

CURRENT MEDICATIONS: (Please list all medications you are currently taking with dosages, or attach a current list):

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Pharmacy: _____ Pharmacy Phone #: _____
ARE YOU ALLERGIC TO ANY MEDICATIONS? ___ YES ___ NO. IF YES, Please list medications and any Allergic Reactions: _____

FAMILY HISTORY:

FATHER: Living? _____ Yes _____ No Illnesses? _____

MOTHER: Living? _____ Yes _____ No Illnesses? _____

Any family history of: (circle all that apply) Heart disease Rheumatoid arthritis Diabetes
 Cancer (type?) _____

SOCIAL HISTORY:

Tobacco use? Present/Past/Never How many packs per day? _____ How many years? _____

Alcohol use? Present/Past/Never How many drinks per day? _____ Week? _____

Current Weight: _____ Height: ___' ___"

SURGICAL HISTORY: (Please list all your past surgeries, stating type and date performed)

TYPE	DATE PERFORMED	TYPE	DATE PERFORMED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems: Please mark all that apply.

<u>CONSTITUTIONAL:</u>	Past	Present	<u>CARDIAC:</u>	Past	Present	<u>ENDOCRINE:</u>	Past	Present
Fever	_____	_____	Palpitations/	_____	_____	Diabetes	_____	_____
Chills	_____	_____	Irregular Heartbeat	_____	_____	Hyperthyroidism	_____	_____
Glaucoma	_____	_____	Chest Pain	_____	_____	Hypothyroidism	_____	_____
Cancer	_____	_____	Heart Attack	_____	_____	<u>HEMATOLOGIC:</u>		
Night Sweats	_____	_____	Heart Failure	_____	_____	Anemia	_____	_____
<u>CENTRAL NERVOUS SYSTEM:</u>			High Blood Pressure	_____	_____	Bleeding disorder	_____	_____
Stroke	_____	_____	High Cholesterol	_____	_____	Sickle Cell Disease	_____	_____
Seizures	_____	_____	Peripheral Vas Disease	_____	_____	Blood Clot/DVT	_____	_____
Blackouts	_____	_____	<u>RESPIRATORY:</u>			Phlebitis	_____	_____
Dizziness	_____	_____	Cough	_____	_____	Bruising	_____	_____
Headaches	_____	_____	Shortness of Breath	_____	_____	<u>GASTROINTESTINAL:</u>		
Visual Problems	_____	_____	Asthma	_____	_____	Nausea	_____	_____
Hearing Problems	_____	_____	Tuberculosis	_____	_____	Vomiting	_____	_____
<u>MUSCULOSKELETAL:</u>			Sinus Infection	_____	_____	Liver Disorder	_____	_____
Rheumatoid Arthritis	_____	_____	Pneumonia	_____	_____	Ulcers	_____	_____
Osteoporosis	_____	_____	<u>URINARY:</u>			GERD	_____	_____
Fibromyalgia	_____	_____	Difficulty Urinating	_____	_____	Internal Bleeding	_____	_____
Birth Defects	_____	_____	Difficulty Urinating	_____	_____	Diarrhea	_____	_____
<u>INTEGUMENTARY:</u>			Kidney Problem	_____	_____			
Rashes	_____	_____	Prostate enlargement	_____	_____			
Burns	_____	_____	I have none of the conditions/symptoms listed above	_____	_____			

Initials

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:

PATIENT Signature: _____ **Date:** _____

INFORMATION REVIEWED BY: _____

PHYSICIAN signature

Date

AUTHORIZATION

AUTHORIZATION/CONSENT FOR EXAMINATION AND TREATMENT:

I hereby acknowledge that I have voluntarily presented myself, or my child (if patient is a minor) for medical treatment at Suncoast Orthopaedic Surgery & Sports Medicine.

ASSIGNMENT OF BENEFITS:

I request that the payment of authorized Medicare and/or Insurance benefits be made on my behalf. I assign benefits to the physician or organization furnishing services.

RELEASE OF MEDICAL INFORMATION:

I authorize the Doctors of Suncoast Orthopaedic Surgery & Sports Medicine to release any information concerning my care to my insurance company. I also authorize the release of information to any agency necessary for payment on my account. I authorize Suncoast Orthopaedic Surgery & Sports Medicine to release records to any doctor and/or medical facility that they deem pertinent to my care.

I understand I may request restrictions regarding how my protected health information is used or disclosed in order to carry out treatment or payment regarding services provided. However, I understand the Suncoast Orthopaedic personnel cannot abide by a restriction that would prohibit the Center from complying with State and Federal regulatory agencies. If, after appropriate discussions and explanations, the Suncoast Orthopaedic personnel agree to my restrictions, I understand the restriction is binding.

I understand that I may revoke this consent in writing.

I hereby request restriction of the following information: _____

The staff at Suncoast Orthopaedics may leave discrete telephone messages on my personal answering machine or other number that I may provide.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE AUTHORIZATIONS. I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION THAT I HAVE PROVIDED IS ACCURATE:

Patient Signature: _____ Date: _____

COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of protected health information (PHI) has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees and managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know you have the right to full access to your personal medical records. Other entities may have indirect treatment relationships with you (such as the physician reading your x-ray) and we may have to disclose PHI for purposes of treatment or payment. These entities are most often not required to obtain patient consent.

You may refuse, in writing, the consent to the use or disclosure of your PHI. Under this law, we then have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent on this document, at some time in the future you may request to refuse all or part of disclosure of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any questions, please ask to speak with our Privacy Officer. Thank you.

