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GARDNER ORTHOPEDICS

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3033 Winkler Ave., Ste. 100
Ft. Myers, FL 33916
Ph: (239) 277-7070 Fax: (239) 277-7071

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Physical Medicine & Rehabilitation
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Naples, Florida 34108

PATIENT INFORMATION

Date: _____ Account #:_____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: ___M___F

Home: ( ) _____ - _____ Mobile: ( ) _____ - _____ Work: ( ) _____ - _____

Preferred Contact Method: Home / Cell / Work Email Address (*please print clearly*): _____

Local Address: _____ City/State: _____ Zip Code: _____

Northern/Other Address: _____ City/State: _____ Zip Code: _____

Race:	White	Black	American Indian	Asian	Native Hawaiian	Other	Decline
Ethnicity:	Hispanic	Non-Hispanic	Type-Unknown	Decline			

Reason for visit: _____ If an injury, how did this occur: _____

Referred By: _____ Primary Care Physician: _____

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's Wk #: _____

Health Ins. Carrier: _____ Auto Ins. Carrier: _____

If patient is a Minor, Parents Name: _____ Parents Employer: _____

Source of Payment (*Please Circle*): Primary Insurance Auto Self-Pay

EMERGENCY CONTACT

In the event of a medical emergency please contact:

_____

First and Last Name Relationship Phone Number

The information above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance(s). I also authorize Gardner Orthopedics to release any information to my insurance(s) required to process my claims

_____

Patient/Guardian Signature Date

Please review forms, make appropriate changes and initial

*******THE SECTION BELOW IS ONLY FOR UPDATING PAPERWORK FOR YOUR SECOND AND THIRD YEAR OF TREATMENT*******

☐ Updated ☐ No Changes _____ _____
Patient Initial Date

☐ Updated ☐ No Changes _____ _____
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Notice of Privacy Practice

You have the right to obtain a paper copy of this notice from us upon request.

Name: _____Date: _____DOB: _____Account #:_____

Release of Information

Do you authorize the release of appointment information, medical and financial claims information?
_____Yes _____ No

If yes, this information may be released to the individual(s) listed below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

This Release of Information will remain in effect until terminated by me in writing.

If unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

☐ Other: _____

When leaving message:
Please call

☐ My Home ☐ My Work ☐ My Cell

Number: _____-_____-_____ Ext: _____

The best time to reach me is (day) _____ between (time) _____ and _____

Patient Signature: _____ Date: _____

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Name: _____Date: _____DOB: _____Account:_____

Accident or Injury Details

Many insurances companies require accident/injury details after they receive our claim. Please answer the following questions and explain how this accident/injury occurred.

NO ___ If not due to an accident, please describe your symptoms; when they started, and the manner in which they started.

_____

_____

YES ___ please answer the following that apply below:

Date of Injury: _____
Location of Injury (home, work, etc.): _____

Please check if Auto, Motorcycle, slip/fall, or "Other Accident" please answer the following:

____ Auto ____ Motorcycle ____ ATV/Dirt Bike ____ Bicycle ____Slip/Fall ____ Other

Provide a brief description of how accident occurred:

_____

_____

If Auto/Motorcycle:

Were you the ____driver or ____passenger?
Do you own the vehicle? ____Yes ____ No

If motorcycle related, do you have PIP insurance that would cover medical expenses relating to this accident? ____Yes ____ No
Has a claim been made with your auto insurance carrier? ____Yes ____ No

If Work related, please answer the following:

Name of employer at the time of injury: _____
Are you self-employed? ____ Yes ____ No
Do you receive a W-2 (employee) or 1099 (subcontractor) from this employer at year end?
____ W-2 ____1099
Have you filed a Workers' Compensation claim? _____
Has the employer or the workers' compensation carrier accepted or denied liability?
____ accepted ____ denied

Attorney Information

Have you sought the assistance of an attorney relating to this accident/injury? ___ Yes ____ No
If yes, please provide: Attorney's name: _____
Attorney's address: _____
Attorney's phone: _____

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company, _____, all records necessary for processing claims filed by me or on my behalf. I authorize all insurance payments, including auto, PIP, and medpay to be made directly to Gardner Orthopedics. I authorize my auto insurance carrier _____ to release information regarding my PIP benefits and to provide a PIP log to Gardner Orthopedics when requested.

Signature: _____ Date: _____

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Name: _____Date: _____DOB: _____Account #:_____

CONSENT TO EXAMINATION, TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and or interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Gardner Orthopedics with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo examinations, x-rays, blood tests and or any other diagnostic modalities that the physician may determine to be important and or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure and or care, treatment therapy, or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, and or trauma, if known, and will explain and proposed examination, diagnostic procedure, and or care, treatment, therapy or remedy. **I agree to clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and or treatment proposed. I agree that I will be provided the opportunity to discuss relevant and available alternatives. **I agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, and or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of not having the examination, diagnostic procedure or treatment proposed. **I agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure and or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure and or treatment and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment and that **I may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken and undisclosed medications or drugs prior to examination and or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure and or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand the examination, diagnostic procedure and or care, treatment, therapy or remedy may make my conditions worse.

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Name: _____Date: _____DOB: _____Account #:_____

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Document of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health Authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that doctors of Gardner Orthopedics have elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductible, co-payments, and fees due, less insurance payments**. As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies, such as braces, slings, splints, etc. necessary for your treatment. You are responsible for these non-covered services.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A $35.00 returned check fee will be added to your account for all retuned checks.

I agree that Gardner Orthopedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient or Patient's Representative Date

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Name: _____ DOB: _____ Account #: _____Sex: ☐ Male ☐ Female

Primary Care Physician: _____

Pain Management Physician: _____

Past Medical History- Have you been diagnosed with any of the following conditions? Please Circle Yes or No.

Heart Disease/Conditions	Yes	No	Blood Clots/DVT	Yes	No	Rheumatoid Arthritis	Yes	No
Heart Attack	Yes	No	Bleeding Disorder	Yes	No	Osteoarthritis	Yes	No
Angina/Chest Pain	Yes	No	Hypertension	Yes	No	Gout	Yes	No
Congestive Heart Failure	Yes	No	Stroke	Yes	No	Thyroid Disease	Yes	No
COPD/Emphysema	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	HIV/AIDS	Yes	No
Pneumonia	Yes	No	Anemia	Yes	No	Seizures	Yes	No
Kidney Disease/Conditions	Yes	No	Sickle Cell Disease	Yes	No	Anxiety	Yes	No
Renal Failure	Yes	No	Stomach/Intestinal Ulcers	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Cancer	Yes	No	Fibromyalgia	Yes	No
[illegible]	Yes	No		Yes	No		Yes	No

Surgeries- Please list all surgeries with the approximate date.

DATE; PROCEDURE

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Please review forms, make appropriate changes and initial
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☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

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Name: _____Date: _____DOB: _____Account #:_____

Medications-Please list all medications with dosage and frequency. (If you have a list of your medications, please attach copy.)

1._____Dosage_____Frequency_____
2._____Dosage_____Frequency_____
3._____Dosage_____Frequency_____
4._____Dosage_____Frequency_____
5._____Dosage_____Frequency_____
6._____Dosage_____Frequency_____
7._____Dosage_____Frequency_____
8._____Dosage_____Frequency_____
9._____Dosage_____Frequency_____
10._____Dosage_____Frequency_____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Drug and Food Allergies or adverse reactions (include penicillin, aspirin, anti-inflammatory drugs and local anesthesia)

_____

_____

Social History:

Marital Status: (Please Circle Choice) Married Single Divorced Widow(er)
Number of Children_____ Presently living alone? ____Yes ____No

Smoking Status:_____ Never Smoker_____ Former Smoker _____ Date Started: _____ Date Ended: _____
_____Current every day smoker - If yes, please list the amount you smoke: _____ pack(s) per day _____ packs per week

Do you drink alcoholic beverages regularly? _____Yes _____ No
If yes please list amount: _____ drink(s) per day _____ drink(s) per week.
What is your occupation? _____

I certify to the best of my knowledge that the information listed above is true and accurate.
Patient Signature: _____Date:_____

Please review forms, make appropriate changes and initial
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☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

☐ Updated ☐ No Changes _____ _____ _____ _____
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Name: _____Date: _____DOB: _____Account #:_____

Family Medical History- (does anyone in your immediate family have any of the following illnesses?)
Please circle all that apply:

Cancer	Father	Mother	Sibling	N/A	Lung Disease	Father	Mother	Sibling	N/A
Diabetes	Father	Mother	Sibling	N/A	Heart Disease	Father	Mother	Sibling	N/A
Immune Disorders	Father	Mother	Sibling	N/A	Thyroid Disease	Father	Mother	Sibling	N/A
Rheumatoid Arthritis	Father	Mother	Sibling	N/A	Kidney Disease	Father	Mother	Sibling	N/A
Degenerative Arthritis	Father	Mother	Sibling	N/A					

Immunizations: (approximate date or age)
Flu: _____ Tetanus: _____

Review of Symptoms: Are you currently or have you had problems with any of the following (circle)?

Musculoskeletal	Body Part		_____	Genitourinary	Yes	No	_____
Weight loss/ Weight changes	Yes	No	_____	Skin	Yes	No	_____
Fever	Yes	No	_____	Neurological	Yes	No	_____
Eyes/ Ears/ Nose/ Throat	Yes	No	_____	Endocrine	Yes	No	_____
Heart/Cardiovascular	Yes	No	_____	Hematologic	Yes	No	_____
Lungs/ Respiratory	Yes	No	_____	Psychiatric	Yes	No	_____
Gastrointestinal	Yes	No	_____	Other	Yes	No	_____

I certify to the best of my knowledge that the information listed above is true and accurate.

Patient Signature: _____Date:_____

Please review forms, make appropriate changes and initial
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☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

For office use only:

Initial	Date	Initial	Date	Initial	Date	Initial	Date				

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Name: _____Date: _____DOB: _____Account #:_____

Height: _____ Weight: _____

BODY PART:

-The "BODY PART" identified for **today's appointment**. (Please Circle)

Left or Right: Knee Hip Shoulder Foot Ankle Other: _____

-The "BODY PART" was normal until when? _____

-Pain level on "1-to-10" scale (Note: "10" is consistent with LOSS OF CONSCIOUSNESS): _____

-What does your pain keep you from doing? _____

_____

DESCRIBE YOUR PAIN:

ACHY STABBING SHARP DULL BURNING ELECTRICAL

-Are you or have you ever taken medicine to decrease your pain? Yes ____ No ____

Ibuprofen….. Aspirin….. Naproxen….. Meloxicam….. Celebrex…..Tramadol….

-Have you ever taken steroids or had medications injected into your joints? Yes ____ No ____

*If so, which joint and when, then, how much pain relief did you get (circle)?

None 25% 50% 75% 95% 100%

IN GENERAL:

-Have you ever had a DEXA or bone density test? Yes ____ No ____

If so, where & when was your last exam? _____

-Have you ever been told you have "Osteoporosis" or "Osteopenia"? Yes ____ No ____

-Do you take medicine, hormones or calcium supplements for your bones? Yes ____ No ____

If so, what and for how long? _____

Do you take the supplement, *Glucosamine & Chondroitin*? Yes ____ No ____

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For KNEES ONLY:

-Do you have swelling? Yes ____ No ____
-Can you sleep on your side with your knees touching/resting on each other? Yes ____ No ____
-Does it hurt to "twist" your knee when:
Getting into and out of your car? Yes ____ No ____
Walking with a sudden "pivot/twist" in one direction or another? Yes ____ No ____
Tapping something out of your path with a 'twist" of your foot? Yes ____ No ____
-Can you squat? Yes ____ No ____
What's worse (circle): Going "down" into the squat or coming "up" out of it?
-Does it your knee "lock" on you? Yes ____ No ____
("Locking" is when your knee is straight & you can't bend it…or vise/ versa)

-Does it "give-way"? Describe: _____ Yes ____ No ____

-Can you go "up" & "down" stairs? What is worse (circle) Up Down Yes ____ No ____

For HIPS ONLY:

-Where is your pain located? "Front" (groin area)…. "Side"…. "Lower Back Area" _____
-Do you have pain with any of the following activities:
Bend forward to touch your toes? Yes ____ No ____
Put your shoes and socks on? Yes ____ No ____
Cross affected leg over the other? Yes ____ No ____
Sleep on the affected side? Yes ____ No ____
-Does your pain radiate:
Down into your knee(s)? Yes ____ No ____
Below the knee and into your foot? Yes ____ No ____

For SHOULDERS ONLY:

-Are you able to tuck in your shirt behind you without pain? Yes ____ No ____
-Are you able to do any of the following activities without pain:
Reach behind you? Yes ____ No ____
Sleep on your shoulder? Yes ____ No ____
-Does your pain radiate:
Down into your hand(s)? Yes ____ No ____
To your neck? Yes ____ No ____

-Can you reach up in front of you to get things from a cabinet? Yes ____ No ____
-Is it painful to bring your elbow up to 90 degrees? (Chicken Wing) Yes ____ No ____