Pinellas Medical Associates

Specializing in Orthopedic Surgery

5880 49th St N Ste N-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: _____ Marital Status: _____

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? _____

Preferred contact number: _____ Preferred contact time: _____

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? _____

Spouse's Name (if not emergency contact): _____

Can we speak to about healthcare? _____ 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: _____

PRIMARY CARE PROVIDER

Primary Care Doctor Name: _____

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

Office Location (City and State): _____

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?

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

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: 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 list which of the below you have ever had:

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? _____ If yes, ____ packs/day Year quit _____

Do you use caffeine? _____ If yes, _____ cups per day

Do you use alcohol? _____ If yes, _____ per _____

Any drug use? _____ If yes, how often? _____

Do you exercise? _____ If yes, _____

Do you use Cannabis? _____ If yes, _____ 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: _____

Medical History: _____ Cause of death if deceased: _____

Father: _____

Medical History: _____ Cause of death if deceased: _____

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

Additional Information: