PATIENT INFORMATION

MEDICAL CONSULTANTS OF SOUTH FLORIDA

DATE: _____ ***E-MAIL ADDRESS: _____

(If e-mail address is not provided, you **MUST** write Patient denied.)

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Location _____

PATIENT NAME: _____

(LAST) (FIRST) (MIDDLE INITIAL)

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____

(NUMBER) (STREET) (APT#) (CITY) (STATE) (ZIP)

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single ☐ Divorced ☐ Child Custodial Parent: _____

Patient's Occupation: _____ Employed at: _____

Name of Primary Care Physician/Pediatrician: _____ Telephone: _____

Name of Referring Physician/Pediatrician: _____ Telephone: _____

WHOM DO WE NOTIFY IN THE EVENT OF AN EMERGENCY: _____

Relationship: _____ Telephone: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID#: _____

Secondary Insurance Company: _____ ID#: _____

Subscriber Name: _____ Group Number: _____

Subscriber's Date of Birth _____

FINANCIAL INFORMATION:

IF PATIENT IS UNDER 18, PLEASE ENTER THE FOLLOWING INFORMATION:

NAME OF PARENT OR GUARDIAN RESPONSIBLE FOR THIS ACCOUNT: _____

Mother's Name: _____ Date of Birth: _____ SS#: _____

Mother's Work Telephone: _____ Occupation: _____

Father's Name: _____ Date of Birth: _____ SS#: _____

Father's Work Telephone: _____ Occupation: _____

ADDITIONAL PATIENT INFORMATION

PATIENT RACE AND ETHNICITY

PER STATE OF FLORIDA REQUIREMENT, PLEASE ELECT YOUR ETHNICITY FROM THE 3 CHOICES BELOW:

(NON-HISPANIC) (HISPANIC) (UNKNOWN)

PER STATE OF FLORIDA REQUIREMENT, PLEASE SELECT YOUR RACE FROM THE 10 CHOICES BELOW:

(ALASKA NATIVE) (AMERICAN INDIAN) (ASIAN) (BLACK) (NATIVE HAWAIIAN)

(NO RESPONSE) (OTHER PACIFIC ISLANDER) (OTHER) (UNKNOWN) (WHITE))

MEDICAL HISTORY

NAME _____ DATE_____

REASON FOR VISIT

_____

IS THIS DUE TO AN ACCIDENT OR INJURY? YES ___ NO ___ IF YES, WHEN? _____

HOW DID IT HAPPEN?_____

WHERE DID IT HAPPEN?_____

HAVE YOU BEEN TREATED FOR THIS PROBLEM BY ANYONE ELSE? YES ___ NO ___

IF YES, DATE _____ PLEASE LIST DR., HOSPITAL OR OTHER _____

AGGRAVATING SYMPTOMS

[] BENDING [] LIFTING [] STANDING [] WALKING
[] COUGHING [] SITTING [] TWISTING

WHAT HELPS RELIEVE YOUR SYMPTOMS?

[] BRACE [] ICE [] PHYSICAL THERAPY
[] HEAT [] MEDICATIONS [] REST

DO YOU HAVE ANY:

[] BUCKLING [] GIVING AWAY [] LOCKING [] SWELLING
[] CLICKING [] JOINT PAIN [] POPPING [] WEAKNESS

ALLERGIES:

[] ASPIRIN [] IODINE [] OR OTHER _____
[] SULFA [] PENICILLIN [] NO KNOWN ALLERGIES

CURRENT MEDICATION

- ☐ **IF MULTIPLE MEDICATIONS PLEASE ATTACH A LIST**

OR CHOOSE FROM THE FOLLOWING LIST

- ☐ NO MEDICATION
- ☐ SIMVASTATIN
- ☐ LISINOPRIL
- ☐ PRILOSEC
- ☐ ATENOLOL
- ☐ OTHER: _____

- ☐ OTHER: _____

PLEASE REVIEW AND COMPLETE ALL QUESTIONS BELOW. IF YOU NEED ANY ASSISTANCE, PLEASE ADVISE OUR OFFICE STAFF.

PAST MEDICAL HISTORY: (Please only check what applies)

- ☐ AIDS/HIV
- ☐ ANGINA
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BIPOLAR DISORDER
- ☐ BLOOD CLOTS
- ☐ BREAST DISORDER
- ☐ CANCER
- ☐ CHRONIC FATIGUE SYNDROME
- ☐ CHRONIC WOUNDS
- ☐ CONGESTIVE HEART FAILURE
- ☐ COPD EMPHYSEMA, BRONCHITIS
- ☐ DEPRESSION
- ☐ DIABETES, TYPE I OR TYPE II
- ☐ DVT (LEG CLOTS)
- ☐ FIBROMYALGIA
- ☐ GASTROINTESTINAL BLEEDING
- ☐ GLAUCOMA
- ☐ GOUT
- ☐ HEADACHES
- ☐ HEART DISEASE
- ☐ HEARTBURN/REFLUX
- ☐ HEPATITIS (A, B, C)
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ INCONTINENCE
- ☐ KIDNEY STONES
- ☐ MACULAR DEGENERATION
- ☐ MI/HEART ATTACK
- ☐ OSTEOPOROSIS
- ☐ PNEUMONIA
- ☐ PROSTATE DISEASE
- ☐ PULMONARY CLOTS(LUNG CLOTS)
- ☐ SEIZURES
- ☐ STROKE
- ☐ STOMACH ULCERS
- ☐ THYROID DISEASE (LOW OR HIGH)
- ☐ URINARY TRACT INFECTIONS
- ☐ VALVE DISORDER

SURGICAL HISTORY (Please only check what applies)

- ☐ APPENDECTOMY
- ☐ BARIATRIC SURGERY
- ☐ BOWEL RESECTION
- ☐ BREAST SURGERY
- ☐ CARDIAC STENTS
- ☐ CATARACT REMOVAL
- ☐ CESAREAN SECTION
- ☐ COLONOSCOPY
- ☐ CORONARY ARTERY BY PASS GRAFT
- ☐ EAR TUBES
- ☐ ENDOSCOPY
- ☐ FRACTURE SURGERY
- ☐ GALLBLADDER SURGERY
- ☐ HEART VALVE REPLACEMENT
- ☐ HERNIA REPAIR
- ☐ HIP REPLACEMENT (RT/LT)
- ☐ HYSTERECTOMY
- ☐ KNEE ARTHROSCOPY (RT/LT)
- ☐ KNEE REPLACEMENT (RT/LT)
- ☐ LASIK
- ☐ ORTHOTIC/JOINTS
- ☐ PACEMAKER, CARDIAC
- ☐ PROSTATE SURGERY
- ☐ SHOULDER ARTHROSCOPY (RT/LT)
- ☐ SPINE SURGERY
- ☐ THYROIDECTOMY
- ☐ TONSILLECTOMY
- ☐ TUBAL LIGATION

TOBACCO USE/SMOKING

- ☐ CURRENT EVERYDAY SMOKER
- ☐ CURRENT SOMEDAY SMOKER
- ☐ FORMER SMOKER
- ☐ NONSMOKER

ALCOHOL SCREEN

HOW OFTEN DID YOU HAVE A DRINK CONTAINING ALCOHOL IN THE PAST YEAR?

- ☐ NEVER
- ☐ MONTHLY OR LESS
- ☐ 2 TO 4 TIMES A MONTH
- ☐ 2 TO 3 TIMES A WEEK
- ☐ 4 OR MORE TIMES A WEEK

MARITAL STATUS

- ☐ SINGLE
- ☐ DIVORCED
- ☐ MARRIED
- ☐ WIDOWED
- ☐ NOT ANSWERED

FAMILY HISTORY

MOTHER ALIVE **OR** DECEASED
FATHER ALIVE **OR** DECEASED

(Please check all that apply to Family History)

- ☐ SCOLIOSIS
- ☐ DIABETES
- ☐ BREAST CANCER
- ☐ HIGH BLOOD PRESSURE
- ☐ COLON CANCER
- ☐ HEART DISEASE

REVIEW OF SYSTEMS

ALLERGY/IMMUNOLOGY
- ☐ ENVIRONMENTAL ALLERGIES
- ☐ FREQUENT INFECTIONS

ENT
- ☐ RINGING IN THE EARS
- ☐ NOSEBLEED
- ☐ DIFFICULTY SWALLOWING

ENDOCRINE
- ☐ HEAT OR COLD INTOLERANCE
- ☐ UNEXPECTED WEIGHT LOSS
- ☐ HAIR LOSS

RESPIRATORY
- ☐ SHORTNESS OF BREATH AT REST
- ☐ SHORTNESS OF BREATH WITH EXERTION

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ FLUID RETENTION
- ☐ LIGHTHEADEDNESS
- ☐ IRREGULAR HEARTBEAT

GASTROINTESTINAL
- ☐ ABDOMINAL PAIN
- ☐ NAUSEA
- ☐ VOMITING
- ☐ BLACK/TARRY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA

HEMATOLOGY
- ☐ LYMPHADENOPATHY
- ☐ EXCESSIVE BRUISING OR BLEEDING
- ☐ ANEMIA

GENITOURINARY
- ☐ FREQUENT URINATION
- ☐ BLOOD IN URINE
- ☐ URINARY URGENCY

MUSCULOSKELETAL
- ☐ MUSCLE SORENESS
- ☐ WEAKNESS
- ☐ SWELLING IN ARMS/LEGS

SKIN
- ☐ CHANGING MOLE(S)
- ☐ DRY SKIN
- ☐ ITCHING

NEUROLOGIC
- ☐ HEADACHE
- ☐ TINGLING/NUMBNESS

PSYCHIATRIC
- ☐ DEPRESSION
- ☐ ANXIETY

GENERAL CONSTITUTIONAL
- ☐ WEIGHT GAIN
- ☐ FATIGUE
- ☐ FEVER
- ☐ LOSS OF APPETITE
- ☐ CHILLS

I HAVE BEEN INSTRUCTED THAT IF I ANSWER YES TO ANY OF THE REVIEW OF SYSTEMS THAT DO NOT PERTAIN TO ORTHOPAEDICS, I MUST CONTACT MY PRIMARY CARE PHYSICIAN AND SEEK IMMEDIATE MEDICAL ATTENTION FOR THESE ISSUES.

NAME:_____

SIGNATURE:_____

DATE:_____

PLEASE MAKE SURE THAT ALL SECTIONS HAVE BEEN COMPLETED TO ENSURE PROPER PROCESSING

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date:_____

Patient Signature: _____

DISCLOSURE AND CONSENT FOR MEDICAL/CHIROPRACTIC CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended treatments and other physical procedures available to you so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic / medical care, including various modes of physical therapy and diagnostic tests, on me (or the patient named below, for whom I am legally responsible) by Medical Consultants of South Florida. I have had the opportunity to discuss with Medical Consultants of South Florida's staff my diagnosis, the nature and purpose of treatments and other procedures and alternatives.

I understand and I am informed that in the practice of chiropractic there are some risks to exam and treatment including, but not limited to. Fractures, disc injuries, strokes, dislocations, sprains, increased symptoms, pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from any test or treatment. Indications, contra-indications, risks and benefits or functional testing, therapeutic laser, and/or spinal decompression-traction have been reviewed with me. Risks and benefits of any medical procedure to be performed in this office have been explained to me.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and any further condition(s) for which I seek treatment.

To be completed by the patient or the patient's representative.
e.g., if the patient is a minor or physically or legally incapacitated:

Print name_____

Signature_____ Date: _____

MEDICAL CONSULTANTS OF SOUTH FLORIDA

LAURA ZITON, D.O. **HEINA ABRAHAM, APRN** **RONALD LEWERT, D.C.**

Date: _____

Patient: _____

I authorize, MEDICAL CONSULTANTS OF SOUTH FLORIDA to discuss my PHI, protected health information with the following people ***(e.g. SPOUSE, ADULT, CHILDREN, FRIEND, ATTORNEY etc...)***:

Please list name and phone#:

1. Name: _____

   Phone#: _____

2. Name: _____

   Phone#: _____

_____
(Patients Signature)

_____
(Witness)

_____
(Witness)

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