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:

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? _____

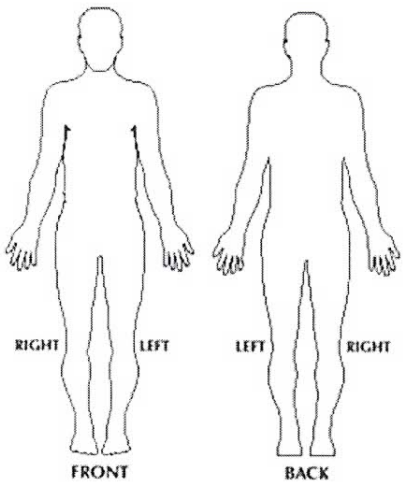
Please list work restrictions, if any: _____

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