Name:
Chart:
Date:

KENNEDY - WHITE ORTHOPAEDIC CENTER

PATIENT INFORMATION

PATIENT Please Print

NAME LAST	FIRST	MIDDLE INITIAL	AGE	TODAY'S DATE

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	SEX	MARITAL STATUS	DATE OF BIRTH	CELL PHONE #

EMAIL ADDRESS

OUT OF STATE # ( )	OUT OF STATE ADDRESS	CITY-STATE-ZIP

EMPLOYER NAME AND ADDRESS	CITY-STATE-ZIP

SOCIAL SECURITY NUMBER	OCCUPATION / STUDENT

FAMILY PHYSICIAN	REFERRED BY

SPOUSE, OR IF YOU ARE A MINOR, YOUR PARENT OR GUARDIAN

NAME FIRST-MIDDLE-LAST (IF MINOR, FATHER'S NAME)	RELATIONSHIP	SPOUSE/PARENT DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE # ( )	WORK PHONE # ( )	SOCIAL SECURITY #

NEAREST RELATIVE NOT LIVING WITH YOU MUST BE COMPLETED

PERSON TO CONTACT IN EMERGENCY (NEXT OF KIN)	THEIR RELATIONSHIP TO YOU	HOME PHONE	WORK PHONE

STREET ADDRESS	CITY-STATE-ZIP

INSURANCE INFORMATION

INSURANCE COMPANY WORKERS COMPENSATION	PHONE	☐ HMO COPAY$___ ☐ PPO COPAY$___

INS. CLAIMS MAIL TO:

STREET

CITY/STATE/ZIP	ADJUSTER NAME

POLICY #	☐ AUTHORIZATION ☐ REFERRAL	☐ CLAIM #

GROUP #

INSURED PERSON	SS #

INSURED PERSONS DATE OF BIRTH

SECONDARY CARRIER

INSURANCE COMPANY	PHONE	☐ HMO COPAY$___ ☐ PPO COPAY$___

INS. CLAIMS MAIL TO:

STREET

CITY/STATE/ZIP	ADJUSTER NAME

POLICY #	☐ AUTHORIZATION ☐ REFERRAL	☐ CLAIM #

GROUP #

INSURED PERSON	SS #

INSURED PERSONS DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits to Kennedy - White Orthopaedic Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE (parent if minor) DATE

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICARE ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to Kennedy - White Orthopaedic Center for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE

SIGNATURE (parent if minor) DATE

Name:
Chart:
Date:

Kennedy-White Orthopaedic Center
HIPAA Notice of Privacy Practices

Acknowledgement of Receipt

I, _____, have been given a copy of the Kennedy-White
(Printed patient name)
Orthopaedic Center Summary Notice of Privacy Practices.

_____ _____
Patient Signature Date

Authorization For Family, Friends, Or Advisors To Receive Information About Your Medical *Condition* Or The *Status* Of Your Bill.

I authorize the following individual(s) to receive written and/or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they will need to be able to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription or to discuss my care or the status of my bill, they will need to bring a photo id.

Authorized Individual(s) Please print name(s)

_____ _____

_____ _____

_____ _____

_____ _____
Patient Signature Date

Name:
Chart:
Date:

KENNEDY-WHITE ORTHOPAEDIC CENTER
NEW PATIENT HISTORY

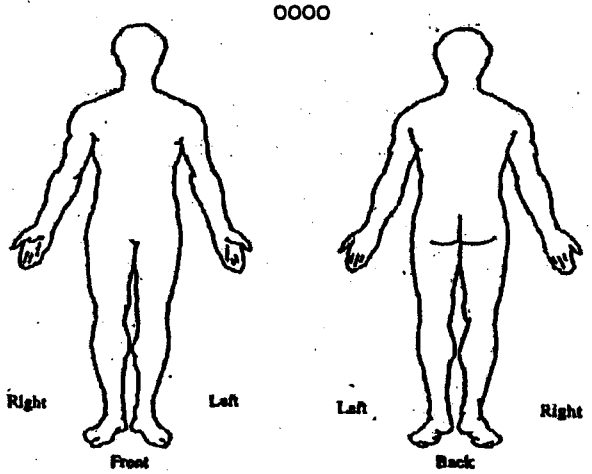
Patient Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Who Referred You To Our Office? _____ **Personal Physician:** _____

Reason for Visit: _____
Vital Signs: T _____ P _____ R _____ B/P _____ Height _____ Weight _____
☐ **Right-handed** ☐ **Left-handed**

On the following diagram, mark the areas on your body where you feel the following sensations:

PAIN
xxxx

NUMBNESS / TINGLING / PINS & NEEDLES
oooo



PLEASE CIRCLE THE NUMBER ON THE SCALE BELOW YOUR CURRENT LEVEL OF PAIN

1 2 3 4 5 6 7 8 9 10

What is the highest number that your pain goes to? _____
What is the lowest number that your pain goes to? _____
What pain level is a realistic goal for you? _____

Under what circumstances did your pain begin?
☐ accident at work date: _____
☐ following motor vehicle accident date: _____
☐ following a fall
☐ unknown
☐ progressive
☐ sports

What best describes your pain? (Please circle all that apply)
Burning Stabbing Shooting Aching Dull Electrical Deep Vague Sharp Constant Intermittent Daily
Do you have any numbness? ☐ Yes ☐ No If yes, where? _____
Do you have any weakness? ☐ Yes ☐ No If yes, where? _____

WHAT ACTIVTIES MAKE THE PAIN WORSE?
☐ Exercise (during)
☐ Exercise (after)
☐ Sitting _____min
☐ Standing _____min
☐ Walking _____min
☐ Coughing/Sneezing
☐ Bending Forward
☐ Bending Backward
What time of day is your pain worse? _____

WHAT REDUCES THE PAIN?
☐ Lying Down
☐ Sitting
☐ Standing
☐ Walking
☐ Manipulation/Chiropractor
☐ Physical Therapy
☐ Pain Pills
☐ Injections for Pain
☐ Muscle Relaxant Pills
☐ Aspirin/Anti-inflammatories/Tylenol
☐ Nothing
☐ Home Exercise Program

Name:

Chart:

Date:

MEDICAL HISTORY

	Y	N	
1	☐	☐	**PACEMAKER**
2	☐	☐	**ON COUMADIN**
3	☐	☐	**ON ASPIRIN**
4	☐	☐	**OTHER BLOOD THINNERS**
5	☐	☐	rheumatoid arthritis
6	☐	☐	lupus arthritis (SLE)
7	☐	☐	ankylosing spondylitis
8	☐	☐	arthritis (other)
9	☐	☐	fibromyalgia
10	☐	☐	osteoporosis
11	☐	☐	polymyalgia rheumatica (PMR)
12	☐	☐	gout
13	☐	☐	psoriasis
14	☐	☐	**HEART DISEASE**
15	☐	☐	heart attack
16	☐	☐	angina
17	☐	☐	**HIGH BLOOD PRESSURE**
18	☐	☐	atrial fibrillation
19	☐	☐	stroke
20	☐	☐	peripheral vascular disease
21	☐	☐	asthma/ emphysema/ COPD
22	☐	☐	TB (tuberculosis)
23	☐	☐	pulmonary embolus
24	☐	☐	blood clot in leg (DVT)
25	☐	☐	**DIABETES**
26	☐	☐	neuropathy
27	☐	☐	thyroid disease
28	☐	☐	HIV (AIDS)
29	☐	☐	kidney failure
30	☐	☐	stomach ulcer
31	☐	☐	gastric bleeding
32	☐	☐	reflux (GERD)
33	☐	☐	hepatitis
34	☐	☐	liver disease
35	☐	☐	**CANCER**, list type(s) _____
36	☐	☐	seizure disorder (epilepsy)
37	☐	☐	multiple sclerosis
38	☐	☐	Parkinson's disease
39	☐	☐	dementia
40	☐	☐	depression
41	☐	☐	bipolar disorder
42	☐	☐	anxiety disorder
43	☐	☐	mental illness
	☐	☐	Other: _____

PREVIOUS SURGERIES

	Y	N	
44	☐	☐	prior problems with anesthesia
45	☐	☐	gallbladder
46	☐	☐	appendix
47	☐	☐	prostate
48	☐	☐	hysterectomy/ovaries
49	☐	☐	heart stents
50	☐	☐	heart bypass
51	☐	☐	heart valve surgery
52	☐	☐	spine surgery
53	☐	☐	hip surgery
54	☐	☐	knee surgery
55	☐	☐	shoulder surgery
56	☐	☐	hand surgery
	☐	☐	other surgeries (list):

_____

_____

_____

_____

_____

FAMILY HISTORY

If a parent or sibling has a history of any of the following conditions, please check the box:

57	☐	Hepatitis
58	☐	Kidney Disease
59	☐	Stroke
60	☐	Cancer
61	☐	Heart Disease
62	☐	Bleeding Disorder
63	☐	High Blood Pressure
64	☐	Alcoholism
65	☐	Diabetes
66	☐	AIDS
67	☐	Arthritis
68	☐	TB
69	☐	Neck or Back Problems
70	☐	Mental Illness
71	☐	Fibromyalgia
72	☐	Seizures
	☐	Other (specify): _____

_____

_____

_____

REVIEW OF SYSTEMS

(Please check those that apply within past year)

	Y	N	
73	☐	☐	chest pain
74	☐	☐	shortness of breath
75	☐	☐	night sweats/fever
76	☐	☐	weight loss (unintentional)
77	☐	☐	heartburn caused by medicine
78	☐	☐	blurred vision
79	☐	☐	blood in urine
80	☐	☐	burning on urination
81	☐	☐	skin rash
82	☐	☐	loss of hearing
83	☐	☐	easy bleeding/bruising
84	☐	☐	seizures/convulsions
85	☐	☐	loss of memory
86	☐	☐	claustrophobia
87	☐	☐	dizziness
88	☐	☐	nausea/vomiting
89	☐	☐	numbness hands/feet
90	☐	☐	constipation
91	☐	☐	sexual dysfunction
92	☐	☐	sleep problems

_____

_____

_____

_____

_____

MEDICATIONS

Name of Medication	Dose (mg or # of pills)	How often? (# of times per day)	What is this medication for?	Date Started	Prescribing Doctor

Are you ALLERGIC to any medications? ☐ **No** ☐ **Yes** If yes, list medication(s) & the reaction:

Medication **Allergic Reaction**

_____ _____

_____ _____

_____ _____

Name:

Chart:

Date:

PSYCHOSOCIAL HISTORY

Highest level of education _____ Are you going to school now? _____

Are you able to care for yourself? _____ If not, who helps you? _____

Do you use any assistive device at home? (walker, cane, etc.) _____

What is your marital status? _____ How many people live in your household? _____

Are you, or have you ever been, involved with any of the following? (Please select appropriate choices)

Current Use	*Past Use*	*Item*	*Comments (how much and how many years?)*
		Tobacco Use	
		Drink Alcohol	
		Caffeine-containing beverages	
		Marijuana use	
		Cocaine	
		Methamphetamine	
		Heroin	
		Other illicit/street drug use	

Have you ever felt the need to cut down on your drinking/drug use? ☐ Yes ☐ No

Have you ever felt annoyed by people complaining about your drinking/drug use? ☐ Yes ☐ No

Have you ever felt guilty about your drinking/drug use? ☐ Yes ☐ No

Do you ever drink/take a pill as an eye-opener in the morning to relieve the shakes? ☐ Yes ☐ No

Do you drink alcohol to decrease or relieve pain? ☐ Yes ☐ No

VOCATIONAL/WORK HISTORY

(select the best description for you)

☐ Homemaker (full time) by choice	☐ Not working due to pain	☐ Retired due to pain
☐ Working full-time	☐ Not working due to other reasons	☐ Retired, not due to pain
☐ Working part-time	☐ On leave from work	☐

What is your current occupation (if working)? _____

LEVEL OF FUNCTION (circle the most appropriate number that corresponds to the description):

MOOD

1 2 3 4 5 6 7 8 9 10

Cheerful & Calm *Depressed & anxious*

QUALITY OF LIFE

1 2 3 4 5 6 7 8 9 10

Excellent *Poor*

EXERCISE

1 2 3 4 5 6 7 8 9 10

Exercise daily *No exercise*

ACTIVITY

1 2 3 4 5 6 7 8 9 10

Normal activity *No activity*

GETTING OUT OF BED

1 2 3 4 5 6 7 8 9 10

No difficulty *Extreme difficulty*

GETTING OUT OF A CHAIR

1 2 3 4 5 6 7 8 9 10

No difficulty *Extreme difficulty*

GAIT (Walking) (Difficulty Due to Pain)

1 2 3 4 5 6 7 8 9 10

No difficulty *Extreme difficulty*

Name:
Chart:
Date:

Kennedy-White Orthopaedic Center
6050 CATTLERIDGE BLVD. #201 SARASOTA, FLORIDA 34232
(941) 365-0655

Medical Supply Waiver

Any medical supplies not covered by your insurance company will be billed to you and will be your responsibility to pay at the time of service.

Any medical supplies that are subject to coinsurance payment will be billed to you after notification from your insurance company indicating your responsibility.

All payments are due within 30 days of our billing statement.

If you have any questions or concerns, please do not hesitate to contact our Business Office at 365-0655.

RETURN POLICY: *Kennedy-White Orthopaedic Center cannot, by law, accept a return on any product that has been worn, even if only for a short period of time. Our company cannot accept a return on any "custom-made" braces as they are manufactured specifically for that patient and therefore cannot be returned to the manufacturer. We will, however, assist in any problems (i.e. fitting, discomfort, etc.) which may occur with the product.*

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Outstanding Balances

Any patients having an outstanding balance that is referred to a collection agency will not be able to make an appointment until the balance is paid in full. Delinquent accounts referred to a collection agency will be subject to an additional $50 charge.

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Name:
Chart:
Date:

We are required to ask the questions below by the United States Government

☐ ***If you have already completed this form please check this box and sign and date below.**

1. Preferred Language

☐ I decline to answer

☐ English
☐ Spanish
☐ French
☐ Other _____

2. Race

☐ I decline to answer

☐ American Indian ☐ Asian ☐ Black
☐ Native Hawaiian ☐ White

3. Ethnicity

☐ I decline to answer

☐ Hispanic Origin ☐ Non-Hispanic Origin

4. Smoking Status

☐ I decline to answer

☐ Current Every Day Smoker Start Date: _____ Packs Per Day: _____
☐ Current Some Day Smoker Start Date: _____ Packs Per Day: _____
☐ Smoker, Current Status Unknown Start Date: _____ Packs Per Day: _____
☐ Former Smoker Start Date: _____ Quit Date: _____
☐ Never Smoker

5. E-mail Address _____ ☐ I decline to answer

_____ _____
Signature Date

Name:
Chart:
Date:

Kennedy-White Orthopaedic Pain Center
6050 Cattleridge Blvd. Suite 201 | Sarasota, FL | 34232
941-365-0655

PRESCRIPTION MEDICATION AGREEMENT

You may have prescription medications ordered by your healthcare provider as a part of your treatment. We request that you carefully read the following guidelines regarding prescription medications, ask any questions you may have, then sign this paper once you have read the guidelines and feel that you understand them. Keep your copy in a safe place for future reference. Some of the medications prescribed by the healthcare provider are federally controlled because of a high potential for misuse.

We require that all patients agree and adhere to the following guidelines:

- ☐ I am responsible for the safety of my medications. If my medication is lost, misplaced or stolen I understand it WILL NOT be replaced or refilled under any circumstance.
- ☐ I am responsible for taking the medication exactly as prescribed by my Kennedy-White Orthopaedic Pain Center physician. If I choose to take my medication more often than it is prescribed, I understand it WILL Not be refilled early and that I might endanger my health.
- ☐ If my medication is not relieving my pain, I will contact Kennedy-White Orthopaedic Pain Center at 365-0655. I understand I may be asked to make an additional appointment with my physician or healthcare provider to discuss my medication use.
- ☐ I will not request or accept prescriptions for pain medication or any other controlled substance from another physician while I am under the care of my Kennedy-White Orthopaedic Pain Center healthcare provider. I agree to tell the health care provider if I have received a controlled substance from any other provider in the last 30 days. I understand that this would endanger my health and I understand I may be discharged from the physician's care if I accept controlled medications from another physician. The only exception is if I am hospitalized. I will inform all other physicians caring for me of the medications I received from my Kennedy-White Orthopaedic Pain Center provider.
- ☐ I will not use any illegal controlled substance such as marijuana, cocaine, heroin, methamphetamine, etc. while receiving these medications.
- ☐ I agree to submit to a blood or urine test if requested by my healthcare provider to determine my compliance with my program of pain control medication.
- ☐ I will not sell, share or otherwise divert any prescription medications I receive. I understand it is illegal to engage in this behavior.
- ☐ I will not alter or copy any prescription I am given by my Kennedy-White Orthopaedic Pain Center physician nor will I forge a prescription using their name. I understand that this is illegal behavior and that my Kennedy-White Orthopaedic Pain Center healthcare provider will cooperate with law enforcement officials to prosecute anyone who writes an illegal prescription.
- ☐ I understand that the renewals/refills of my medications will only be made during office appointments. I understand the on-call healthcare provider WILL NOT refill medications after hours, on weekends, or on holidays.
- ☐ I will allow three (3) working days for all prescription renewal/refill requests. I will not request that medications be refilled on the same day as my call. I will not request refills from the front office staff.
- ☐ I will not "DROP IN" to the office requesting a renewal/refill without having a scheduled appointment.
- ☐ I will present photo identification when picking up a prescription. If someone is picking up the prescription for me, I will inform him or her of the need to have a photo ID available. The prescription will not be given to anyone without proper identification.
- ☐ ***I understand if I violate any of the above conditions, my healthcare provider may change my treatment plan OR discharge me from his/her practice and all prescriptions I am receiving from them will be immediately terminated.*** I understand that this information will be shared with my primary care physician, Workers' Compensation adjuster, referring physician, and any other health care provider known to be caring for me.
- ☐ ***I understand and agree to all of the above guidelines.***

Patient's Signature / Date _____

Patient Name: _____

Witness Signature / Date: _____

Name:

Chart:

Date:

INFORMED CONSENT - OPIOID TREATMENT AGREEMENT

Dr. Donald L. Erb is prescribing an opioid medication, sometimes called a narcotic analgesics, for me for a diagnosis of

_____.

This decision was made after discussion with my Healthcare Provider because it may help control my pain.

☐ I am aware that the use of such medication has certain risks associated with it including but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time. Also, I am aware that there is the possibility that the medication will not provide complete pain relief.

☐ My Healthcare Provider has discussed alternate forms of treatment with me.

☐ I will keep my Healthcare Provider informed about all other medications and treatments that I receive from other health care providers.

☐ I will not be involved in any activity that may be dangerous to me or to someone else. I am aware that even if I do not notice it, my reflexes and reaction time might be slowed. Such activities include but are not limited to: using heavy equipment, driving a motor vehicle, working in unprotected heights, or being responsible for another individual who is unable to care for himself or herself.

☐ I am aware that certain medications such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol) may reverse-the action of the medication I am taking for pain control. Taking any of these other medications while I am taking my pain medication may cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medications and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medications listed.

☐ I am aware that addiction is defined as the use of medications for non-medical reasons, loss of control over the use of the medication, and continued use despite adverse physiologic, psychologic, and /or social consequences. I am aware that the chance of becoming addicted to my pain medication is very low when used for legitimate medical reasons. I agree to tell my doctor my complete and honest personal drug history and that of my family, or other household members, to the best of my knowledge.

☐ I understand that physical dependence is a normal and expected result of treatment with these medications over a long period of time. I understand that physical dependence means that if my use of the medication is markedly decreased, stopped, or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening and can be treated.

☐ I am aware that tolerance to the medication means that I may need more medication in order to get the same amount of pain relief. I am aware that tolerance to medication does not seem to be a big problem for most patients with chronic pain. However, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause undesirable side effects. Tolerance or failure to respond well to medication changes may cause my doctor to choose another form of treatment.

☐ I am aware that the chronic use of opioids may lead to bone density and/or osteoporosis.

☐ Males Only — I am aware that the chronic use of opioids has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance.

☐ Females Only - If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and this office to inform them. I am aware that should I carry a baby to delivery while taking opioid medications the baby will be physical dependent on them at birth. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is taking medication and there is always the possibility that my child will have a birth defect while I am taking opioids.

Patient's questions and explanation given _____

_____

_____

Patient's Signature/Date: _____

Witness Signature/Date: _____