OPTIMOTION ORTHOPAEDICS

Phone 407-355-3120 | Fax 407-355-3119

Referred By:

☐ Friend ☐ Family ☐ Social Media (Google, Facebook, etc) ☐ Seminar ☐ Emergency Room

☐ Billboard ☐ Other: _____

☐ Physician Name: _____ Phone: _____

Address/City/State/Zip: _____

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____

DOB: _____ SSN: _____

Gender _____ Race: _____ Ethnicity: _____

Marital Status: _____ Spoken Languages: _____ , _____

Address/City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Occupation: _____ Employer/Phone Number: _____

PRIMARY CARE DOCTOR

Physician Name: _____ Phone: _____

Address/City/State/Zip: _____

☐ Same as referring doctor listed above

EMERGENCY CONTACT

Contact Name: _____ Relationship to Patient: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

CONSENT TO EXAMINATION AND TREATMENT
INSURANCE ASSIGNMENT AND RECORDS AUTHORIZATION

I hereby consent to examination and treatment as deemed necessary by and its physicians. I Hereby authorize **Optimotion Orthopaedics** to furnish patient health information concerning my relevant medical history (including but not limited to the super confidential information listed above) to any of the following: Other healthcare providers involved in my care, insurance carriers, attorneys and adjustors. I hereby assign to **Optimotion Orthopaedics** all payments for Medical Services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to [name of provider] providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Optimotion Orthopaedics at (407) 355-3120. As long as this consent is in force (has not been revoked) Optimotion Orthopaedics may provider health care services to me via telemedicine without the need for me to sign another consent form.

Signature: _____ ☐ Patient ☐ Parent/Guardian Date/Time: _____

PATIENT RELEASE

I, _____, hereby authorize Optimotion Orthopaedics to release any or all of my patient health information including super confidential information to the person(s) listed below. (Example: A Spouse or relative may be involved in billing and insurance inquires or medication refills.)

Signature:_____ Date/Time: _____

Name:	Relationship to Patient	Phone:

PRIVACY NOTICE

Inspect and Copy Your Protected Health Information (PHI): You have the right to inspect and copy your protected health information that may be used to make decisions about your care, with the exception of psychotherapy notes. If you want to see or copy your medical information, you must submit your request in writing to the Privacy Site Coordinator or to the Optimotion Orthopaedics Privacy Officer. If you request copies of information, the cost will be $1.00 per page for the first 25 pages then .25 per page after. You may also access your patient records through your patient portal free of charge.

In accordance with Health Information Portability and Accountability Act (HIPPA), patients of Optimotion Orthopaedics are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. Optimotion Orthopaedics will strive to ensure that patient information is used only for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies. Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice. Please review our complete Notice of Privacy Practice on our website at www.optimotion.com or at our clinic locations.

CANCELLATION POLICY

If unable to keep your appointment, kindly give 24-hour notice to avoid $25.00 no-show charge.

Copays, deductibles, and coinsurance will be collected prior to treatment. If payment is not received at the time services are rendered the patient will receive 3 statements in regards to an outstanding balance. If your account is still delinquent, your account will be sent to collections.

Signature: _____ Date/Time: _____

Patient Name: _____

BODY PART #1 (Use second page if you are being seen for more than one body part)

Chief Complaint:

Laterality	☐Right ☐Left Body Part:_____

Current pain level (No pain 0 - 10 Severe pain): _____

When did this condition start? _____

Have you ever tried any of the following conservative treatment options?	**Dates/Duration**
Anti-inflammatory medications (such as Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam) Other: _____	☐At least 3 months ☐ More than 3 months
Physical Therapy: ☐At least 6 weeks ☐ 3 months	Date started:
Assistive devices: ☐cane ☐walker ☐crutches ☐wheelchair	Duration:
Knee brace	Duration:
Injections: ☐ Cortisone ☐ Gel/Synvisc How many injections:	Date of last inj:
Exercise program	Duration:
Weight Loss	

Have you ever consulted any other physician regarding this condition?	**Y/N**	**Date(s)**	**Doctors Name & Contact Info**

Recommended Treatment:

Have you ever undergone surgery on this body part?	**Y/N**	**Date(s)**	**Surgeons Name & Contact Info**
Arthroscopic (scope surgery)			
Joint Replacement Component/Prosthesis (If known): _____			
Other Surgery:			

If Yes, please send the **OPERATIVE REPORT** to our office as soon as possible before the date of your appointment. If unable to submit beforehand, please bring the report with you.

Failure to bring in your medical records may delay your course of treatment.

Patient Name: _____

BODY PART #2

Chief Complaint:

Laterality	☐Right	☐ Left	Body Part: _____

Current pain level (No pain 0 - 10 Severe pain): _____

When did this condition start? _____

Have you ever tried any of the following conservative treatment options?	**Dates/Duration**
Anti-inflammatory medications (such as Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam) Other: _____	☐At least 3 months ☐ More than 3 months
Physical Therapy: ☐At least 6 weeks ☐ 3 months	Date started:
Assistive devices: ☐cane ☐walker ☐crutches ☐wheelchair	Duration:
Knee brace	Duration:
Injections: ☐ Cortisone ☐ Gel/Synvisc How many injections:	Date of last inj:
Exercise program	Duration:
Weight Loss	

Have you ever consulted any other physician regarding this condition?	**Y/N**	**Date(s)**	**Doctors Name & Contact Info**

Recommended Treatment:

_____

Have you ever undergone surgery on this body part?	**Y/N**	**Date(s)**	**Surgeons Name & Contact Info**
Arthroscopic (scope surgery)			
Joint Replacement Component/Prosthesis (If known): _____			
Other Surgery: _____			

If Yes, please send the **OPERATIVE REPORT** to our office as soon as possible before the date of your appointment. If unable to submit beforehand, please bring the report with you.

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FALL RISK ASSESSMENT

Patient Name: _____ DOB: _____

1. Do you use an assisted device? (walker, cane or crutches) ☐ YES ☐ NO
2. Have you fallen within the past year? ☐ YES ☐ NO
3. Do you feel a buckling sensation? ☐ YES ☐ NO
4. Are you wheelchair or home bound? ☐ YES ☐ NO

Patient Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Height: _____ **Weight:** _____

Allergies	Reaction	Severity (none, mild, moderate, severe)

Are you a tobacco user? ☐ **Yes** ☐ **No**

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over the counter medications, herbals, vitamin/mineral/dietary supplement. **ALL FIELDS ARE REQUIRED**

Name of Current Medication (example: Aspirin tablet)	**Dosage** (example: 325 mg)	**Frequency/Route of Administration** (example: 3 times daily orally)	**Length of Use**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

PHARMACY INFORMATION: Please indicate the pharmacy you would like your medications sent to:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

Patient Name: **Date:**

Medical disorders: If you have had any of the following, Place Mark inside Circles

○ No Medical History	○ Stroke	○ Sleep Apnea
○ AIDS/HIV	○ Cancer Breast	○ Gout
○ **Alcoholism**	○ Cancer **Colon**	○ Heart Attack
○ **Alzheimer's**	○ Cancer **Lung**	○ High Blood Pressure
○ **Anemia**	○ Cancer **Prostate**	○ Hepatitis
○ **Rheumatoid Arthritis**	○ **COPD**	○ Kidney Disease
○ **Asthma**	○ **Depression**	○ Osteoarthritis
○ **Blood Clot Leg**	○ **Diabetes**	○ Seizures
○ **Blood Clot Lung**	○ **Drug Abuse**	○ Ulcers, Bleeding
○ **Other Disease (list below)**	○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**	

Surgical History: If you have had any of the following, Place Mark inside Circles

○ No Surgical History Reported	○ Cardiac (Heart)
○ Carpal Tunnel Left Wrist	○ Carpal Tunnel Right Wrist
○ Arthroscopy Left Elbow	○ Arthroscopy Right Elbow
○ Arthroscopy Left Shoulder	○ Arthroscopy Right Shoulder
○ Arthroscopy Left Ankle	○ Arthroscopy Right Ankle
○ Arthroscopy Left Knee	○ Arthroscopy Right Knee
○ Arthroscopy Left Hip	○ Arthroscopy Right Hip
○ Left Hip Replacement	○ Right Hip Replacement
○ Left Knee Replacement	○ Right Knee Replacement
○ Spinal Fusion	○ Laminectomy
○ Other Surgery (list in the box below)	○ Fracture Surgery

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ **AIDS/HIV**
- ○ **Anemia**
- ○ **Blood Clots**
- ○ **Cancer**
- ○ **Coronary Artery Disease**
- ○ **Diabetes**
- ○ **Gout**
- ○ **Heart Attack**
- ○ Hemophilia
- ○ **Hypertension**
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- ○ Weight Loss/Gain
- ○ Weakness
- ○ Fatigue
- ○ Fever

Cardiovascular
- ○ High Blood Pressure
- ○ Chest Pain
- ○ Rheumatic Fever
- ○ Palpitations
- ○ Has Pacemaker

Musculoskeletal
- ○ Joint Pain
- ○ Arthritis
- ○ Muscular Weakness
- ○ Stiffness
- ○ Muscular Pain

Eyes
- ○ Glasses or Contacts
- ○ Blurred Vision
- ○ Glaucoma
- ○ Cataracts
- ○ Excessive Tearing

Skin
- ○ Rashes
- ○ Sores
- ○ Lumps
- ○ Dryness
- ○ Itching

Blood or Lymph
- ○ Anemia
- ○ Easy Bruising
- ○ Easy Bleeding
- ○ Swollen Glands

Ear Nose Mouth Throat:
- ○ Ears Ringing
- ○ Earaches
- ○ Hearing Aid
- ○ Frequent Colds
- ○ Nasal Discharge
- ○ Hay Fever
- ○ Nosebleeds
- ○ Dentures
- ○ Bleeding Gums
- ○ Frequent Sore throats

Neurological
- ○ Headache
- ○ Dizziness
- ○ Seizures
- ○ Loss of Sensation
- ○ Vertigo

Gastrointestinal
- ○ Heart Burn
- ○ Rectal Bleeding
- ○ Abdominal Pain
- ○ Gallbladder trouble
- ○ Hepatitis

Respiratory
- ○ Shortness of Breath
- ○ Cough
- ○ Wheezing
- ○ Asthma
- ○ Bronchitis

Genitourinary
- ○ Blood in Urine
- ○ Urinary Infections
- ○ Kidney Stones
- ○ Burning Urination
- ○ Sexual Disease

Endocrine
- ○ Thyroid Trouble
- ○ Excessive Sweating
- ○ Excessive thirst

Immunologic
- ○ Reactions to Drugs
- ○ Skin Rashes
- ○ Reactions to Foods

Psychological
- ○ Nervousness
- ○ Depression
- ○ Mood Changes

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box