PLEASE PRINT ENTIRE FORM COMPLETELY

DATE_____

PATIENT'S NAME_____ PARENT/GUARDIAN _____

PATIENT'S BIRTHDATE_____ AGE_____ SEX_____ MARITAL STATUS _____

PERMANENT ADDRESS_____ CITY_____ STATE_____ ZIP_____

LOCAL ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE # _____ SOCIAL SECURITY # _____

CELL PHONE # _____

EMPLOYER_____ OCCUPATION _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

EMPLOYER PHONE #_____ EMAIL _____

REFERRED BY: _____

ATTORNEY'S NAME _____ PHONE # _____

TYPE OF INJURY/ILLNESS:_____ DATE OF ACCIDENT:_____

IF ACCIDENT, TYPE: _____, _____, _____
On the Job Auto Accident Other, Please Explain

INSURANCE INFORMATION:

1ST COMPANY NAME _____	2ND COMPANY NAME_____
POLICY # _____	POLICY #_____
GROUP #/NAME _____	GROUP #/NAME_____
POLICY HOLDER _____	POLICY HOLDER_____
POLICY HOLDER DATE OF BIRTH_____	POLICY HOLDER DATE OF BIRTH _____
POLICY HOLDER SOCIAL SECURITY # _____	POLICY HOLDER SOCIAL SECURITY # _____

PERSON RESPONSIBLE FOR MEDICAL EXPENSES:

NAME _____ RELATIONSHIP_____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

PHONE #_____ EMPLOYER_____

EMPLOYER PHONE #_____

IN CASE OF EMERGENCY NOTIFY: *(Person outside of your home)*

NAME _____ PHONE #_____

ALLERGIES (please list all allergies to medications you may have)

_____

_____

ORTHOPEDIC PATIENT QUESTIONNAIRE

Name _____ Date _____

Physical Data: Height _____ Weight _____

This medical history included here can be of critical importance to you and your physician. It provides a general outline of your entire health background, points up areas that may need additional investigation and increases the effectiveness of your physician's contact with you.

Please complete thoughtfully each item of the following Orthopedic Patient Questionnaire and have it available to the physician when you are seen.

PRESENT ILLNESS	Please Print or Write Answer	Physician's Comments
1. For what condition or symptoms are you being seen at this time?		
2. Date of injury or when did you first notice onset of symptoms?		
3. Was this an accident or injury? If so, was this injury related to: Auto Accident? On the Job Injury? Liability Claim? If so, where and how did it happen?		
4. History of illness: In outline form, please try to give chronological step by step history of the progression or symptoms from onset to present. When possible, record the approximate dates of important changes or developments.		
5. Is there any history of this or a similar problem prior to the current condition or symptoms?		
6. Prior Medical Treatment: A. Name & address of 1st Doctor to see you for this problem (do not include ER Doctor). B. If above was recommended by Employer or Ins. Co., is he your initial choice of Treating Dr.? If not, who is? C. Surgery? D. Special Tests? E. X-rays? F. Other Doctors you have seen for this problem? G. Have you worked since your injury?	_____ _____ _____ _____Yes _____No _____ _____ _____ _____ _____ _____ Yes, light duty since_____ Yes, regular duty since_____ No, no work since_____	

ORTHOPEDIC SCREEN - Please circle any of the following conditions you have had or now have.

Rheumatism; recurrent joint swelling or pain; dislocated joints; loose body in joint; torn cartilage or ligaments; severely injured or sprained joints; known arthritic condition; gout or joint infection; joint laxity; loss of joint motion or other abnormality involving joints.

Neck or back pain; ruptured disc or sciatica; spinal curvature or other spine abnormality; chest deformity.

Brittle or soft bones; osteoporosis; known bone cyst or bone infection.

Inherited or congenital abnormality of extremities, trunk or any other areas; amputations.

Bursitis; tendinitis; painful bone spurs; torn muscles or tendons.

Fractures and other serious injuries; Please list date and type:_____

_____

_____

_____

_____

PREGNANCY - Do you have reason to believe that you might be pregnant or are you pregnant at this time?_____

_____

PAST HISTORY OF OTHER MEDICAL PROBLEMS - If you have had any operations, please list them and indicate the approximate date or your age at the time of the procedure.

_____

_____

_____

_____

_____

If you have had or have any significant illnesses, please circle the condition or list if not included below.

Tension or migraine headache; heart trouble or rheumatic fever; heart murmur; bladder or kidney trouble; diabetes; neurological disease; poliomyelitis; epilepsy; tumor or cancer; respiratory illness; pneumonia or emphysema; tuberculosis; asthma.

Psyoriasis or other skin disease; chronic alcoholism or other drug addiction; inguinal, diaphragmatic or other hernia; high blood pressure or stroke; phlebitis; peptic ulcer or pancreatitis; anemia; other blood disorder or bleeding problem or easy bruisability; mental or nervous disorder; liver or gallbladder trouble; jaundice; thyroid disorder; colitis; tropical disease; genital or gynecological conditions, other than listed:

_____

_____

ALLERGIES (INCLUDE ALL DRUG ALLERGIES). (List) _____

_____

_____

_____

Right or Left Handed

R L (Circle One)

Physician's Comments

Please list all medicines or drugs (include birth control medication) which you are taking now or have already taken. Give dose and frequency.
(If necessary, please check bottle label or consult your pharmacist):

Drug or Medicine	Amount or Dose	Frequency

Please indicate your approximate use or intake of the following:

Coffee _____ Tobacco Products _____

Alcoholic Beverages _____

Recreational Drugs _____

REVIEW OF SYSTEMS: Please draw a circle around any symptoms or conditions in this section which you have had or now have. If your symptoms or condition is not in the list, please write it in.

Eye & Vision - Loss or change of vision; eye pain or redness; excessive watering; double vision; other than listed: _____

Ear & Hearing - Loss of hearing; buzzing or noises in ears; ear infection or drainage; other than listed: _____

Nose & Throat: - Horseness; excessive sneezing; blocked nasal passages; nosebleeds; frequent running nose; difficulty swallowing; other than listed: _____

Respiratory - Wheezing; large quantity of sputum; blood sputum; excessive cough; shortness of breath with little exercise or at rest; night sweats; pain with breathing; other than listed: _____

Cardiovascular - Chest pain; abnormal or fast heartbeat; abnormally low blood pressure; calf cramps with walking; excessive sensitivity of fingers & toes to cold; varicose veins; frequent & marked swelling of ankles & feet; other than listed: _____

Gastrointestinal - Digestion difficulties; frequent nausea or vomiting; bloody vomitus; lack or loss of appetite; stomach or abdominal pain; frequent belching; frequent loose bowel movements; recurring diarrhea; blood in the stool; hemorrhoids or piles; gallbladder trouble; frequent or severe constipation; persistent anal itch; other than listed: _____

Genital-Urinary - Urinary incontinence or dribbling; bloody urine; increased frequency of urination; chronic urgency of urination; difficulty starting or passing urine; painfull urination; narrowing of urinary stream; flank pain; excess urine; other than listed: _____

Genital-Urinary - (Male Patients) Penile pain, infection, or sores; abnormality of testicles; scrotal swelling; varicocele; prostatitis; stricture; sterility, difficulty in sexual functioning; other than listed: _____

Genital-Urinary - (Female Patients) Breast discharge, swelling, lumps, pain or infection; nipple changes or irritation; vaginal pain, infection, discharge or itch; known uterine fibroids or tumores; tubal infections; abnormality of menstrual flow; painful menses; infertility or difficulty in becoming pregnant; marked change in body hair distribution; difficulty in sexual functioning; other than listed: _____

Physician's Comments

please turn to next page

Neurological - Severe or frequent headaches; unusual head or neck tension; dizziness; fainting spells; seizures; fits or convulsions; shaking or twitching spells; paralysis of limbs; frequent or constant numbness or tingling of parts of body; severe lapses of memory; blackouts; other than listed: _____

Emotional or Psychological - Emotional illness; depression; recurrent feelings of loneliness or hopelessness; excessive worry; severe tension; feelings of worthlessness; recurrent fear; nervous exhaustion; frequent crying; insomnia; nervous breakdown; frequent nightmares; hysterical attacks; constant unhappiness; other than listed: _____

Work Compensation Claim or Litigation Involving Illness or Injury. Prior, present, pending or anticipated: _____ Explain: _____

_____

Attorney, if any: _____

Other Medical or Surgical Conditions Not Already Listed - Include hospitalizations not previously noted. (List): _____

_____

_____

FAMILY HISTORY: Please complete the following and enter all medical conditions of each person. Refer to List of Conditions under **Past History Section** and also add any orthopedic condition or symptoms that you now have and any member of your family has now or did have.

	Deceased or Living	Age Now or at Time of Death	Medical Conditions including Cause of Death, if deceased
Father			
Mother			
Brothers (List)			
Sisters (List)			
Children (List)			

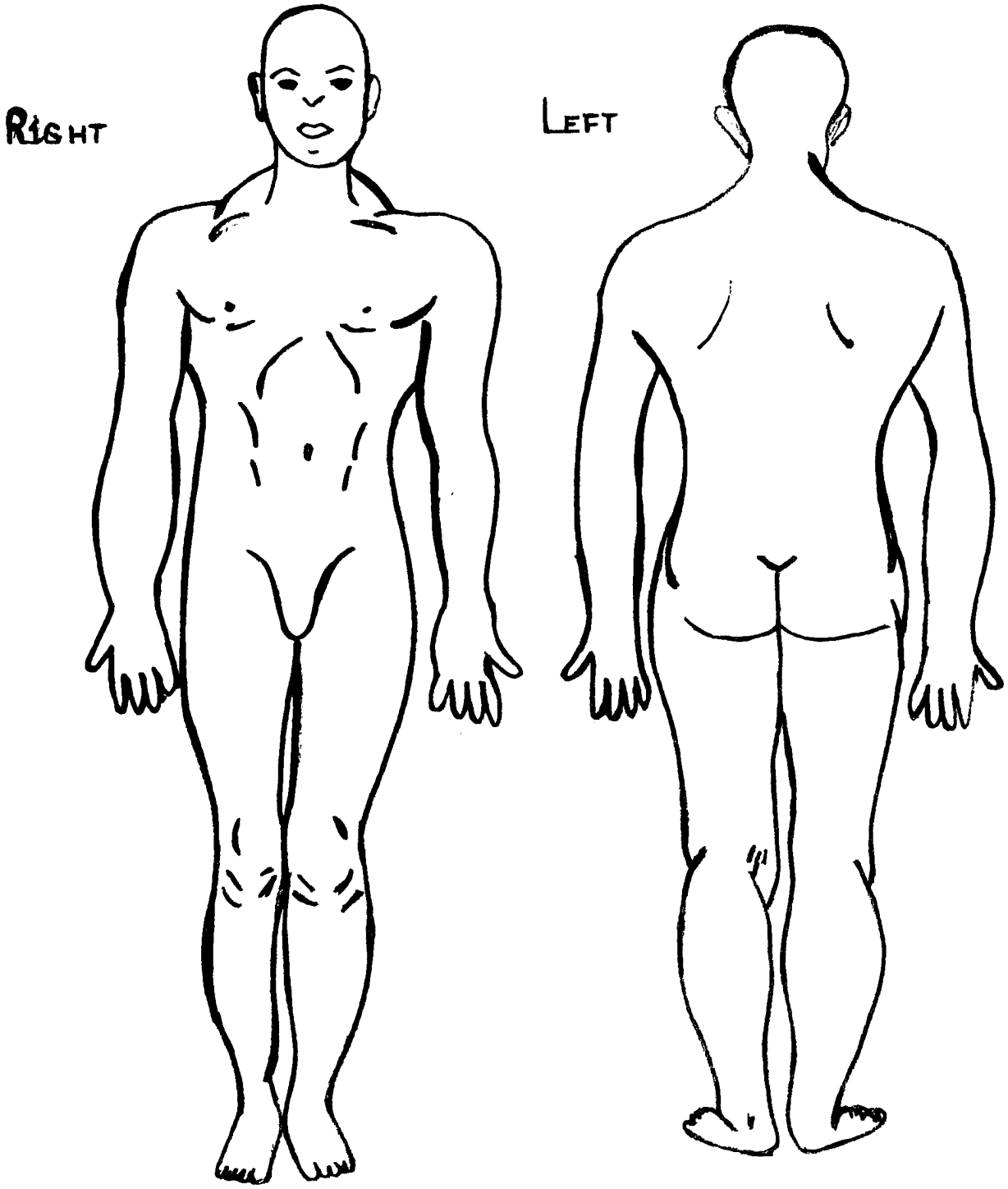
Physician's Comments

Physician's Comments:

NAME_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

NUMBNESS ≡≡≡ PINS & NEEDLES 000 BURNING xxx STABBING ////



Fort Lauderdale Ortho and Sports Medicine, LLC

POWER OF ATTORNEY AND MEDICAL RELEASE AND ASSIGNMENT OF BENEFITS

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by the these presents does hereby make, constitute and appoint Fort Lauderdale Ortho and Sports Medicine, LLC, and any of its' duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Fort Lauderdale Ortho and Sports Medicine, which checks, drafts and/or money orders are made payable for services which have been made by Fort Lauderdale Ortho and Sports Medicine, LLC., at the request or with the knowledge and approval of the undersigned and or the maker of the check, draft or money order.

Furthermore, the undersigned allows Fort Lauderdale Ortho and Sports Medicine, LLC or any of its agents to sign any paper that will be necessary to enhance, expedite and / or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these present does give and grant the said Fort Lauderdale Ortho and Sports Medicine, LLC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Ortho Florida, LLC or any issuer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page

ASSIGNMENT OF BENEFITS

I,_____ Hereby authorize_____

(Name of Insured / Patient) (Name of Insurance Carrier)

to make medical benefits payment otherwise payable to me for services rendered by Fort Lauderdale Ortho and Sports Medicine, LLC but not to exceed the charges of those services, payable to and mailed directly to.
Ortho Florida, LLC PO Box 100988, Atlanta, GA 30384-0988

Furthermore, I hereby IRREVOCABLY ASSIGN to Fort Lauderdale Ortho and Sports Medicine, LLC the rights and benefits under any policy or insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Fort Lauderdale Ortho and Sports Medicine, LLC.

IN WITNESS WHERE OF the undersigned have hereunto set their hands, this _____day of _____, 2013.

_____ _____

PATIENT"S SIGNATURE PATIENT'S NAME (PLEASE PRINT)

Fort Lauderdale
Orthopaedic Surgery & Sports Medicine

Kevin B. Shrock, MD* Matthew E. Wells, MD* Richard D. Goldstein, MD* Ray Rakhar, PA-C
Diplomate American Board of Orthopaedic Surgery

Dear Patient:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Your physician, **Kevin B. Shrock, M.D., Matthew E. Wells M.D.** and **Richard D. Goldstein M.D**. has chosen not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Please sign below to acknowledge receipt of this notice.

Signature Date

7/10

1414 SE 3rd Ave
Ft. Lauderdale, Fl. 33316
954-764-8033
954-764-5522

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Please Print (Last Name) (First) MI

Do we have permission to:

Send a recall appointment reminder to your home Y____ N ____

Leave the following information to you answering machine/voicemail/cell phone:

Appointment Information Y____ N ____

Billing Information Y____ N ____

Medical Information Y____ N ____

If no to any of the above, I request that all telephone calls be made to phone #_____

Leave appointment information with the person answering the phone in your home when you are out:
Y____ N ____

Leave the following information on your work answering machine/voicemail/cell phone:

Appointment Information Y ____ N ____

Billing Information Y ____ N ____

Medical Information Y ____ N ____

Please note medical information includes lab test results, x-ray results, more testing is required or additional information is needed from another physician's office.

I give permission to share appointment information with the person named below:

Name:_____

I give permission to share medical information with the person named below:

Name:_____

I give permission to share billing information with the person named below:

Name:_____

Print Patient Name Print Name of Legal Representative

Signature of Patient/Legal Representative Date Singed

FORT LAUDERDALE
ORTHOPAEDIC SURGERY & SPORTS MEDICINE

RICHARD D. GOLDSTEIN, M.D.* • KEVIN B. SHROCK, M.D.* • MATTHEW E. WELLS, M.D.*

Diplomate American Board of Orthopaedic Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ HAVE RECEIVED THE Notice of Privacy Practices From Fort Lauderdale Orthopaedic Surgery & Sports Medicaine, P.A..

X_____ DATE:_____

In Lieu of patient signature, I, _____, a staff member of Fort Lauderdale Orthopaedic Surgery & Sports Medicine state that_____ _____, has been given our current Notice of Privacy Practices.

X_____ DATE:_____

1414 Southeast 3 Avenue • Fort Lauderdale, FL 33316
954-764-8033 • Fax: 954-764-5522