



# Pinellas Medical Associates

## Orthopedic Surgery and Neurology

5880 49<sup>th</sup> Street N, Ste 104, St. Petersburg, FL 33709

2191 9<sup>th</sup> Ave N, Ste 105, St. Petersburg, FL 33713

Phone: 727-528-6100 Fax: 727-528-7895

**\*\* If you experience any drastic changes in your pain, loss of control of bladder or bowels, changes in muscle strength or weakness, and/or fever over 102 degrees please contact us directly. If you are unable to get through to our office within a timely manner please go IMMEDIATELY to your nearest Emergency Room \*\***

Today's Date: \_\_\_\_\_

### Patient Information

Patient's Name: \_\_\_\_\_  
Last First MI

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Sex: M F Marital Status: Married / Single / Divorced

### Contact Information

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**\*\*EMAIL ADDRESS:** \_\_\_\_\_

### ***Permanent Address (include out of state/country address):***

Address: \_\_\_\_\_ City: \_\_\_\_\_

State/Province: \_\_\_\_\_ Country: \_\_\_\_\_ Zip: \_\_\_\_\_

### ***Alternate/Current Address:***

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

***Can we leave a phone message confirming your appointments? Y / N***

Preferred contact number: Home / Cell

Preferred contact time: A.M / P.M.

**PRIMARY CARE DOCTOR:** \_\_\_\_\_ Phone: \_\_\_\_\_

**REFERRING DOCTOR:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Employment**

Employment Status (disabled, full-time, part-time, retired, student or not employed): \_\_\_\_\_

If retired or disabled approximately what date? \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact**

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Relationship: \_\_\_\_\_ Can we speak to about healthcare? Y / N

Spouse's Name (if not emergency contact): \_\_\_\_\_

Can we speak to about healthcare? Y / N Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance Company:** \_\_\_\_\_

**ID NUMBER:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**ID NUMBER:** \_\_\_\_\_ **GROUP NUMBER:** \_\_\_\_\_

**PHARMACY INFORMATION**

*We send out prescriptions electronically so we must have this information on file.*

Pharmacy Name: \_\_\_\_\_

Pharmacy Location: \_\_\_\_\_

Phone: \_\_\_\_\_

**RELEASE OF INFORMATION**

*Please list all contacts you would like us to speak to regarding your care. If you do not list them, we will not speak to them for any reason, including appointments.*

Can we leave a message confirming your appointments on your voice mail? Y / N

What **family members** can we speak to regarding your medical care?

| <u>Name</u> | <u>Relation</u> | <u>Phone Number</u> |
|-------------|-----------------|---------------------|
| 1. _____    | _____           | _____               |
| 2. _____    | _____           | _____               |
| 3. _____    | _____           | _____               |
| 4. _____    | _____           | _____               |

What **facility, doctor's office, or attorney** can we speak to regarding your care?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



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## Notices and Releases

### ASSIGNMENT & RELEASE

I assign directly to Pinellas Medical Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Signature

Date

### MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pinellas Medical Associates for any services furnished to me. I authorize medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits payable to related services.

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Signature

Date

### Notice of Privacy Practices

I, \_\_\_\_\_, acknowledge that I have received the Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the practice and myself or others. For a full copy of the act please inquire with the receptionist.

***There will be a \$50.00 charge for non-canceled appointments within a 24<sup>th</sup> hr. period as well as not bringing films that result in rescheduled appointment.***

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Signature

Date

## NEW ORTHOPEDIC PATIENT INFORMATION SHEET

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant Hand (*circle*): Right or Left

Referring doctor: \_\_\_\_\_

### Reason for visit (injury & body part):

Date of Injury:

How did the injury occur?

Treatment received (MRI, x-ray, seen by another doctor etc.):

Previous problems related to this injury: No/Yes. If yes, please explain:

### Please list all ALLERGIES / reactions:

**Current Medications:** Please attach a list if you need more space

| MEDICINE NAME | DOSAGE (MG) | HOW YOU TAKE IT<br>(Example: 1 a day) | NAME OF DOCTOR<br>WHO PRESCRIBED MEDS |
|---------------|-------------|---------------------------------------|---------------------------------------|
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |
|               |             |                                       |                                       |

**Medical problem(s) you follow a doctor for / previous diagnosis:**

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**List prior surgeries:**

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**REVIEW OF SYSTEMS**

Please **CIRCLE** if you have had any of the below:

**(You may also type into the box below)**

**CONSTITUTIONAL:** anorexia, chills, fatigue, fevers, sweats, weight loss, weakness, falls in the last year

**ALLERGIC/IMMUNOLOGIC:** hay fever, HIV exposure, persistent infections, hives

**VISION:** Eyes blurring, double vision, discharge, eye pain, irritation, light bothering your eyes, vision loss

**ENMT:** ear pain or discharge, ringing in the ears, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, trouble swallowing

**ENDOCRINE:** cold / heat intolerance, excessive thirst, frequent eating, frequent urination, weight change, diabetes'

**RESPIRATORY:** cough, shortness of breath, excessive mucus, coughing up blood, wheezing

**CARDIOVASCULAR:** chest pains, palpitations, fainting, shortness of breath on exertion, difficulty breathing while laying down, difficulty breathing at night, swelling

**GI:** abdominal pain, change in bowel habits, constipation, diarrhea, bloody stool, jaundice, vomiting blood, nausea, vomiting

**HEMATOLOGICAL/LYMPHATIC:** abnormal bruising, bleeding, enlarged glands

**GENT/GENITOURINARY:** decreased sex drive, discharge, painful urination, genital sores, blood in your urine, hesitancy, impotence, incontinence, frequent nighttime urination

**MUSKOSKELETAL:** arthritis, back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness

**SKIN/INTEGUMENTARY:** dryness, itching, rash, suspicious lesions

**NEUROLOGICAL:** memory loss, headache, head injury, numbness, tingling, vertigo

**PSYCHIATRIC:** anxiety, depression, hallucinations, memory loss, mental disturbance, paranoia, suicidal thoughts

Do you use/or have you ever used tobacco? Yes / No If yes, \_\_\_\_ packs/day Year quit \_\_\_\_\_

Do you use caffeine? Yes / No If yes, \_\_\_\_\_ cups per day

Do you use alcohol? Yes / No If yes, \_\_\_\_\_ per day / week / month

Any drug use? Yes / No If yes, how often? \_\_\_\_\_

Do you exercise? Yes / No If yes, daily / weekly / monthly

Do you use Cannabis? Yes / No If yes, daily / weekly / monthly and for what purpose?

**Family History:**

*Please circle alive or deceased, and list the number(s) that correspond with the ailment (using the chart below) for medical history and cause of death (if applicable):*

**Mother:** Alive or Deceased

Medical History: \_\_\_\_\_ Cause of death if deceased: \_\_\_\_\_

**Father:** Alive or Deceased

Medical History: \_\_\_\_\_ Cause of death if deceased: \_\_\_\_\_

- |                   |                   |                         |                      |
|-------------------|-------------------|-------------------------|----------------------|
| 1. EPILEPSY       | 6. THYROID        | 11. OSTEOPOROSIS        | 16. HIGH CHOLESTEROL |
| 2. MIGRAINE       | 7. HAYFEVER       | 12. ARTHRITIS           | 17. ALCOHOLISM       |
| 3. MENTAL ILLNESS | 8. ASTHMA         | 13. HEART DISEASE       | 18. HEPATITIS        |
| 4. GLAUCOMA       | 9. ANEMIA         | 14. STROKE              | 19. CANCER           |
| 5. DIABETES       | 10. BLEEDS EASILY | 15. HIGH BLOOD PRESSURE |                      |

***Additional Information:***