# 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 ____________

POPB (09/25/11)

* For workers compensation 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 undersignea 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 ____________

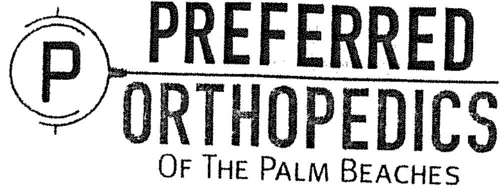
If Patient is under age 18, I hereby give my permission for ______________________ to be treated by POPB.

______________________ ______________________ ______________________
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



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

# Confidential Health History

Gregory M. Martin, M.D.
Board Certified Orthopedic Surgeon
Specializing in Hip and Knee

**Patient Name:**____________________________________

**Date:**____________________ **Time:**_______________

**Age:**______________________ **Birthdate:**_____________

**Who Referred You?**__________________________________________

**Primary Care Doctor?**________________________________________________

**What is the Reason for today's visit?** ___________________________________________

________________________________________________________________________

**When did problem start?** Date________________

**Was there an injury?** No Yes If Yes, Describe______________________________________

**How long has this been going on** (circle one): Days Weeks Months Years **NUMBER** _________

**Please Circle all areas with Pain and or Functional Problem:**

| | | | |
|---|---|---|---|
| **Low Back** | Right | Left | **Other**(please write in space below): |
| **Hip** | Right | Left | |
| **Buttock** | Right | Left | |
| **Groin** | Right | Left | |
| **Thigh** | Right | Left | |
| **Knee** | Right | Left | |
| **Leg (below knee)** | Right | Left | |

**What is the intensity of the pain on a scale of 0 to 10**(10 being severe/unbearable)?:__________

**Pain feels like** (circle all that apply): Sharp Dull Throbbing Stabbing Burning

**Pain is** (circle all that apply): Constant Intermittent Daily Weekly

**Pain occurs with** (circle all that apply): Activity (eg. Walking, sports, etc) Rest Sleep

**Pain improves with** (circle all that apply) Activity Rest Sleep Other______________

**Pain worsens with** (circle all that apply): Activity Rest Sleep Other______________

**Is there any associated Locking, Catching or Buckling?** Yes No

**Any numbness or tingling in legs?** No Yes Right leg Left leg

**Do you Limp?** No Yes

**Is there any trouble getting dressed, tying shoes, or clipping toenails?** No Yes

**Do you use a walking aid**(circle all that apply)? No Cane Walker Wheelchair

**Do you feel a difference in the length of your legs?** No Yes

**If yes, which leg feels longer?** Right Left

**What have you done or taken to help** (circle all below that apply)?:

Tylenol Alleve Ibuprofen(Motrin/Advil) Ice Heat Brace Ointments

Glucosamine/Chondroitan Other________________________________________

**Have you taken any prescription pain pills or prescription anti-inflammatories**? Yes No

Vicodin/hydrocodone Percocet/oxycodone Mobic/meloxicam Naprosyn Celebrex

Other(please list)________________________________________

**Have you had any injections**? No Yes Where? Back Hip Knee Side Right Left

**If Yes, what was injected** (circle all that apply)?
Cortisone Viscosupplement (synvisc, hyalgan, supartz, orthovisc, euflexxa)

**Of the above, what has helped the most?**________________________________________

**Past Surgical History** (circle all that apply, list Surgeon, Hospital and date performed):

None

Spinal Surgery________________________________________

Hip R L ________________________________________

Knee R L ________________________________________

Other Surgery: ________________________________________

________________________________________

**Do you have any allergies to medications?** No Yes (please list)____________________

**Please list current Medications/Doses (include ALL over the counter/vitamins and nutritional pills:**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

**Is there any past or current history of:**

| | | |
|---|---|---|
| Anemia? | No | Yes |
| Blood Clot/Venous Thrombosis? | No | Yes |
| Pulmonary embolus? | No | Yes |
| Sickle Cell? | No | Yes |
| Angina/chest pain? | No | Yes |
| Heart arrhythmia? | No | Yes |
| Heart attack? | No | Yes |
| Heart disease? | No | Yes |
| High Blood Pressure? | No | Yes |
| High Cholesterol? | No | Yes |
| Asthma? | No | Yes |
| COPD/Emphysema? | No | Yes |
| Cancer? | No | Yes |
| Diabetes? | No | Yes |
| Epilepsy/seizures? | No | Yes |
| TIA or Stroke? | No | Yes |
| Depression? | No | Yes |
| Anxiety? | No | Yes |
| Kidney disorders? | No | Yes |
| Gastritis? | No | Yes |
| Hepatitis? | No | Yes |
| Ulcers? | No | Yes |
| Thyroid disease? | No | Yes |
| Peripheral vascular disease? | No | Yes |
| Osteoarthritis? | No | Yes |
| Rheumatoid arthritis? | No | Yes |
| Psoriatic arthritis? | No | Yes |
| Gout? | No | Yes |
| Osteoporosis/Osteopenia (poor bone health) | No | Yes |

If Yes, Type?____________________________

***Please list below any other past medical history not otherwise identified:**

**Social History:**

Marital Status: Single Married Divorced Widowed Separated

Any Children?: No Yes Number__________________ Parents: Living Deceased

Do you smoke tobacco products? No Yes Packs/day?_____________ #Years__________________

Do you drink alcohol? No Yes Type?__________________________ How much?______________

Do you use prohibited substances? No Yes Type?_________________________________________

Circle current work status: Employed Retired Disabled Unemployed

List current/former occupation:______________________________

**Family History (Parents, Siblings, Children)**(Circle all that apply):

High Blood Pressure Heart Disease Stroke Diabetes Thyroid Disease

Cancer Arthritis Kidney Disease Other______________________

**Review of Systems** (Are any of the following symptoms present? Circle all that apply):

| | | | | |
|---|---|---|---|---|
| Constitutional: | Fevers | Chills | Night sweats | Fatigue |
| Eyes: | Double vision | Watery eyes | Itching eyes | Eye pain |
| EarNoseThroat: | Nose bleeds | Bleeding gums | Hoarseness | Swollen glands |
| Cardiovascular: | Chest pain | Palpitations | Swollen ankles | Fainting |
| Respiratory: | Cough | Sputum | Wheezing | Shortness of Breath |
| Gastrointestinal: | Heartburn | Reflux | Jaundice | Nausea |
| GenitoUrinary: | Frequency | Burning | Incontinence | Sexual Dysfunction |
| Neurologic: | Numbness | Dizziness | Weakness | Balance issues |
| Endocrine: | Excessive thirst | Weight gain | Weight loss | Heat/Cold intolerance |
| Hematologic: | Easy bruising | Bleeding problems | Previous Blood Transfusion | |
| Psychiatry: | Anxiety | Depression | Mood Changes | Nervousness |
| Allergy: | Itching | Environmental | Food Allergies | |
| Skin: | Rashes | Hives | Psoriasis | Nonhealing wounds |
| Musculoskeletal: | Joint pain | Joint swelling | Stiffness | Cramps |

Please list any other thing you believe is important to let the doctor know?

______________________________________________________________

______________________________________________________________

**Height**______________________ **Weight**______________________**Pulse**______________

**Initial Visit Attestation:**

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

**Patient** Signature:______________________________Date:______________________

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FOR PHYSICIAN USE ONLY:

**Provider Attestation:**

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

**Physician** Signature:_______________________________Date:_______________________________