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Arthroscopic Reconstructive Surgery & Joint Replacement

Robert Martinez, M.D.
Arthroscopic Shoulder Surgery Joint Replacement

Brad Castellano, D.P.M
Foot & Ankle Specialty

W. Andrew Hodge, M.D.
Hip & Knee Joint Replacement

GARDNER ORTHOPEDICS

GardnerOrthopedics.com

3033 Winkler Ave., Ste. 100
Ft. Myers, FL 33916

Ph: (239) 277-7070 Fax: (239) 277-7071

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Physical Medicine & Rehabilitation

Alan Nguyen, D.O.
Physical Medicine & Rehabilitation
Interventional Spine & Sports Medicine

Madhish Patel, D.0.
Adult Reconstruction & Arthroscopy

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 _____ _____
Patient Initial Date

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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: _____ ACCT#: _____

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. **Please be advised, all no-show appointments and all appointments not cancelled within 24 hours prior to the scheduled time are subject to a $25 fee.**

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: _____Date: _____DOB: _____Account:_____

Consent to Obtain Patient Medication History

- Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.
- The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes a part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.
- It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over- the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance pian. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Name (Printed) Date of Birth

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Name: _____ Date: _____ DOB: _____ Account #: _____

Patient's Age: _____

PATIENT INFORMATION

Please complete this form in its entirety so Dr. Kini can better assess your problem and all other factors related to the problem for which you are being seen today. Thank you.

Primary Care Physician: _____Referring Physician: _____

Is this a work-related incident or an automobile accident? YES/NO If so, date of injury: _____

Reason for today's visit / describe where/what is the problem:

_____

When did the problem start? _____ Is the problem worsening? YES/NO

Does the pain keep you awake at night? YES/NO

What makes your problem better?

heat ice exercise rest sitting standing laying down medications walking injections therapy

What makes your problem worse?

heat ice exercise rest sitting standing laying down walking bending coughing sneezing lifting

Does the pain travel anywhere?

head/face shoulders arms elbows hands fingers stomach ribs buttock legs knees feet heels toes

Please describe what you feel, circle all that apply:

burning throbbing aching sharp dull stabbing pressure pins and needles numbness nagging pinching stiffness tightness pulling deep superficial constant occasional falls asleep electric

Rate your pain from 0-10 (0 is no pain, 10 being the worst pain you have ever felt) Pain at its worst (the "bad" days) _____

Average pain level (usual "everyday" pain) _____

Pain level at its least (the "good) days) _____

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PREVIOUS TREATMENT

Have you seen any other Physician for this problem? YES / NO

Name of Doctors? _____

When was your last visit with the above doctor? _____

What medications, if any, were you prescribed? _____

_____

Have you had any recent X-RAY/MRI/CT SCANS for this problem? YES / NO

Where was it done? _____

Have you had Physical Therapy/Chiropractic care for this problem? YES / NO

If so, when, and where was it done? _____

Have you had any injections for this problem? YES / NO

If so, when was the last injection? _____ Do you exercise regularly? YES/NO

Do you wear a seat belt when in the car? YES / NO

Do you wear a helmet when riding a bike or motorcycle? YES / NO

Do you see your primary care physician for routine checkups? YES / NO

How often do you see your primary care physician? _____

SURGICAL HISTORY

Surgery Name	Date of Surgery	Doctor who performed surgery

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Name: _____ Date: _____ DOB: _____ Account #: _____

LIST CURRENT MEDICATIONS

Prescribing Doctor's Name	Medication Name/Frequency	Medication Strength/ Medication

LIST ALL ALLERGIES (include medications, environmental and food allergies)

Allergy	Reaction

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PERSONAL AND SOCIAL HISTORY

Tobacco History:	**Cigarettes per day:**
current every day smoker	10 (half pack)
current some day smoker	20 (one pack)
former smoker	30 (one and half packs)
(quit date:_____)	40 (two packs)
never smoker	

Have you ever quit and restarted? YES/NO If so, for how long? _____

Alcohol History:	**Frequency of Drinks:**
currently drinks	1-6 drinks per week
rarely drinks	7-10 drinks per week
former drinker	11-15 drinks per week
never drinks	16 or more drinks per week
recovering alcoholic	rarely drinks (holidays and etc.)

Have you or anyone else ever considered your drinking a problem? YES/NO

Has drinking ever interfered with work or relationships? YES/NO

Are you currently using, or have you ever used any of the following illicit substances?

Marijuana Cocaine Heroin Methamphetamine Ecstasy PCP

Have you currently or in the past misused or abused prescription medications? YES/NO

If so, which ones? _____

Have you been in a substance abuse program for help? YES/NO

Did you quit on your own? YES/NO

Have you had any recent weight gain or weight loss? YES/NO

If so, what have you done about it? _____

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Work History

Currently employed as: _____

Previously employed as: _____

Retired now but was previously employed as a: _____

Disabled from work due to: _____

Marital Status: Married Single Divorced Widowed/Widower

Number of living children: _____ **Handedness:** right handed left handed ambidextrous

Living arrangements: house alone shared house apartment/condo townhome care facility assisted living facility homeless trailer

Do you drive? YES/NO

Past Medical History (circle all that apply)

Hypertension	Anemia	Chlamydia	T.B.I.
Thyroid Problems	Diabetes	Gonorrhea	COPD
Liver Disease	Arthritis	Food Poisoning	Cerebral Palsy
Jaundice	Multiple Sclerosis	H.P.V.	Paraplegia
Heart Disease	Scoliosis	Hepatitis B	Quadriplegia
Fractures	Gout	Tuberculosis	Hemiplegia
Osteoporosis	Mental Illness	Pseudomonas	Amputation
Headaches	Cancer	Genital Herpes	Spinal Cord Injury
Cataracts	Kidney Trouble	MRSA	Shingles
Stroke/TIA	Neuropathy	Polio	Guillain Barre
Seizures	HIV/AIDS	Neck Pain	E. coli
Back pain	Syphilis	Alcoholism	Depression

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Family History (circle all that apply)

Diabetes	Lung Disease	Heart Disease	Cancer Alcoholism
Hypertension	Depression	Neuropathy	Suicide
Osteoporosis	Psychiatric Disease	Arthritis	
Dementia	Vascular Disease	Other Addictions	

Review of Systems (circle all that apply)

Anaphylactoid Reaction	Weight Loss	Diabetes
Medication Allergy Food	Swelling in Legs	Prednisone Use
Allergy	Nose Bleeds	Thyroid Disease
Hives	Hoarseness Difficulty	Menopause
Seasonal/Pet Allergies	Swallowing Ear Pain	Blurred Vision
Arrhythmia	Hearing Loss	Cataract
Chest Pain/Pressure	Choking	Diabetic Retinopathy
Palpitations Exercise	Itching	Eye Floaters
Intolerance Chills	Skin Cancer	Glaucoma
Loss of Appetite Fatigue	Warts	Macular Degeneration
Fever	Rash Psoriasis	Reading Glasses
Recent Illness	Pressure Ulcer	Double Vision
Night Sweats	Excessive Sweating	Changes in Vision
Weight Gain	Cyst	Difficulty Urinating
		Blood in Urine
		Loss of Bowel or Bladder Control

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Continued Review of Systems (circle all that apply)

Night time Urinating	Anemia	Muscle Ache
Sexual Dysfunction	Clotting Disorder	Sciatica Spasm
Urinary Frequency	Lymph Node Enlargement	Stiffness
Urinary Incontinence	Petechiae/Red Spots	Balance Problems
Urinary Retention	Prolonged Bleeding Time	Dizziness
U.T.I.	Pain in Limb	Gait Abnormality
Kidney Stones	Pain in Joint	Headaches
Abnormal Bleeding	Back Pain Neck	Morning Headaches
Abnormal Bruising	Pain Seizures	Speech Difficulties
Pins and Needles	Weakness	Numbness
Tremor	Tingling	Anxiety Panic
Passing out Spells	Hallucination	Attack
Depression	Memory Problems	Suicidal Thoughts
Sleep Disorder	Shortness of Breath	Sleep Apnea
Oxygen use at Home	Wheezing	
Cough		

Other:_____

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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

Edward R. Dupay, Jr., D.O.
Adult Reconstruction Specialist

Aileen Padilla, D.O.
Physical Medicine & Rehabilitation
840 111th Ave. N, Ste. #7; Naples, Florida 34108

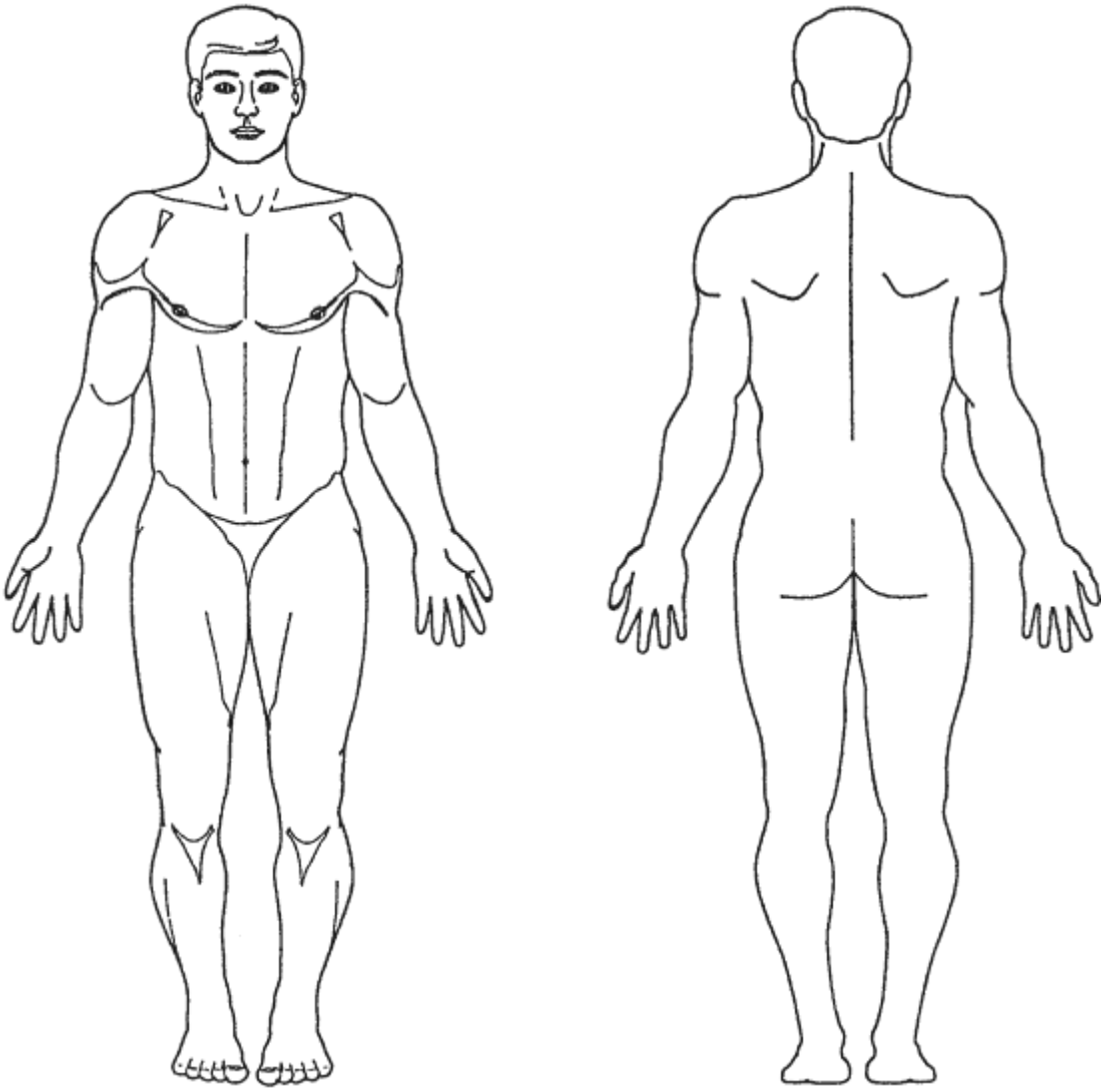
Stephanie van Heerden, DPM
Foot & Ankle Specialty

Vidya P. Kini, M.D.
Physical Medicine & Rehabilitation

Name: _____ Date: _____ DOB: _____ Account #: _____

Please mark on the drawing below all the areas where you feel pain, numbness or weakness, related to today's visit, using the symbol keys below

Use an X for pain **Use a ---- for numbness** **Use a o-o-o-o for weakness**



FRONT **BACK**

Ronald D. Gardner, M.D.
Arthroscopic Reconstructive Surgery & Joint Replacement

Robert Martinez, M.D.
Arthroscopic Shoulder Surgery Joint Replacement

Brad Castellano, D.P.M
Foot & Ankle Specialty

W. Andrew Hodge, M.D.
Hip & Knee Joint Replacement

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Edward R. Dupay, Jr., D.O.
Adult Reconstruction Specialist

Vidya P. Kini, M.D.
Physical Medicine & Rehabilitation

Alan Nguyen, D.O.
Physical Medicine & Rehabilitation
Interventional Spine & Sports Medicine

Madhish Patel, D.0.
Adult Reconstruction & Arthroscopy

MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ SSN: XXX-XX- _____ DOB: _____

INFORMATION NEEDED:

☐ **Complete** Medical Records
☐ Operative Report
☐ Radiology Films
☐ DEXA Scan / Nerve Conduction Study
☐ Lab Reports
☐ Physical/Occupational Therapy Records
☐ **Complete** Billing Records
☐ **Complete** Work Comp Records
☐ **Complete** Auto Accident Records
☐ X-ray CD **($5.00 fee in house)**
☐ Other: _____

FOR PATIENT RECORDS TO BE RELEASED FROM GARDNER ORTHOPEDICS - PLEASE ALLOW 5-10 BUSINESS DAYS

Purpose for Request: ☐ Continuing Care ☐ 2nd Opinion ☐ Personal Record Keeping

Delivery Option:

☐ I will pick up ☐ To be picked up by _____ (Photo ID Required)

Send to:

_____

Address: _____ City: _____ State: _____ Zip:

FOR PATIENT RECORDS TO BE OBTAINED FROM OTHER FACILITIES

I hereby authorize and request that you release the following medical information to:

To Physician/Hospital/Facility: Gardner Orthopedics

Address: 3033 Winkler Ave. Suite 100 City: Fort Myers State: FL Zip: 33916

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDs virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all healthcare information pertaining to such diagnosis, testing, or treatment. As required by state and federal law, Gardner Orthopedics may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures on the protected health information described on the form.

*****I understand that requested copies of my x-rays have a cost of $5.00 per CD and requested copies of my Medical Records have a processing fee of $1.00 per page (up to 25 pages) with a cost of .25 cents per page thereafter*****

I hereby authorize _____ to release information as described above.

Patient's Signature or Legal Representative: _____ Date: _____

Signature of Parent or Guardian (if minor):