

Atte Sports Ortho Consults

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: African American Asian Caucasian Native American/Alaskan Pacific Islander Other _____
 Unknown Decline to Answer

Ethnicity: Hispanic Non-Hispanic Unknown Decline to Answer

Preferred Language: English Spanish Chinese Other _____

Preferred Pharmacy: _____

Date of your appt.: _____ **Doctor your appt. is with:** _____

Chief Complaint

Dominant Hand: Right Left Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

Pain Numbness/Tingling Fracture Stiffness Annual Follow Up **Other:** _____

Shoulder	<input type="radio"/> Right	<input type="radio"/> Left	Pelvis	<input type="radio"/> Right	<input type="radio"/> Left	Neck	<input type="radio"/>
Upper Arm	<input type="radio"/> Right	<input type="radio"/> Left	Hip	<input type="radio"/> Right	<input type="radio"/> Left	Upper Back	<input type="radio"/>
Elbow	<input type="radio"/> Right	<input type="radio"/> Left	Thigh	<input type="radio"/> Right	<input type="radio"/> Left	Mid Back	<input type="radio"/>
Forearm	<input type="radio"/> Right	<input type="radio"/> Left	Knee	<input type="radio"/> Right	<input type="radio"/> Left	Low Back	<input type="radio"/>
Wrist	<input type="radio"/> Right	<input type="radio"/> Left	Lower Leg	<input type="radio"/> Right	<input type="radio"/> Left	Buttocks	<input type="radio"/>
Hand	<input type="radio"/> Right	<input type="radio"/> Left	Ankle	<input type="radio"/> Right	<input type="radio"/> Left	Tail Bone	<input type="radio"/>
Thumb	<input type="radio"/> Right	<input type="radio"/> Left	Foot	<input type="radio"/> Right	<input type="radio"/> Left		
Index	<input type="radio"/> Right	<input type="radio"/> Left	Great Toe	<input type="radio"/> Right	<input type="radio"/> Left		
Middle	<input type="radio"/> Right	<input type="radio"/> Left	2nd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Third	<input type="radio"/> Right	<input type="radio"/> Left	3rd Digit	<input type="radio"/> Right	<input type="radio"/> Left		
Little	<input type="radio"/> Right	<input type="radio"/> Left	4th Digit	<input type="radio"/> Right	<input type="radio"/> Left		
			5th Digit	<input type="radio"/> Right	<input type="radio"/> Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

- No Injury Injury Injury at Work Auto Accident
 Sport Injury Prior Surgery Surgery Complication

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: Acute (sudden) Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? Yes No

Attorney Name: _____

Will there be any legal actions with respect to this problem? Yes No

3. Have you had a problem like this before? Yes No

Describe: _____

4. Have you been seen in an ER for this problem? Yes No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

- 0 1 2 3 4 5 6 7 8 9 10

6. Do the symptoms wake you from sleep?

- Yes No

7. Please describe the symptoms:

- Sharp Dull Stabbing Throbbing Aching Burning Shooting

8. What is the timing of the symptoms?

- Constant Intermittent (comes and goes)

9. Is the problem getting better or worse?

- Getting better Getting worse Unchanged

10. What makes the symptoms worse?

- Squatting Kneeling Sitting Bending Stairs Twisting Moving Lying in bed
 Running Walking Athletics Standing Gripping Lifting Reaching Overhead

11. Are there any other symptoms associated with this problem?

- Redness Bruising Swelling Numbness Stiffness Limping Clicking Locking
 Popping Tingling Weakness Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

- None X-rays MRI CT Scan Nerve Test (EMG/NCV) Bone Scan

Have you had any prior treatment for this problem? Yes No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Heat	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
Rest	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	
NSAIDs	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Muscle Relaxers	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Chiropractor	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Physical Therapy	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Home Exercise Program	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Surgery	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Injections	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
Bracing	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____
TENS unit	<input type="radio"/> Improved	<input type="radio"/> Worsened	<input type="radio"/> Unchanged	_____

Other/Comments: _____

Select all previous hospitalizations/surgeries: **None**

- | | |
|--|---|
| <input type="radio"/> Aneurysm (Brain) Surgery | <input type="radio"/> Hysterectomy |
| <input type="radio"/> Aortic Bypass / Vascular Surgery | <input type="radio"/> LAP Band / Gastric Bypass Surgery |
| <input type="radio"/> Appendectomy | <input type="radio"/> Lumpectomy |
| <input type="radio"/> Cataract (Eye) Surgery | <input type="radio"/> Mastectomy |
| <input type="radio"/> Cholecystectomy (Gallbladder) | <input type="radio"/> Malignancy/Cancer |
| <input type="radio"/> Heart Surgery | <input type="radio"/> Stents |
| <input type="radio"/> Hernia Repair | |

Orthopedic on side:	Right	Left
Arthroscopy: Knee	<input type="radio"/>	<input type="radio"/>
Arthroscopy: Shoulder	<input type="radio"/>	<input type="radio"/>
Carpal Tunnel Release	<input type="radio"/>	<input type="radio"/>
Rotator Cuff Repair	<input type="radio"/>	<input type="radio"/>
Total Hip Replacement	<input type="radio"/>	<input type="radio"/>
Total Knee Replacement	<input type="radio"/>	<input type="radio"/>
Total Shoulder Replacement	<input type="radio"/>	<input type="radio"/>
Spinal Surgery - Indicate Level: _____		

Other Surgery

Other Orthopedic Surgery

Medical Questions

Mark all that currently apply:

- Metal in body Claustrophobic Pregnant Sleep Apnea Uses a CPAP Snores

Are you taking blood thinners? Yes No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

None for all

				None	Comments
1) CON	<input type="radio"/> Weight Loss	<input type="radio"/> Loss of Appetite	<input type="radio"/> Fatigue	<input type="radio"/>	_____
2) EYE	<input type="radio"/> Blurred Vision	<input type="radio"/> Double Vision	<input type="radio"/> Vision Loss	<input type="radio"/>	_____
3) ENT	<input type="radio"/> Hearing Loss	<input type="radio"/> Hoarseness	<input type="radio"/> Trouble Swallowing	<input type="radio"/>	_____
4) CV	<input type="radio"/> Chest Pain	<input type="radio"/> Palpitations		<input type="radio"/>	_____
5) RS	<input type="radio"/> Chronic Cough	<input type="radio"/> Pneumonia	<input type="radio"/> Shortness of Breath	<input type="radio"/>	_____
6) GI	<input type="radio"/> Heartburn, Ulcers	<input type="radio"/> Nausea, Vomiting	<input type="radio"/> Blood in Stool	<input type="radio"/>	_____
7) GU	<input type="radio"/> Painful Urination	<input type="radio"/> Blood in Urine	<input type="radio"/> Kidney Problems	<input type="radio"/>	_____
8) SK	<input type="radio"/> Frequent Rashes	<input type="radio"/> Skin Ulcers	<input type="radio"/> Lumps <input type="radio"/> Psoriasis	<input type="radio"/>	_____
9) NEU	<input type="radio"/> Frequent Falls	<input type="radio"/> Loss of Coordination	<input type="radio"/> Numbness	<input type="radio"/>	_____
	<input type="radio"/> Change in Bowel	<input type="radio"/> Change in Bladder	<input type="radio"/> Dizziness		
10) PSY	<input type="radio"/> Depression/Anxiety	<input type="radio"/> Drug/Alcohol Addiction	<input type="radio"/> Sleep Disorder	<input type="radio"/>	_____
11) ENDO	<input type="radio"/> Fever	<input type="radio"/> Heat or Cold Intolerance	<input type="radio"/> Night Sweats		
12) HEM	<input type="radio"/> Easy Bleeding	<input type="radio"/> Easy Bruising	<input type="radio"/> Anemia	<input type="radio"/>	_____

Family History

Have any direct relatives had any of the following disorders? None for all

Father	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Mother	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			
Sibling	<input type="radio"/> None	<input type="radio"/> Diabetes	<input type="radio"/> Heart Disease	<input type="radio"/> Hypertension
	<input type="radio"/> Bleeding Problems	<input type="radio"/> Epilepsy	<input type="radio"/> Connective Tissue	<input type="radio"/> Muscular Dystrophy
	<input type="radio"/> Stroke	<input type="radio"/> Osteoporosis	<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? Current, every day smoker Current, some day smoker Former smoker Never
 Heavy tobacco smoker Light tobacco smoker

Do you drink alcohol? Daily Occasionally Rarely Never

Marital Status: Married Single Divorced Widowed Domestic Partnership

Are you currently working? Yes No Retired Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ **Student**

Do you have any allergies: Yes, if so list below No Please list current Medications and strength below

Do you have a history of:

Aneurysm	Emphysema	Kidney Disease
Angina	Epilepsy	Kidney Stones
Arthritis	Heart Attack	MRSA
Asthma	Hepatitis	Pacemaker
Bone Infection	HIV/AIDS	Blood Clots
Cancer	High Cholesterol	Embolism
COPD	Hypertension	Seizures
Diabetes	Hyperthyroidism	Stroke

Atte Sports Ortho Consults

7950 SW 30th St #201 Davie, FL 33328/ 5555 Hollywood Blvd #201 Hollywood, FL 33021

******_DEMOGRAPHICS_******

DATE: _____

PATIENT NAME (PRINT): _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED RACE/ETHNICITY: _____

LOCAL ADDRESS: _____ APT #: _____

CITY: _____ ST: _____ ZIP CODE: _____

MAILING ADDRESS: _____ APT #: _____

CITY: _____ ST: _____ ZIP CODE: _____

HOME #: _____ CELL #: _____

***** PREFERRED PHONE #:** _____

EMAIL ADDRESS (FOR APPOINTMENT PURPOSES ONLY): _____

EMPLOYER'S NAME: _____ OCCUPATION: _____

IS THIS DUE TO AN ACCIDENT? NO YES IF YES, DATE OF ACCIDENT: _____

IS THIS A WORK OR AUTO ACCIDENT? WORK AUTO OTHER (PLEASE LIST): _____

***** EMERGENCY CONTACT:** _____ PHONE #: _____ RELATIONSHIP: _____

PRIMARY MEDICAL INSURANCE: _____ ID _____

SECONDARY MEDICAL INSURANCE: _____ ID _____

SUBSCRIBER/POLICY HOLDER: _____ SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER: _____

WHO WERE YOU REFERRED BY: _____

YOUR PRIMARY CARE PHYSICIAN: _____ PCP PHONE #: _____

PRIMARY PHARMACY/ADDRESS:

PHARMACY PHONE:

Atte Sports Ortho Consults
7950 SW 30th St #201 Davie, FL 33328/ 5555 Hollywood Blvd #201 Hollywood,
FL 33021

CANCELLATION POLICY

Our cancellation policy states that any scheduled appointment (either an office visit or procedure) must be canceled with a 24 hour advanced notice during normal operating hours (Monday through Friday; 8:30 AM. – 4:30 PM.) An “untimely cancellation” is noted as a cancellation provided to our office with less than a 24 hour notice of the scheduled appointment. **These missed appointments are labeled as a “no show.”**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work of family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book.

Please be informed that it is the policy of **Atte SOC** to monitor and manage appointment “no shows.”

Patient’s who fail to arrive for a scheduled appointment, without 24 hour advanced notice, will be considered a “no show.”

Patient’s who consistently fail to arrive for more than (1) scheduled appointment are considered a CHRONIC “no show.”

“No show” appointments will incur the following fees

- ❖ **Follow up appointment: \$30.00**
- ❖ **Procedure appointment: \$150.00**

Please note: This fee will not be covered by your insurance company. You **MUST** pay this fee in full balance before a future appointment can be made. Chronic “no show” patients are subject to dismissal from the Practice.

By signing below, I have reviewed the above, fully understand and agree with the terms provided herein.

Patient Signature: _____

Date: _____

Printed name: _____

Atte Sports Ortho Consults

PLEASE READ AND SIGN BELOW

In the event insurance is filed for surgery or other services rendered to me, I hereby authorize this office to request information to my insurance company and assign benefits directly to **Atte Sports Ortho Consults**.

1. MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process a claim or any related claims for my physician, or to my attorney. As well as releasing any medical records to Dr. Paul Meli regarding my care.

2. INSURED PATIENTS (*THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENT'S*)

I have been notified by my physician that my insurance is likely to deny payment for certain items (i.e., injections, x-rays, office visit durable medical equipment, etc.) If my insurance denies payment, I agree to be personally and fully responsible for payment.

3. SIGNATURE ON FILE/LIFETIME AUTHORIZATION

I request that payment of authorized medical benefits be made to my physician for services rendered and any information needed to determine these benefits for any related services.

4. By appointing **Akere Atte, MD PharmD.** to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize **Akere Atte, MD PharmD.** to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request.

5. By signing below, I acknowledge that I have received/or viewed a copy of the **Atte Sports Ortho Consults** notice of privacy practices.

6. PAYMENT POLICY: Payment is due at the time services are rendered. *PLEASE NO EXCEPTIONS*

7. With my signature I agree that Atte SOC and its collections department/agency may contact me at any of the phone numbers I have provided to discuss all balances to my account. Paul Meli Orthopedic also has permission to contact me via email if any of my phone numbers have been changed or disconnected.

8. Any unpaid balances after 90 days will be forwarded to collections.

PRINT NAME (PLEASE PRINT): _____

SIGNATURE: _____ **DATE:** _____

Please save to your computer and email to admin@attesoc.com