All-Pro
BIRTH ORTHOPEDICS AND SPORTS MEDICINE
Dr. Jesse Shaw
17779 SW 2nd St.
Pembroke Pines, FL 33029

2013 PATIENT INFORMATION

Name (First) _____ (M) ____ (Last) _____ Marital Status: _____

Address: _____ Apt No. _____

City_____ State_____ Zip_____

HomePhone: _____ Cell Phone: _____ E-Mail: _____

DOB: ___/___/___ Age____ Sex____ Social Security No:_____ Occupation: _____

Language:_____ Race: _____ Ethnicity: _____

Employer/School_____ Business Phone: _____

Pharmacy name _____ Pharmacy Phone: _____

If patient is a minor: Parent/Guardian name: _____ DOB: ___/___/___

Who may we thank for referring you to us? _____

Primary care physician _____ Phone_____

Please list the name of a person to contact in case of an emergency other than a spouse or parent:

Name: _____ Relationship: _____ Phone: _____

Address: _____ Apt No._____ City_____ State_____ Zip_____

PRIMARY INSURANCE

Insurance Company: _____

ID#_____ Group #_____

Insured's full name: _____ Insured SS#_____ Insured DOB: _____

Relationship to Insured (self, spouse, child, other) _____

SECONDARY INSURANCE

Insurance Company: _____

ID#_____ Group #_____

Insured's full name: _____ Insured SS#_____ Insured DOB: _____

Relationship to Insured (self, spouse, child, other) _____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN: _____ DATE: _____

ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment of insurance benefits to be made directly to All-Pro Orthopedics and Sports Medicine for services provided to me by All-Pro Orthopedics. I understand that I am financially responsible to All-Pro Orthopedics and Sports Medicine for charges not covered by this assignment. I authorize All-Pro Orthopedics and Sports Medicine to refund overpayment of insurance benefits where my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. This is authorization will remain in effect until revoked in writing by the undersigned.

Patient Signature: _____ Date: _____

PATIENT CONSENT TO TREATMENT AT ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE

I give my consent for evaluation and treatment to All-Pro Orthopedics and Sports Medicine, and its staff members. I understand I may rescind this consent at any time, formally in writing, and then will not permit or receive further treatment. As regards the treatments which may be rendered to me at All-Pro, these may include the following:

Initial examination, follow up examination, radiographs, injections, fluid drainage, medications for pain, muscle spasm or inflammation. This will be at the discretion and judgment of me and my medical physician.

Patient signature: _____ Date: _____

Witness name & signature _____ Date: _____

Jesse Shaw, Orthopedic Surgeon

www.AllProOrthopedics.com

17779 SW 2nd Street, Pembroke Pines, FL 33029
Phone 954-322-1110 fax 954-322-1099

All-Pro Orthopedics & Sports Medecine P.A.
17779 SW 2nd Street
Pembroke Pines, Fla 33029
Phone: (954) 322-1110
Fax: (954) 322-1099

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND CONSENT TO USE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. to use health information about you for treatment, payment, and health care operations purposes.

NOTICE OF PRIVACY PRACTICES: ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A. has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

AMENDMENTS: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: 17779 SW 2nd St, Pembroke Pines, Fl 33029 Tel: 954-322-1110/Fax: 954-322-1099

Acknowledgement and Consent

I have received the Notice of Privacy Practices for ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A.. They are authorized to use health information about (please print patient's name) _____ for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____ _____

Signature of Patient Date Account #

Personal representative information (if applicable):

_____ _____

Name of Personal Representative Relationship to Patient

IDENTITY OF RECIPENTS: Provide the name or other specific identification of the person(s) or class of persons to whom the covered entity may disclose the covered information:

Permission to Leave Message: YES_____ NO_____

___Daytime Phone@#_____

___On My Home Answering Machine Phone@#_____

___On My Voicemail@#_____

___With My Designated and Authorized Person(s) Named Below:

Dr. Jesse Zisholtz Shaw, D.O.

ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A.

17779 SW 2nd Street
Pembroke Pines, FL 33029-3924
Phone: (954) 322-1110
Fax: (954) 322-1099
E-mail: orthoshaw@gmail.com

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS: I_____,

Do hereby IRREVOCABLY ASSIGN to the above-named medical provider, any right or benefits under my policy of insurance with_____, for any service and/or charges provided by the above medical provider. Pursuant to this ASSIGNMENT OF BENEFITS, you are hereby directed to mail any and all checks directly and solely payable to the above named medical provider at the address listed on the HCFA-1500A form in box 33. As part of this ASSIGNMENT OF BENEFITS, I hereby instruct the insurance carrier that in the event the medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of benefits claimed by **ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE PA** is to be set aside and not disbursed until the dispute is resolved.

IN WITNESS WHEREOF the undersigned has hereunto set his/her hand, this ____day of _____, 20____.

_____ _____

Patient's Signature Patient's Name (please print)

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/her own hand):*

Jesse Z. Shaw, D.O.	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

LETTER OF PROTECTION
ALL-PRO ORTHOPEDICS AND SPORTS MEDICINE P.A.

Jesse Z. Shaw D.O.
17779 SW 2nd Street, Pembroke Pines, FL 33029-3924
Phone: (954) 322-1110 Fax: (954) 322-1097

The undersigned patient ("Patient") authorizes All-Pro Orthopedics and Sports Medicine P.A. ("The Provider") to furnish the undersigned attorney ("Attorney") a full report of examination, diagnosis, treatment, operation and/or prognosis, as filed by the Patient's doctor with respect to health care services and procedures that Patient received or may be receiving the future with Provider (in the aggregate, "Services") and Provider's bill for services ("the Bill") as related to injury(s) that the Patient sustained as the result of an **accident that occurred on** _____ (date of accident) (the "Accident"). With respect to the Provider providing such services to Patient:

A. Patient further authorizes and directs Attorney to: **1.** Pay directly to the Provider any and all sums that are due and owing pursuant to the Provider's bill (at Provider's usual and customary charges) and **2.** Withhold from the proceeds of any settlement, judgment or verdict (the "Award") all sums owing to the Provider equal to Obligation: and **3.** Pay Obligation owed to Provider without right of set-off after client signs closing statement and check clears trust account.

B. Patient further agrees and grants the Provider an irrevocable lien on the Award to the extent of such obligation. Additionally Patient agrees that this Letter of Protection shall be irrevocable once the Obligation arises. Finally, Patient agrees that, as a material condition of the Provider entering into this Letter of Protection and providing the services to Patient, any substitute legal counsel shall be bound by and required to execute this Letter of Protection.

C. The Patient understands and further agrees that: **1.** Patient is fully responsible for the Obligation and **2.** This Letter of Protection is entered into to provide protection to the Provider in consideration of Provider agreeing to await payment for the Obligation: and **3.** Payment for any services provided to Patient by Provider is not contingent upon any award and the Provider may collect at any time for such services from any source (including, but not limited to a Patient's other party payer for health related items and services); and **4.** Patient agrees to pay all of the Provider's cost, claims, damages of any kind if this Letter of Protection is breached by Patient or if any dispute regarding it arises.

The execution of this Letter of Protection by the Attorney is a material condition of the Obligation and Provider entering into this Letter of Protection.

THE UNDERSIGNED PATIENT AGREES TO ALL OF THE FOREGOING TERMS AND CONDITIONS:

Signature of Patient	Patient's Printed Name	Date
Witness Signed Name	If patient is a minor, name and relationship to patient	

THE UNDERSIGNED ATTORNEY AGREES TO ALL OF THE FOREGOING TERMS AND CONDITIONS AND FURTHER SPECIFICALLY AGREES (1) TO WITHHOLD THE AMOUNT OF THE OBLIGATION FOR SERVICES OF PROVIDER FROM THE AWARD AND (2) IN THE EVENT THAT THERE IS COVERAGE IN THIS CASE FROM WORKERS' COMPENSATION, AN HMO, PPO, IPA OR ANY OTHER HEALTH INSURANCE AND /OR HEALTH PLAN (IN THE AGGREGATE, THE "PAYERS") FOR WHICH THE PROVIDER HAS AGREED TO ACCEPT FULL PAYMENT AT A LEVEL THAT IS BELOW THE PROVIDER'S USUAL AND CUSTOMARY BILLED FEES, THE PROVIDER SHALL ACCEPT AS FULL PAYMENT AND APPROPRIATE AND APPLICABLE NEGOTIATED FEE SCHEDULE AMOUNT(S) FOR SEVICES RENDERED BY PROVIDER IN THIS CASE ONLY IF THERE IS NO OTHER RECOVERY FROM ANY OTHER PARTY OR PAYMENT BY SOME COLLATERAL SOURCE OTHER THAN THE PAYERS NOTED ABOVE.

Attorney Signed Name	Attorney's Printed Name	Date

ALL-PRO ORTHOPEDICS

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○	
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○	
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○	
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○	
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○	
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○	
Thumb	○ Right	○ Left	Foot	○ Right	○ Left			
Index	○ Right	○ Left	Great Toe	○ Right	○ Left			
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left			
Third	○ Right	○ Left	3rd Digit	○ Right	○ Left			
Little	○ Right	○ Left	4th Digit	○ Right	○ Left			
			5th Digit	○ Right	○ Left			

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):
   ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10
6. Do the symptoms wake you from sleep?
   ○ Yes ○ No
7. Please describe the symptoms:
   ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting
8. What is the timing of the symptoms?
   ○ Constant ○ Intermittent (comes and goes)
9. Is the problem getting better or worse?
   ○ Getting better ○ Getting worse ○ Unchanged
10. What makes the symptoms worse?
    ○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
    ○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead
11. Are there any other symptoms associated with this problem?
    ○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
    ○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests? ○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	_____
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	_____
Chiropractor	○ Improved	○ Worsened	○ Unchanged	_____
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	_____
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	_____
Surgery	○ Improved	○ Worsened	○ Unchanged	_____
Injections	○ Improved	○ Worsened	○ Unchanged	_____
Bracing	○ Improved	○ Worsened	○ Unchanged	_____
TENS unit	○ Improved	○ Worsened	○ Unchanged	_____

Other/Comments: _____

_____

_____

Select all previous hospitalizations/surgeries: ○ None

- ○ Aneurysm (Brain) Surgery
- ○ Aortic Bypass / Vascular Surgery
- ○ Appendectomy
- ○ Cataract (Eye) Surgery
- ○ Cholecystectomy (Gallbladder)
- ○ Heart Surgery
- ○ Hernia Repair
- ○ Hysterectomy
- ○ LAP Band / Gastric Bypass Surgery
- ○ Lumpectomy
- ○ Mastectomy
- ○ Malignancy/Cancer
- ○ Stents

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○

Spinal Surgery - Indicate Level: _____

Other Surgery

_____
_____
_____

Other Orthopedic Surgery

_____
_____
_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None for all

					None	Comments
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Frequent Falls ○ Change in Bowel	○ Loss of Coordination ○ Change in Bladder	○ Numbness ○ Dizziness		○	_____
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you use tobacco? ○ Daily ○ Occasionally ○ Former smoker ○ Never ○ Unknown

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

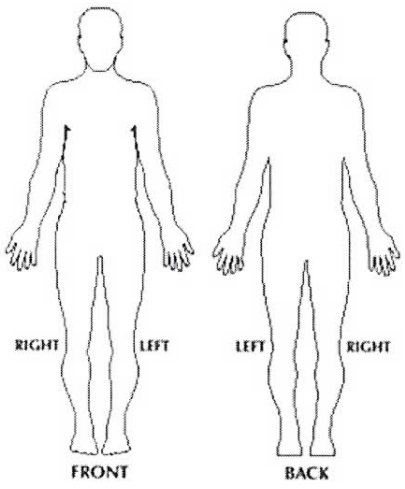
Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ ○ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

- ○ Aneurysm Where: _____
- ○ Angina (Chest Pain)
- ○ Arthritis Type: _____
- ○ Asthma
- ○ Bone or Joint Infections
- ○ Cancer Type: _____
- ○ Chemotherapy / Radiation
- ○ COPD
- ○ Congestive Heart Failure
- ○ Diabetes Type: _____
- ○ Emphysema
- ○ Epilepsy
- ○ Heart Attack
- ○ Hepatitis Type: _____
- ○ HIV / AIDS
- ○ High Cholesterol
- ○ Hypertension
- ○ Hyperthyroidism
- ○ Hypothyroidism
- Last A1C: _____
- ○ Kidney Disease
- ○ Kidney Stones
- ○ MRSA Infection
- ○ Pacemaker
- ○ Phlebitis (Blood Clots)
- ○ Pulmonary Embolism
- ○ Reaction to Anesthesia Type: _____
- ○ Seizures
- ○ Stomach Ulcers
- ○ Stroke / TIA
- ○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date