# Pinellas Medical Associates

## Specializing in Orthopedic Surgery

5880 49th Street N, Ste 104, St. Petersburg, FL 33709
Phone: 727-528-6100 Fax: 727-528-7895

***If the below-identified patient experiences any urgent symptoms, which may include, but are not limited to, sudden severe changes in level of pain, severe headache/dizziness, confusion, seizures, change of vision, loss of control of bladder or bowels, changes in muscle strength or weakness, and/or a fever of over 102 degrees, IMMEDIATELY contact the office directly at 727-528-6100. If unable to get through to the office or get a response from the physician within a 15-minute period, or if experiencing any urgent/unexpected symptoms, including, without limitation, STROKE symptoms, IMMEDIATELY either go to your nearest hospital Emergency Room or call 911.***

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 / Widowed

Transgender male (female to male)

Transgender female (male to female)

**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.

**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: _____

**PRIMARY CARE PROVIDER**

Primary Care Doctor Name: _____

Office Phone: _____ Office Fax (if known): _____

Office Location (City and State): _____

**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?

| | Name | Relation | Phone Number |
|---|---|---|---|
| 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.

_____

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.

_____

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 24th hr. period as well as not bringing films that result in rescheduled appointment.***

_____

**Signature** **Date**

# NEW ORTHOPEDIC PATIENT INFORMATION SHEET

Date: _____

Patient Name: _____ DOB: _____ Age: _____

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

**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 (Example: 1 a day) | NAME OF DOCTOR WHO PRESCRIBED MEDS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

_____

_____

_____

**List prior surgeries:**

_____

_____

_____

## REVIEW OF SYSTEMS

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

**MUSCULOSKELETAL:** 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:***