Welcome to the West Coast Musculoskeletal Institute and Access Health Care. We would like to thank you for allowing us to care for your orthopedic condition. Please help us service your needs by answering the questions below regarding your situation.

Is your injury/pain related to your **Employment**?	☐ Yes	☐ No
Is your injury/pain related to an **Accident**?	☐ Yes	☐ No
Is your injury/pain related to a **Law Suit**?	☐ Yes	☐ No
Is there an **Attorney** related to this injury/pain?	☐ Yes	☐ No

If yes, please list the name, address and phone number:

_____

_____

_____

- If you have answered yes to any of the above questions, please see the receptionist (or call the scheduling department if forms were downloaded from the website) before completing the remaining paperwork.

ESTABLISHED PATIENT – NEW CASE INFORMATION:

First Name: _____ MI: _____ Last Name: _____

DOB: _____ SSN: _____ Sex: ☐ M ☐ F

Marital Status: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Today's Date: _____ Date of Injury: _____ Are you: ☐ Right-handed ☐ Left-handed

Preferred Pharmacy (with cross streets): _____

INSURANCE INFORMATION:

Policy Holder's Name: _____ Date of Birth: _____

Insurance Company: _____ Phone: _____

Insurance Claims Address: _____

Group/Policy #: _____ Subscriber ID: _____

_____

Signature of Patient/Parent of Minor/Legal Representative Date of Birth Date

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION – *Please fill in ALL blanks.*

First Name: _____ MI: _____ Last Name: _____

Sex: ☐ M ☐ F DOB: _____ Phone: _____

Street Address: _____

Minor Pre-Authorization for Medical Care

I request and authorize West Coast Musculoskeletal Institute and its personnel to deliver medical care to my child listed above.

Guardian Name (Print): _____ Guardian's Signature: _____

Relationship to Patient (Print): _____ Date: _____

HISTORY OF PRESENT ILLNESS:

Height: _____ Weight: _____ lbs. Age: _____ Problem with: ☐ Right Extremity ☐ Left Extremity

Why are you here today? _____

SYMPTOMS:

Location: _____
(Where is the pain? Does it travel to other areas?)

Quality: _____
(Is the pain dull, throbbing, sharp? If a bump, is it warm, tender, red?)

Severity: _____
(How severe on a scale of 1 to 10, with 10 being the most severe?)

Duration: _____
(How long have you had this pain/problem? When did it start?)

Time: _____
(Does the pain/problem occur at a specific time? Is it rare, intermittent, constant?)

Context: _____
(What were you doing at the onset of the pain/problem?)

Associated signs/symptoms: _____
(Do you have numbness? Abnormal sounds like cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain?)

Modifying factors: _____
(What makes the problem worse or better? Example: Activities)

PAST HISTORY OF PRESENT ILLNESS:

Have you ever experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No

If so, please provide details: _____

_____

Please list any hobbies/sports you enjoy:

_____

Which of the above activities are you unable to perform due to your pain?

_____

Name: _____ DOB: _____

Have you seen any other physicians regarding THIS condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

PAST MEDICAL HISTORY:

☐ AIDS or HIV	☐ Cancer	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Anemia	☐ Chicken Pox	☐ Hemorrhoids	☐ Mumps	☐ Tuberculosis
☐ Arthritis	☐ COPD	☐ Hepatitis	☐ Pneumonia	☐ Ulcer
☐ Asthma	☐ Dementia	☐ High Blood Pressure	☐ Polio	☐ Venereal Disease
☐ Back Trouble	☐ Diabetes	☐ Infectious Mono	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bladder Infections	☐ Diphtheria	☐ Kidney Disease	☐ Scarlet Fever	☐ Other (Please List)
☐ Bleeding Tendency	☐ Epilepsy/Seizures	☐ Low Blood Pressure	☐ Sleep Apnea	☐ _____
☐ Blood Transfusions	☐ Fibromyalgia	☐ Measles	☐ Smallpox	☐ _____
☐ Bronchitis	☐ Glaucoma	☐ Migraine Headache	☐ Stroke	☐ _____

Please list **all medications** you are taking (Include non-prescription and herbal supplements):

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Are you allergic to any medications?

Medication	Reaction

Tape Allergy: ☐ Yes ☐ No

Latex Allergy: ☐ Yes ☐ No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

PATIENT SOCIAL HISTORY:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
☐ Single	☐ Never	☐ Never	☐ With family
☐ Married	☐ Rarely	☐ Previously, but quit	☐ With friends
☐ Divorced	☐ Moderate	☐ Currently:	☐ Alone
☐ Widow	☐ Daily	_____ packs a day	☐ Other: _____

Name: _____ DOB: _____

FAMILY MEDICAL HISTORY:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

REVIEW OF SYSTEMS: Please indicate any personal history below:

Musculoskeletal
Joint pain ☐ No ☐ Yes
Joint stiffness or swelling ☐ No ☐ Yes
Weakness of muscles/joints ☐ No ☐ Yes
Muscle pain or cramps ☐ No ☐ Yes
Back pain ☐ No ☐ Yes
Cold extremities ☐ No ☐ Yes
Difficulty in walking ☐ No ☐ Yes

Constitutional Symptoms
Bad general health lately ☐ No ☐ Yes
Recent weight change ☐ No ☐ Yes
Fever ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes
Headache ☐ No ☐ Yes

Ear/Nose/Mouth/Throat
Hearing loss or ringing ☐ No ☐ Yes
Earaches or drainage ☐ No ☐ Yes
Chronic sinus problems ☐ No ☐ Yes
Nose bleeds ☐ No ☐ Yes
Bleeding gums ☐ No ☐ Yes
Sore throat or voice change ☐ No ☐ Yes
Swollen glands in neck ☐ No ☐ Yes

Cardiovascular
Heart trouble ☐ No ☐ Yes
Chest pain or angina ☐ No ☐ Yes
Palpitations ☐ No ☐ Yes
Shortness of breath while walking ☐ No ☐ Yes
Swelling of feet, ankles or hands ☐ No ☐ Yes

Genitourinary
Frequent urination ☐ No ☐ Yes
Burning or painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Incontinence or dribbling ☐ No ☐ Yes
F-number of pregnancies _____
F-number of deliveries _____

Integumentary (skin, breast)
Rash or itching ☐ No ☐ Yes
Changes in skin color ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes
Breast pain ☐ No ☐ Yes
Breast lump ☐ No ☐ Yes

Neurological
Light headed or dizziness ☐ No ☐ Yes
Numbness/tingling sensations ☐ No ☐ Yes
Tremors ☐ No ☐ Yes
Paralysis ☐ No ☐ Yes

Hematologic/Lymphatic
Bleeding/bruising tendency ☐ No ☐ Yes
Anemia ☐ No ☐ Yes
Enlarged glands ☐ No ☐ Yes
Slow to heal after cuts ☐ No ☐ Yes

Endocrine
Excessive thirst or urination ☐ No ☐ Yes
Heat or cold intolerance ☐ No ☐ Yes
Dry Skin ☐ No ☐ Yes

Psychiatric
Memory loss or confusion ☐ No ☐ Yes
Nervousness/Anxiety ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Insomnia ☐ No ☐ Yes

Gastrointestinal
Loss of appetite ☐ No ☐ Yes
Nausea or vomiting ☐ No ☐ Yes
Frequent diarrhea ☐ No ☐ Yes
Constipation ☐ No ☐ Yes
Rectal bleeding/blood in stool ☐ No ☐ Yes
Abdominal pain ☐ No ☐ Yes

Respiratory
Chronic or frequent coughs ☐ No ☐ Yes
Spitting up blood ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Wheezing ☐ No ☐ Yes

Eyes
Eye disease or injury ☐ No ☐ Yes
Wear glasses/contacts ☐ No ☐ Yes
Blurred or double vision ☐ No ☐ Yes

Allergic/Immunologic
List food/environmental allergies:
_____
_____
_____
_____

<u>Patients 65 or older</u>: Spiritual/Cultural Preference? _____

Healthcare Proxy? ☐ Yes ☐ No Name: _____

Power of Attorney for Healthcare? ☐ Yes ☐ No Name: _____

Copy of POA? ☐ Yes ☐ No **Do Not Resuscitate? ☐ Yes ☐ No**

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Signature of Patient/Parent of Minor/Legal Representative Today's Date

PATIENT PRIVACY QUESTIONNAIRE

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Name: _____

Address: _____ Address**:** _____

Phone Number: _____ Phone Number: _____

Relationship: _____ Relationship: _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

Name: _____ Phone #: _____

Name: _____ Phone #: _____

☐ I understand that all correspondence from our office will be sent in a sealed envelope marked ***"CONFIDENTIAL".***

Confidential messages (i.e., appointment reminders) ☐ May / ☐ May **not be left on answering machine or voicemail.

Please print the phone number where you want to receive calls about your appointments:

_____

☐ I am fully aware that a cell phone is not a secure and private line.

CONSENT TO TREAT
and
RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, the undersigned, voluntarily give consent to my West Coast Musculoskeletal Institute and Access Health Care Physicians medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. Also, I have received/reviewed a copy of the West Coast Musculoskeletal Institute/Access Health Care Notice of Privacy Practices and the Florida Patient Bill of Rights.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Please *print* Patient Name Date of Birth

_____ _____
Legal Representative Relationship to Patient

OFFICE USE ONLY

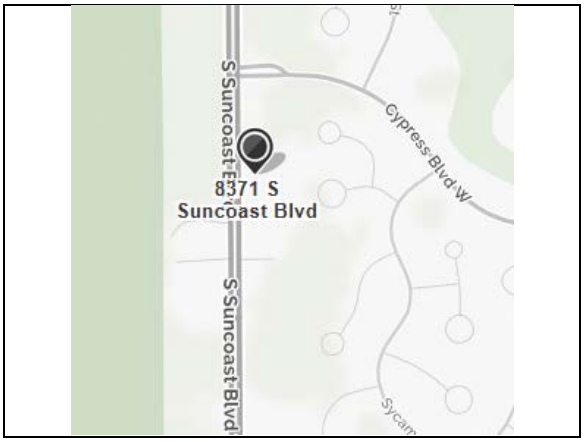
I attempted to obtain the patient's signature in acknowledgement for the Notice of Privacy Practices Acknowledgement, but was unable to do so for the reason documented below:

Date	Initials	Reason

Office Locations

Citrus County

N

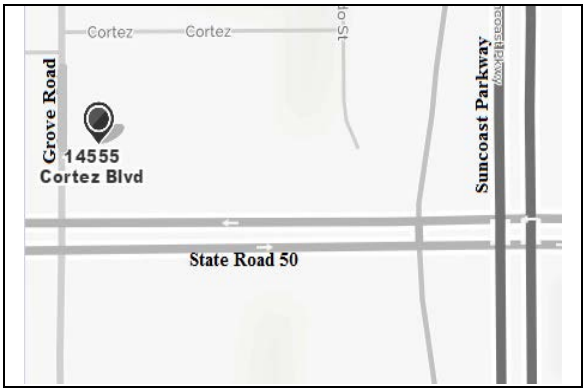


8371 South Suncoast Blvd.
Homosassa, FL 34446

South of Cypress Blvd at Sugar Mills Woods Entrance

Hernando County

N



14555 Cortez Blvd.
Brooksville, FL 34613

On the corner of Cortez Blvd and Grove Rd.

Pasco County

13944 Lakeshore Blvd, Suite B
Hudson, FL 34667

Take Hudson Avenue to Fivay Road.
The office is across the street from Bayonet Point Hospital.

Please Enter through Suite A.