

Orthopaedic Center of South Florida
954-473-6344

WORKERS' COMPENSATION PATIENT INFORMATION

PHYSICIAN _____

NAME _____ DATE _____
FIRST MIDDLE LAST

ADDRESS _____ CITY _____ STATE ___ ZIP _____

PHONE _____ AGE _____ DATE OF BIRTH ___ / ___ / ___

SOCIAL SECURITY # _____ - _____ - _____ DRIVERS LICENSE # _____

YOUR OCCUPATION _____

MALE _____ FEMALE _____ MARITAL STATUS: S M W D

HOW DID THE ACCIDENT HAPPEN? _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE NUMBER _____

ATTORNEY INFORMATION

ATTORNEY NAME _____

ATTORNEY ADDRESS _____

ATTORNEY PHONE _____

INITIAL MEDICAL HISTORY FORM

NAME: _____ DATE: _____ SS# _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE #: _____

HISTORY OF PRESENT ILLNESS/CONDITION

WHY ARE YOU SEEING THE DOCTOR TODAY: _____

DATE OF ACCIDENT OR ONSET, IF APPLICABLE: _____

HOW WERE YOU INJURED? _____

WHERE DOES IT HURT, IF APPLICABLE? _____

IF IN PAIN, HOW SEVERE IS THE PAIN USING SCALE FROM 1 - 10? _____

WHAT MAKES IT BETTER AND/OR WORSE? _____

PAST MEDICAL HISTORY

WHAT MEDICATIONS DO YOU TAKE DAILY? (DRUG NAME ONLY)

DO YOU HAVE ANY ALLERGIES? (SPECIFIC TO MEDICATIONS, ASPIRIN OR DYES)

ARE YOU RIGHT () OR LEFT HANDED () CAN YOU POSSIBLY BE PREGNANT? YES () NO ()

DO YOU NOW OR HAVE YOU IN THE PAST HAD ANY OF THE FOLLOWING:

HEART DISEASE	NO () YES ()	BLEEDING OR BRUISING PROBLEMS	NO () YES ()
HIGH BLOOD PRESSURE	NO () YES ()	HIGH CHOLESTEROL	NO () YES ()
DIABETES	NO () YES ()	URINARY DISORDERS	NO () YES ()
THYROID	NO () YES ()	DEEP VENOUS THROMBOSIS	NO () YES ()
STOMACH ULCER	NO () YES ()	LUNG OR BREATHING PROBLEMS	NO () YES ()
CANCER	NO () YES ()	RASHES OR NON-HEALING LESION	NO () YES ()
EPILEPSY	NO () YES ()	PULMONARY EMBOLUS	NO () YES ()
ARTHRITIS	NO () YES ()		

HAVE YOU HAD ANY SURGERY IN THE PAST? IF YES, LIST TYPE AND DATE OF SURGERY : _____

HAVE YOU HAD ANY COMPLICATIONS WITH ANESTHESIA? IF YES, PLEASE EXPLAIN: _____

HAVE YOU BEEN HOSPITALIZED FOR A PROBLEM OTHER THAN LISTED ABOVE? IF YES, PLEASE SPECIFY CONDITION: _____

FAMILY HISTORY

FAMILY MEMBER	ALIVE/DECEASED	AGE	IF DECEASED, WHAT WAS THE CAUSE?
FATHER	A / D	_____	_____
MOTHER	A / D	_____	_____

SOCIAL HISTORY

HEIGHT: _____ WEIGHT: _____ MARITAL STATUS: S M W D

SMOKE CURRENTLY? YES () NO () _____ PACKS PER DAY FOR _____ YEARS

DRINK ALCOHOL? YES () NO () AMOUNT PER WEEK _____

WITHIN THE LAST 30 DAYS HAVE YOU USED: MARIJUANA, COCAINE, NARCOTICS OR ANY OTHER MIND-ALTERING SUBSTANCES? (I.E. STREET DRUGS) YES () NO ()

IF YES, WHAT HAVE YOU USED? _____

ARE YOU CURRENTLY EMPLOYED? YES () NO () IF NO, HOW LONG HAVE YOU BEEN UNEMPLOYED?

WHAT IS YOUR OCCUPATION? _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ R/L Handed: _____

Referring Physician: _____ Height: _____ Weight: _____

Is this a work related injury or illness? Yes No

Is this an accidental injury? Yes No Fall Car Accident

If this is a car accident, were you:

wearing your seat belt? Yes No

the driver? Yes No

the passenger? front rear

rear-ended broad-sided side-swiped head-on collision

Date of injury: _____

Describe what happened (mechanism of injury): _____

When did you first notice the pain? _____

Was the onset of your pain sudden or gradual? _____

Did you go to the Emergency Room? Yes No

Were you treated? Yes No

Were any tests performed? Yes No If yes: _____

What treatment did you receive? _____

List other physicians who have treated you for this problem: _____

Which of the following diagnostic tests have been performed for this problem?

- X-rays
- CT Scans
- MRI Scans
- EMG/Nerve conduction Studies
- Discogram or Myelogram

Have you ever had a similar problem with this type of pain? Yes No

If yes, did you ever completely recover from this problem? Yes No

Have you had any previous medical or surgical treatment for this condition prior to your current injury? Yes No

Please describe: _____

Are you currently working? Yes No

Are you currently working full duty? Yes No Light duty? Yes No

How many hours per day do you work? _____

What is your occupation? _____

What are your job responsibilities (including lifting requirements)? _____

If not working, how long have you been out of work? _____

Have you tried to return to work? Yes No When? _____

Is there a Rehab Nurse or Counselor or Vocational Specialist working with you? Yes No
Who? _____

Is there a lawyer involved in your case? Yes No Name: _____

Have you applied for social security disability? Yes No

Are you receiving social security benefits? Yes No

PAIN DESCRIPTIVES

Describe your pain: (Examples: sharp, stabbing, shooting, burning, aching, tingling, numbness, pulsating, etc.) _____

Is the pain constant, intermittent or occasional? _____

How many hours per day do you have the pain? _____

How many days per week do you have the pain? _____

What activities are most affected by your pain? _____

Activity level is:

- unchanged
- pain with manual labor
- diminished
- unable to perform manual labor
- significantly restricted
- unable to perform daily household chores

Where is your worst pain? neck back R/L leg R/L arm

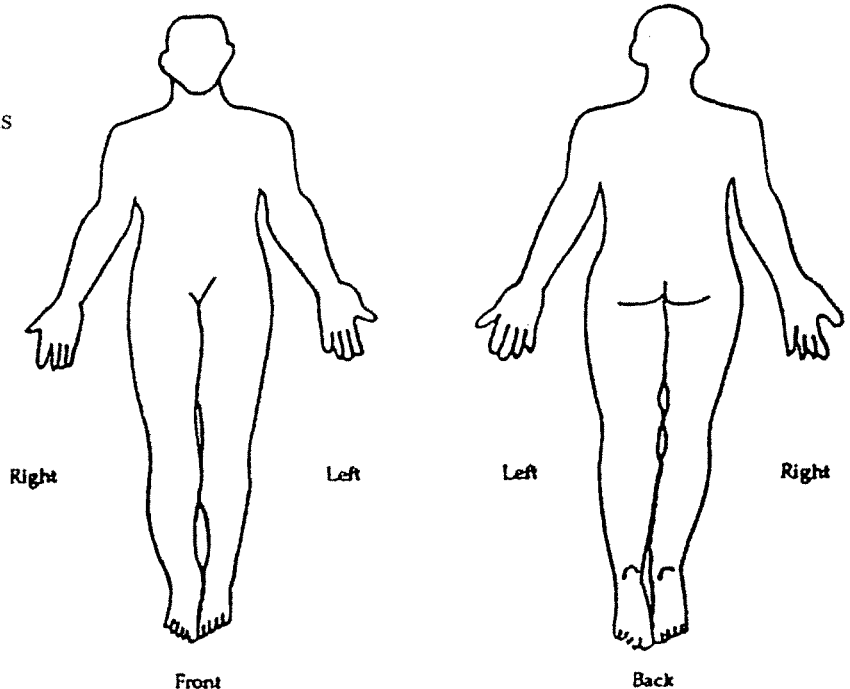
Please rate your pain (on a scale of 1-10). Please circle appropriately:

	No Pain	Minimal	Moderate	Intense	Emergency
Neck	0	1 2 3	4 5 6	7 8 9	10
Back	0	1 2 3	4 5 6	7 8 9	10
Arm	0	1 2 3	4 5 6	7 8 9	10
Leg	0	1 2 3	4 5 6	7 8 9	10

Pain Diagram: Please make the areas of your pain.

You may use the key below to indicate different kinds of pain sensations.

- Key: → = shooting
/// = stabbing
xxx = aching
ooo = throbbing
●●● = pins & needles
--- = burning



What makes your pain better? *(Please check all that apply)*

- | | | | | |
|-------------------------------------|-----------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> lying down | <input type="checkbox"/> walking | <input type="checkbox"/> sitting | <input type="checkbox"/> standing | <input type="checkbox"/> medication |
| <input type="checkbox"/> sleep | <input type="checkbox"/> heat/ice | <input type="checkbox"/> massage | <input type="checkbox"/> exercise | <input type="checkbox"/> stretching |
| <input type="checkbox"/> traction | <input type="checkbox"/> TENS | <input type="checkbox"/> forward bending | <input type="checkbox"/> backward bending | <input type="checkbox"/> compression |

Other: _____

What makes your pain worse? *(Please check all that apply)*

- | | | | | |
|--|-------------------------------------|-----------------------------------|----------------------------------|---|
| <input type="checkbox"/> standing | <input type="checkbox"/> sitting | <input type="checkbox"/> walking | <input type="checkbox"/> bending | <input type="checkbox"/> driving |
| <input type="checkbox"/> lack of sleep | <input type="checkbox"/> lying down | <input type="checkbox"/> lifting | <input type="checkbox"/> weather | <input type="checkbox"/> housework activity |
| <input type="checkbox"/> reaching overhead | <input type="checkbox"/> coughing | <input type="checkbox"/> sneezing | <input type="checkbox"/> tension | <input type="checkbox"/> arising from chair |

Other: _____

Do you have severe night time pain? Yes No

Do you wake up in the middle of the night because of pain? Yes No If yes, how many times? _____

Do you take sleeping medications? Yes No

Do you have difficulty falling asleep at night? Yes No

Average number of hours you sleep per night? _____

Do you experience any associated symptoms such as:

- | | | | |
|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> weakness in arms or legs | <input type="checkbox"/> problems with sexual functions | <input type="checkbox"/> vomiting | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> numbness/tingling of arms or legs | <input type="checkbox"/> headaches | <input type="checkbox"/> dizziness | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> leg pain with walking | <input type="checkbox"/> depression | <input type="checkbox"/> fatigue | |
| <input type="checkbox"/> leg pain not relieved by rest | <input type="checkbox"/> anxiety | <input type="checkbox"/> fever | |
| <input type="checkbox"/> bowel dysfunction | <input type="checkbox"/> balance disturbance | <input type="checkbox"/> chills | |
| <input type="checkbox"/> bladder dysfunction | <input type="checkbox"/> nausea | <input type="checkbox"/> night sweats | |

Which of the following treatments have you had for this condition?

- Physical Therapy *(including ultrasound, hot packs, traction, electrical stimulation, massage, exercise)*
- TENS Unit
- Traction
- Biofeedback
- Chiropractic
- Chiropractic Adjustments
- Psychological Supports
- Braces / supports
- Back School Education
- Work Hardening
- Injections *(including trigger points, facet blocks, epidural steroids, stellate ganglion blocks, BIER blocks)*
- Acupuncture
- Medications *(including anti-inflammatories, muscle relaxants, pain medications)*
- Hospitalization
- Surgery

Which treatment(s) provide(s) the most relief? _____

OCSF FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

The purpose of this form is to help our patient(s) understand Orthopaedic Center of South Florida, PA (OCSF) Financial Policy.

PAYMENT IS EXPECTED AT TIME OF SERVICE

OCSF accepts the following Types of Payments: Cash, Personal Checks, Major Credit Cards (i.e. American Express, Discover, MasterCard and Visa), and Care Credit with No interest for 6 months. There will be a \$25 fee for all returned checks.

All patients are required and responsible for the following:

- To bring any Referral and/or Authorization required by their health insurance, either Primary or Secondary, for services rendered;
- To provide OCSF with current home address and updated insurance;
- To pay for the co-payment, deductible and/or coinsurance at the time of service as designated by the insurance company;
- To pay for any previous balance at the time of service;

MEDICARE PATIENTS:

If patient is a Medicare member, patient will be responsible to review and sign the Medicare "ABN" Advanced Beneficiary Notice for services non-covered or not deemed Medically Necessary by Medicare, including orthotics, injections, etc. If patient has no secondary insurance, 20% coinsurance is required to be paid at time of service. The patient must notify OCSF if enrolled with any HMO/PPO.

MOTOR VEHICLE ACCIDENT PATIENTS:

If related to MVA accident, patient is to report accident to their own Automobile insurance within time limit and provide our office with the claim number. If patient does not have Automobile insurance, they need to report accident to the Automobile insurance in their household. If we file patient's health insurance, co-payment, deductible, and/or coinsurance is expected at the time of service.

WORKER'S COMP PATIENTS:

Patient will be treated for Worker's Comp. accident as long as we are the authorized treating physician(s). Once patient reaches MMI (Maximum Medical Improvement), patient shall be responsible for co-payment designated by Worker's Comp. If case is settled, we cannot file future claims to Worker's Comp., therefore, patient shall provide us with their health insurance information.

BILLING & COLLECTION PROCEDURES:

If eligible for Insurance benefits, it should be understood that the agreement is between the patient and their health insurance. Patient is responsible to pay for our services regardless of the status with their insurance company. Orthopaedic Center of South Florida, PA files claims promptly to the insurance company for services rendered as a courtesy to the patient. If there is a patient balance, statements are mailed monthly, around the 10th of every month, for a period not to exceed three (3) months. Any balance due beyond 30 days is subject to interest of 1.5%, which accumulates every month thereafter until balance is paid in full. OCSF may use an outside collection

agency in an attempt to collect any outstanding patient balance, and collection fees may be added.

OTHER ENTITIES:

During the course of your treatment, patient may be referred to other institutions for diagnostic testing, lab work, durable medical equipment and/or therapy. These Referrals are based solely on medical necessity and our affiliation with these institutions is based on providing our patients with the highest quality and professional medical care possible. Comments on patient's experience of these institutions will be used to modify and improve the Referral process. This notice will serve to advise our patient(s) that OCSF participates as a partner in the Centers listed below and that patient's signature acknowledges that he/she has been apprised of this information. The Centers are as follows:

- Coral Springs Surgical Center
- Memorial Same Day Surgery Center East
- Memorial Same Day Surgery Center West
- The Surgery Center of Ft Lauderdale

OCSF will make every attempt possible to refer our patient(s) to a facility participating with the patient's insurance plan; however, it is ultimately the patient's responsibility to find out if the facility is participating with their insurance company. OCSF will not be help responsible for any referral of a non-participating facility.

ASSIGNMENT OF BENEFITS:

The undersigned patient assigns the insurance benefits to Orthopaedic Center of South Florida, PA for services rendered. The medical provider agrees to accept the irrevocable assignment benefits for services rendered to the patient. A photocopy of this assignment is to be considered valid as an original.

DIRECTION TO PAY: The undersigned patient directs their Health Insurance to pay Orthopaedic Center of South Florida, PA directly for services rendered. In the event health insurance pays the patient directly, the patient agrees to endorse and turn payment over to Orthopaedic Center of South Florida immediately.

RELEASE OF INFORMATION: The undersigned patient authorizes Orthopaedic Center of South Florida, PA to furnish insurance and/or business associates with any and all information that may be necessary for treatment, for payment or for health care operations.

I certify that I have read, understand and agree to the terms and conditions indicated on this form. If Patient is under 18, I hereby give my permission and consent for patient to be treated by any physician part of Orthopaedic Center of South Florida, P.A.

Patient's Name

Patient's Signature (if minor, Parent or Guardian)

Date