypass Graft) x______ ☐ Interventional Cardiac Catherization x____

☐ Total Hip: Right/Left/Both ☐ Total Knee: Right/Left/Both ☐ Total Shoulder: Right/Left/ Both

☐ Spinal Surgery: What kind/what level____

☐ Hand/Wrist: ___________________________ ☐ Foot/Ankle:______________________________________

☐ Knee Arthroscopy: Right/Left/both ☐ Shoulder Arthroscopy Right/Left/both ☐ Other surgeries:______________

☐ NO KNOWN SURGICAL HISTORY/HOSPITALIZATIONS

Past Family History (Please check applicable boxes)

	Father	Mother	Brother	Sister	Son	Daughter
Cancer:						
Heart Disease:						
High Blood Pressure						
Kidney Disease:						
Liver Disease:						
Thyroid:						
Diabetes:						
Respiratory:						
Stroke:						
Mental Illness:						
Epilepsy/Seizures:						

☐ UNKNOWN FAMILY HISTORY

Medications You Currently Taking: Name & Dosage

(PLEASE INCLUDE VITAMINS)

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____

____

____

____

____

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____

Allergies To Any Medication/Food:

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____

____

symptoms within past 7 days

Constitutional: ☐ Recent Weight Change ☐ Fever/Chills ☐ Sweating heavily at night ☐ Feeling poorly

Eyes/Head: ☐ Vision problems ☐ Blurry Vision ☐ Vision Prescription ☐ Headache

HENT: ☐ Loss of hearing ☐ Ringing in the ears (tinnitus) ☐ Issues with gums/teeth ☐ Hoarseness/difficulty swallowing

Respiratory: ☐ Difficulty breathing ☐ Cough ☐ Shortness of breath ☐ Coughing up blood

Digestive: ☐ Belching/Bloating/Heartburn ☐ Nausea/Vomiting ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain

Heart: ☐ Chest pain/discomfort ☐ Fast heart rate ☐ Palpitations

Musculoskeletal: ☐ Muscle weakness ☐ Neck Pain ☐ Low Back Pain ☐ Joint Swelling ☐ Joint Pain

Nervous System: ☐ Fainting ☐ Convulsions/Seizures ☐ Tingling ☐ Numbness ☐ Dizziness

Skin: ☐ Pruritus ☐ Skin Lesions ☐ Rash ☐ Psoriasis

Endocrine/Glands: ☐ Excessive thirst/fluid intake ☐ Hot flashes ☐ Temperature intolerance (Heat/Cold)

Blood/Lymph: ☐ Easy Bleeding ☐ Easy Bruising ☐ Swollen Glands in the neck

Urinary System: ☐ Blood in urine ☐ Painful urination ☐ Incontinence ☐ Penile discharge ☐ Decreased urination

Female Reproductive: ☐ Normal Menstruation ☐ Menopausal ☐ Vaginal discharge ☐ Pelvic pain ☐ Painful urination

Emotional Status: ☐ Sleep Disturbances ☐ Depression ☐ Feeling Nervous

ACKNOWLEDGMENT OF OFFICE POLICIES RELATING TO PAYMENT OF MEDICAL EXPENSES

Initial

X ______ If you have a fracture we will be billing a fracture management code to your insurance. This entitles you to 90 days of follow-up care in which the office visit will be at no charge to you or your insurance. Casting supplies and x-rays are not included during these 90 days and are an additional charge. Please advise our office if your care will be followed up by an orthopaedist in another area.

X ______ I understand and acknowledge that it is my responsibility to know and understand the nature and extent of any insurance coverage that may apply to medical bills for this claim. This may include any available health insurance, Medicare, Medicaid, automobile, liability or other insurance benefits. Specifically, I understand that it is my responsibility to know and be responsible for any DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, ETC., and further acknowledge that it is not the responsibility or duty of the The Center for Bone and Joint Disease to determine this information.

X ______ I understand and acknowledge that all co-payments and/or co-insurances are to be paid at the time that medical services are provided. I further understand that my account may be turned over to a collections agency and/or an attorney for collection. In that event, I will be responsible for reasonable attorney fees and costs that may apply and which are incurred in collection of the account.

X ______ In the event that my check is returned for insufficient funds, I am aware that the following fees (in addition to the amount of the bill) will apply in accordance with Section 832.07, Fla Stat.:
$25.00 if the amount of the check does not exceed $50.00
$30.00 if the amount exceeds $50.00 but does not exceed $300
$40.00 if the amount exceeds $300.00 or 5% of the amount of the check, which ever is greater.

X ______ I have been informed that The Center for Bone and Joint Disease will not retroactively file to any type of Medicaid for any service for this injury.

X ______ I understand that a minimum fee of $30.00 is charged for missed appointments. I agree to pay any missed appointment fees charged as a result of my failing to keep a scheduled appointment without providing at least twenty-four (24) hours previous notice that I will not be able to keep the appointment.

By signing below, I acknowledge that I understand and agree to the above terms. If I am signing on behalf of another, I represent that I have full legal authority and representative capacity to execute this document on behalf of the patient.

______________________________ ________________
Patient / Representative Signature Date

____
Patient's Name (PLEASE PRINT)

______________________________ ________________
Center for Bone and Joint Disease Representative Date

The Center for Bone & Joint Disease
7544 Jacque Road
Hudson, FL 34667
727-697-2200
Fax 727-863-8774

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice=s Notice of Privacy Practices.

You have a right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy officer at 727-697-2200.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Dated: ______________________________

Persons that may be given Private Health Information:

____

____

____

X ______________________________

Patient or Patient=s Representative

Print Patients=s Name: ______________

If signed by Representative, state name of Representative: ______________

Relationship to Patient: ______________

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