PREFERRED ORTHOPEDICS
OF THE PALM BEACHES

Patient # _____

Registration Form

Circle One:
Workers Compensation Yes* No

Today's Date _____ Treating Physician _____

Medical condition seen for today _____ Date of Accident / Injury / / Date Problem began / / ☐ Initial

Patient Information (please print)

Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ Date of Birth / / Age Sex: M F

Marital Status: Married Single Widowed Divorced Separated Other _____

Home Ph# _____ Mobile # _____ Work Ph# _____ x _____

Patient Address _____

City _____ State _____ Zip _____

Out-of-State Address _____

City _____ State _____ Zip _____

Primary Care Physician: _____

Pharmacy name: _____ Pharmacy phone: _____

Referred BY (Circle one Below)
Family Physician Internet Community News
Patient Referral Yellow Pages Other: _____

Email: _____

I would like to receive updates via email. ☐ Yes

Please Circle One

Race: White Black/African American Other Race _____

Birth Order: First Second Third Fourth Fifth

Primary Language _____

Please Circle One

Ethnicity: Not Hispanic or Latino
Hispanic or Latino/Spanish
Cuban
Mexican Other _____

Primary Insurance Information

Insurance _____

Subscriber's Name _____

Subscriber'sSocial Security # _____

Subscriber's Sex M F Date of Birth / /

Relationship to Patient _____

Secondary Insurance Information

Insurance _____

Subscriber's Name _____

Subscriber'sSocial Security # _____

Subscriber's Sex M F Date of Birth / /

Relationship to Patient _____

* For workers compenstation claims please fill out page 3 of this form.

Patient's Employer Information

Employer Name _____

Employer Phone # _____

Employer Address _____

Emergency Contact

In case of emergency whom may we contact ? _____

Phone # _____

Address _____

City _____ State _____ Zip _____

Assignment of Insurance Benefits: *I hereby authorize payment directly to Preferred Orthopedics of the Palm Beaches, (hereinafter referred to as "POPB") and assign to them any and all rights and benefits that I or the patient may have under any policy of insurance including medical, automobile, personal injury protection, workers compensation, or any other coverage and further direct any such insurance company to make payment of benefits directly to POPB. I understand I am financially responsible to POPB for charges not covered by this assignment.*

_____ Initial _____ Date

Lifetime Signature Authorization: *I hereby authorize POPB to furnish to my insurance company or their representative, or Social Security Administration or the Center for Medicare and Medicaid, or Medigap or its intermediaries or to the billing agent of POPB any information needed for this claim or related claims. I permit a copy of this authorization to be used in place of the original.*

_____ Initial _____ Date

Notice of Privacy Practce: *I have been provided information by POPB regarding their privacy practices.*

Patient signature _____ Date _____

Responsible party signature _____ Relationship to Patient _____ Date _____

Consent to Medical or Surgical Treatment: *The undersigned hereby consents to all medical care and services, surgical treatment, examinations, tests and procedures, including but not limited to x-ray examination, laboratory and diagnostic procedures and tests, anesthesia, which a Physician, their employees, nurses, associates, assistants or designees may deem advisable to the ndersigned patient during this treatment.*

Payment Guarantee: the undersigned patient and guaranttor, if any, hereby agree to pay all POPB charges to POPB in accordance with the regular rates and terms of POPB and agree to pay for any charges not covered by any third party payer. the Medical Practive files insurance as a courtesy to the patient, but the patient is ultimately responsible for payment of the total incurred charges. The undersigned agree that if this account is turned over to a collection agency or attorney, that the undersigned patient and guarantor, if any, shall be obligated to pay the outstanding blance plus all costs of collection including reasonable attorneys fees. The undersigned agree that any overpayments collected on this account may be applied to any delinquent account for which the undersigned patient is legally reponsible. The undersigned patient and guarantor, if any, hereby agree that they are jointly and severally liable to pay the entire balance due and that POPB is relying upon the undersigned(s) promise to pay in treating the patient.

Patient signature _____ Date _____

Responsible party signature _____ Relationship to Patient _____ Date _____

If Patient is under age 18, I hereby give my permission for _____ to be treated by POPB.

_____ Signature _____ Witness _____ Date

Joseph B. Chalal, M.D. • Michael S. Zeide, M.D. • Jeffrey A. Press, M.D. • Gregory M. Martin, M.D.

Ansca Building • 7593 Boynton Beach Blvd., Suite #280 • Boynton Beach, FL 33437
T 561.733.5888 • F 561.733.5851 • www.popb.md

PREFERRED ORTHOPEDICS
OF THE PALM BEACHES

JOSEPH B. CHALAL, M.D. — SPORTS MEDICINE, ARTHROSCOPIC KNEE AND SHOULDER SURGERY
MICHAEL S. ZEIDE, M.D. — GENERAL ORTHOPEDIC SURGERY
JEFFREY A. PRESS, M.D. — ORTHOPEDIC SURGERY, SPORTS MEDICINE, JOINT REPLACEMENT
GREGORY M. MARTIN, M.D. — HIP & KNEE REPLACEMENT, REVISION SURGERY
KATHLEEN L. DAVENPORT, M.D. — PHYSIATRY, PERFORMING ARTS AND SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize and request copies of my medical records to be released:

FROM:

_____ ALL MEDICAL FACILITIES

OR:

Name: Dr. _____

Address: _____

Phone #: _____

Fax #: _____

TO:

Preferred Orthopedics of the Palm Beaches
7593 Boynton Beach Blvd. Suite 280
Boynton Beach, Florida 33437
Fax#: 561-733-5851

I further authorize Preferred Orthopedics to discuss my medical condition with:

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

If not signed by patient, please indicate relationship.

_____ Parent/guardian of minor patient

_____ Other (Specify) _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released by this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the authorization. This authorization is valid until _____ (one year from date of signature if not specified).

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information my not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Medical Records Department at (561) 733-5888.

PRINT NAME _____ DATE OF BIRTH: _____ SIGNATURE _____ DATE _____

PREFERRED ORTHOPEDICS
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Confidential Health History

Date:_____ Physician: Dr. Chalal Dr. Press Dr. Zeide

Name:_____ Age:_____ Birthdate:_____

Primary Physician:_____

Pharmacy Name and Phone Number:_____

What is the reason for today's visit?_____

Date of onset:_____

Rate your pain on a scale of **0** (no pain) to **10** (severe pain): 0 1 2 3 4 5 6 7 8 9 10

List current medications and dosages:

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

Past Surgical History:_____

_____

Past Medical Problems

- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Arrhythmia's
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gastritis
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disorders
- ☐ Mitral Prolapse
- ☐ Liver Disorders
- ☐ Peripheral Vascualr Disease
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Stroke
- ☐ TIA's
- ☐ Ulcer
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ Other Arthritic Conditions

Have you had a flu shot?_____ When?_____

Have you had a bone density scan?_____ When?_____

Do you have an advance care plan / advance directive? Y N

Do you have a surrogate decision maker? Y N If yes, who?_____

Name: _____

Do you have a **family history** of:

	Mother	Father		Mother	Father
☐ High Blood Pressure	____	____	☐ Thyroid Disease	____	____
☐ Heart Disease	____	____	☐ Cancer	____	____
☐ Stroke	____	____	☐ Arthritis	____	____
☐ Diabetes	____	____	☐ Kidney Disease	____	____

Social History:

What is your occupation? _____

Marital Status: Single Married Divorced Widowed Separated

Number of Children: _____ Mother: Living Deceased Father: Living Deceased

Do you smoke cigarettes? Y N How many packs/day? _____ How many years? _____

If you quit, when? _____

Do you drink alcohol? Y N How many drinks/day? _____

Height _____ Weight _____ Dominant Hand: Right Left

Review of Systems:

Constitutional:	☐ Fevers	☐ Chills	☐ Night sweats	
Eyes:	☐ Double vision	☐ Watery eyes	☐ Itching eyes	
ENT:	☐ Nose bleeds	☐ Hoarseness	☐ Swollen glands	☐ Ringing in ears
Cardiovascular:	☐ Chest Pain	☐ Palpitations	☐ Swelling of the ankles	
Respiratory:	☐ Cough	☐ Sputum	☐ Wheezing	☐ Shortness of breath
Gastrointestinal:	☐ Heartburn	☐ Reflux	☐ Jaundice	☐ Nausea
Genito-urinary:	☐ Frequency	☐ Burning	☐ Incontinence	
Neurologic:	☐ Seizures	☐ Dizziness	☐ Headaches	☐ Balance disruptions
Endocrine:	☐ Excessive thirst	☐ Excessive weight gain		☐ Excessive weight loss
Hematologic:	☐ Easy bruising	☐ Bleeding Problems		☐ Past blood transfusion
Psychiatric:	☐ Anxiety	☐ Depression	☐ Mood changes	☐ Nervousness
Allergy:	☐ Itching	☐ Environmental	☐ Severe or topical sensitivities	
Skin:	☐ Rashes	☐ Hives	☐ Color changes	
Musculoskeletal:	☐ Joint pain	☐ Cramps	☐ Stiffness	☐ Joint swelling

☐ **Unless checked above, all systems are negative.**

Patient Attestation:

I have read and answered the above questions. I affirm that they are complete and true to the best of my knowledge.

Patient Signature: _____ Date: _____

Provider Attestation:

I have personally reviewed and gathered the above information on the date noted.

Physician Signature: _____ Date: _____