Office Use Only:

Acct # _____

DOS: _____

Orthopedic Specialists Of SW FL
New Patient Information Form

Patient Name: _____ DOB _____ Age: _____ Sex: M / F / Unk

SS# _____ Home Ph# _____ Cell Ph# _____ Work# _____

Email Address (Please Print Clearly): _____

Preferred Contact Method (Please Circle): Home Phone Cell Phone Work Phone Email Fax Mail

Local Address _____ City/State _____ Zip Code _____

Northern/Other Address _____ City/State _____ Zip Code _____

Race (Circle): White Black Asian Native Hawaiian American Indian Type-Unknown Decline

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Ethnicity (Circle): Hispanic Origin Non-Hispanic Origin Type-Unknown Decline

Reason for visit: _____ If an injury, how did this occur: _____

Date of Injury: _____ Is Injury Auto or Work Related: _____

Referred By: _____ Prim. Care Physician: _____ Phone#: _____

Employer Name: _____ Occupation _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's Wk#: _____

Health Ins. Carrier: _____ Auto Ins. Carrier _____

If Patient Is A Minor, Parent's Name: _____ Parent's Employer: _____

Wk Ph#: _____ In Case Of An Emergency Notify: _____ Phone: _____

Source of Payment (Please Circle): Primary Insurance Work Comp Auto Selfpay

I hereby authorize Orthopedic Specialists of Southwest Florida (hereinafter "OSSWF") to release any information concerning my care to my insurance company and/or any company under whose policy I am considered an insured and/or omnibus insured. I hereby irrevocably assign all insurance benefits (and/or rights to collect the same) to which I am entitled including, but not limited to, Health Insurance, Personal Injury Protection (PIP), Medical Payments, and/or Medicare benefits, to OSSWF. Moreover, I hereby direct any such insurer to make the necessary payment exclusively and directly to OSSWF in a form payable to OSSWF, only. This irrevocable assignment is given in exchange and/or in consideration for the medical treatment, care, or services rendered to the undersigned by OSSWF.

Notwithstanding the granting of this irrevocable assignment, the undersigned agrees to be directly responsible to OSSWF for **ALL** bills for services rendered to the undersigned, and this agreement and/or assignment is made solely for OSSWF's additional protection. The undersigned agrees that payment to OSSWF for services rendered is not contingent upon any insurance claim or insurance payment but said charges are due and payable in full upon the rendering of said services. I also understand that payment is due at the time of each visit and I am personally financially responsible for the same. I authorize OSSWF to release records to any physicians and/or medical facility that they may deem pertinent to my case or care.

I_____, and/or my representative agree not to bring ***frivolous*** medical malpractice case or cause of action against the physician or physician's legal entity providing care. Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I _____, and/or my representative agree to use an expert medical witness who adheres to the guidelines and/or code of conduct defined by the specialty society for expert witnesses in the area of medicine who would typically have the background experience to render an opinion on such a case.

_____ Date: _____

(Signature)

Office Use Only:

Acct # _____

DOS:

Orthopedic Specialists Of SW FL
2531 Cleveland Avenue, Ste. 1
Fort Myers, Florida 33901

Notice of Privacy Practices

We are required to provide you with our "Notice of Privacy Practices" upon request. Please notify the receptionist if you would like a copy.

Please provide the information below.

Your Name (please print) _____

Date of Birth _____

Do you want to give us permission to discuss your medical and financial information with family members and/or friends.

_____ Yes _____ No

If yes, please list the friends/family members that you would like to authorize us to speak to:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

The "Notice of Privacy Practices" was made available to me.

Your Signature _____ Today's Date _____

Office Use Only:

Acct # _____

Name: Date of Birth: DOS:

Orthopedic Specialists Of SW FL
2531 Cleveland Avenue, Ste. 1
Fort Myers, Florida 33901

CONSENT TO EXAMINATION, TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and/or an interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Orthopedic Specialists of Southwest Florida with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo any examinations, x-rays, blood tests and / or any other diagnostic modalities that the physician may determine to be important and / or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure, and / or care, treatment, therapy or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, or trauma, if known, and will explain any proposed examination, diagnostic procedure, and / or care, treatment, therapy or remedy. **I agree to ask for clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and / or treatment proposed. I agree that I will be provided with the opportunity to discuss relevant and available alternatives. **I agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and / or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of **not** having the examination / diagnostic procedure / treatment proposed. **I agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure, and / or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure, and / or treatment, and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment, and that **I may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken any undisclosed medications or drugs prior to examination and / or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand that the examination, diagnostic procedure, and/or care, treatment, therapy or remedy may make my condition worse.

Office Use Only:

Acct # _____

Name: Date of Birth: DOS:

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Documentation of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI, and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition
- Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the doctors of Orthopedic Specialists of Southwest Florida have elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductibles, co-payments, and fees due, less insurance payments.** As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies, such as braces, slings, splints, etc. necessary for your treatment. You are responsible for these non-covered services. There is a fee for requests for form(s) completion up to $50 per request.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A $35.00 returned check fee will be added to your account for all returned checks.

I agree that Orthopedic Specialists of Southwest Florida may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient or Patient's Representative Signature Date

Print Patient's Name: _____

Office Use Only:

Acct # _____

Name: Date of Birth: DOS:

Accident/Injury Detail- (this form must be completed, signed and dated)

Many insurance companies require accident/injury details after they receive our claim. Please answer the following questions and explain how this accident/injury occurred.

Is this claim related to an accident?

NO _____ If not due to any type of accident, please describe your symptoms; when they started, and the manner in which they started.

_____

_____

_____

YES _____ **Please answer the following that apply below:**

Date of Injury: _____

Location of Injury (home, work, etc.): _____

If Auto, Motorcycle, slip/fall, or "Other Accident" please answer the following:

_____ Auto _____ Motorcycle _____ ATV/Dirt Bike _____ Bicycle _____ Slip/Fall _____ Other (animal bite, tools, etc.)

Provide description of how accident occurred: _____

_____

_____

If Auto/Motorcycle:

Were you the _____ driver or _____ passenger?

Do you own the vehicle? _____ Yes _____ No

If motorcycle related, do you have PIP insurance that would cover medical expenses relating to this accident? _____ Yes _____ No

Has a claim been made with your auto insurance carrier? _____ Yes _____ No

If Work related, please answer the following:

Name of employer at the time of injury: _____

Are you self employed? _____ Yes _____ No

Do you receive a W-2 (employee) or 1099 (subcontractor) from this employer at year end? _____ W-2 _____ 1099

Have you filed a Workers' Compensation claim? _____ Yes _____ No

Has the employer or the workers' compensation carrier accepted or denied liability? _____ accepted _____ denied

Attorney Information

Have you sought the assistance of an attorney relating to this accident/injury? _____ Yes _____ No

If yes, please provide: Attorney's name: _____

Attorney's address: _____

Attorney's phone: _____

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply.
My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company, _____, all records necessary for processing claims filed by me or on my behalf.
I authorize all insurance payments, including auto, PIP, and medpay to be made directly to Orthopedic Specialists of SW Florida.
I authorize my auto insurance carrier _____ to release information regarding my PIP benefits and to provide a PIP log to OSSWF when requested.

Signature: _____ Date: _____

Name: Date of Birth:

Office Use Only:
Acct # _____
DOS:

Why call when you can click? Use our *new* online…

Patient Portal

The Patient Portal is a web-based system that is your secure communication link with our office. When you log in to the Patient Portal with your private user name & password, you can:

- *Use the Messaging feature to contact us*
- *Request a medication refill*
- *Notify us or request any changes to your information*
- *View your Clinical Summary, and print or save an electronic copy of your Health Record*

Patient Portal Consent Form

The patient portal is a secure way to access your medical records including medications and your clinical summaries through the Internet. You can also communicate with our office via secure messaging to ask questions, provide information, request appointments, and request medication refills.

Please read the following policy carefully:

- **The portal is for non-emergency uses only**. We will reply to your request/inquiry within two business days
- We are offering the patient portal as a convenience to you at no cost. We will not sell or give away any private information, including email addresses
- We are not allowed to refill narcotics or other controlled medications through the Internet portal
- If you do not receive a timely reply from us, please check your Junk or Spam email folder. Messages are sometimes redirected to those folders

By using this online Patient Portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to protect this information, as well as notify us should your password be lost or stolen. You agree not to hold Orthopedic Specialists of Southwest Florida responsible for any network infractions beyond our control.

Patient Name:	Date of Birth:	Email Address (Please Print Clearly):

_____ _____
Signature of Patient (or Legal Representative) *Date*

*** You will receive an email from *"DoNotReply@myportal.srssoft.com"* within 24 hours with instructions to set up your online account ***

Name: Date of Birth:

Office Use Only:
Acct # _____
DOS:

Orthopedic Specialists Of SW Florida

Medical History Form

Patient's Name _____ Date of Birth _____ Age _____ Sex M ☐ F ☐

PAST MEDICAL HISTORY - Have you been diagnosed with any of the following medical conditions?

	Yes no		Yes no		Yes no	
Heart Disease	__Yes	__No	Blood Clots/DVT	__Yes __No	Rheumatoid Arthritis	__Yes __No
Heart Attack	__Yes	__No	Bleeding Disorder	__Yes __No	Osteoarthritis	__Yes __No
Angina/chest pain	__Yes	__No	Hypertension	__Yes __No	Gout	__Yes __No
Congestive heart failure	__Yes	__No	Stroke	__Yes __No	Thyroid Disease	__Yes __No
COPD/Emphysema	__Yes	__No	Liver Disease	__Yes __No	Tuberculosis	__Yes __No
Asthma	__Yes	__No	Hepatitis	__Yes __No	HIV/AIDS	__Yes __No
Pneumonia	__Yes	__No	Anemia	__Yes __No	Seizures	__Yes __No
Kidney Disease	__Yes	__No	Sickle Cell Disease	__Yes __No	Anxiety	__Yes __No
Renal Failure	__Yes	__No	Stomach/intestinal ulcers	__Yes __No	Depression	__Yes __No
Diabetes	__Yes	__No	Cancer	__Yes __No	Fibromyalgia	__Yes __No

SURGERIES-please list all surgeries with approximate date.

Problem Date

1. _____
2. _____
3. _____
4. _____

Medications-List all medications with dosage and frequency, (attach list if extensive)

Medication Dosage Frequency

1. _____
2. _____
3. _____
4. _____
5. _____

Pharmacy Name _____ Phone _____

Drug and Food Allergies or adverse Reactions (include penicillin, aspirin, and anti-inflammatory drugs And local anesthesia)

_____

_____

_____ _____

Patient signature Date

Physician Signature _____ Date _____ Medical history form (cont.)

Physician Signature _____ Date _____

Name: Date of Birth:

Office Use Only:
Acct # _____
DOS:

Social History:

Marital status: Single Married Divorced Widow(er)

Number of children _____ Presently living alone? Yes No

Smoking Status: (Please circle one option)

- Current every day smoker _____ (Date Started)
- Current some day smoker _____ (Date Started)
- Please list amount you smoke: _____ pack(s)/day _____ pack(s)/week
- Former smoker _____ (Date Started) _____ (Date Ended)
- Never smoker
- Unknown if ever smoked

Do you drink alcohol regularly? Yes No

If yes, please amount and type ingested per day _____ Per week _____

What is your occupation? _____

Family Medical History: (do you have a family history of any of the following illnesses?)

	Circle All That Apply						Circle All That Apply				
Cancer	Father	Mother	Sibling	Child	N/A	Lung Disease	Father	Mother	Sibling	Child	N/A
Diabetes	Father	Mother	Sibling	Child	N/A	Heart Disease	Father	Mother	Sibling	Child	N/A
Immune Disorders	Father	Mother	Sibling	Child	N/A	Thyroid Disease	Father	Mother	Sibling	Child	N/A
Rheumatoid Arthritis	Father	Mother	Sibling	Child	N/A	Kidney Disease	Father	Mother	Sibling	Child	N/A
Degenerative Arthritis	Father	Mother	Sibling	Child	N/A						

Immunizations: (approximate date or age)

Flu _____ Tetanus _____

Review of Systems:

Are you currently having or have you had problems with any of the following?

	Circle		Describe all Yes responses
Musculoskeletal (reason you are here today; ex. Joint pain, muscle pain, etc.)	no	yes	_____
Weight loss/weight changes	no	yes	_____
Fever	no	yes	_____
Eyes, ears, nose, throat	no	yes	_____
Heart/Cardiovascular	no	yes	_____
Lungs/Respiratory	no	yes	_____
Gastrointestinal	no	yes	_____
Genitourinary	no	yes	_____
Skin	no	yes	_____
Neurological	no	yes	_____
Endocrine	no	yes	_____
Hematologic	no	yes	_____
Psychiatric	no	yes	_____

I certify that to the best of my knowledge the preceding information is true and accurate.

_____ Patient signature

_____ Date

For office use only:

Initial	date	Initial	date	Initial	date	Initial	date	Initial	date