Kendall Orthopedic, Surgical, and Pediatric Specialists

11760 Bird Road, Suite 722 • Miami, FL 33175 • PHONE: (305) 559-1883 • FAX: (305) 559-1887

Patient Name: _____ Date: _____

Age: _____ Date of birth: _____ Sex: ☐ Male ☐ Female Marital status: _____

Occupation: _____

Primary care provider: _____ Primary Care Provider Phone #: _____

Who referred you to this practice? _____

List any other doctors that you are currently under the care of (ex: cardiology, pulmonology):

_____

_____

Which pharmacy do you use:_____ Pharmacy#: _____

Have you had x-rays taken and if so where? _____ Did you bring them with you today? ☐ Y ☐ N

Handed: ☐ Right ☐ Left Height: _____ inches Weight: _____ LBS

In the past year did you receive a flu shot? ☐ Y ☐ N If so date when you received it: _____

If you are over 65 have you received a pneumococcal: ☐ Y ☐ N If so, date when you received it: _____

What are you seeing the doctor for today? _____

When did the problem fist start? _____

Is this the result of an injury? ☐ Y ☐ N If so, is there pending legal action? ☐ Y ☐ N

Is this work related? ☐ Y ☐ N

Explain in your own words how this injury occurred?

_____

_____

_____

_____

_____

What treatment have you had so far?

_____

_____

_____

_____

_____

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CURRENT MEDICATIONS

Please list all medications that you are currently taking:

Medication	Dosage

PAST MEDICAL HISTORY:

Please circle any of the problems that you have

I have no past medical problems	Liver disease
High blood pressure	High Cholesterol
Heart disease	Thyroid disease
Peripheral vascular disease	COPD/lung problem
Diabetes	Sleep apnea
Heart attack	Rheumatoid arthritis
Crohn's Disease	Hepatitis A/B/C
Asthma	Obesity/overweight
Ulcers	Osteoporosis
Hepatitis	HIV/AIDS
Cancer	Tuberculosis

Other: _____

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ALLERGIES:

Please circle anything listed below that you are allergic to:

No known allergies	Latex	penicillin
Codeine	Tetracycline	Morphine
Erythromycin	Iodine/Betadine	Lidocaine
Sulfa	Adhesive Tape	Radiographic Dyes

Other: _____

SURGICAL HISTORY:

Please circle any surgeries that you have had and indicate the year of the procedure.

No previous surgeries	Tonsillectomy _____	Appendectomy _____
Hip Replacement _____	Knee Replacement _____	Shoulder Replacement _____
Knee scoped _____	Shoulder Scoped _____	Fracture pinned _____
C-Section _____	Gastric Bypass _____	Carpal Tunnel Release _____
Open Heart Surgery _____	Gall bladder _____	Hernia Repair _____
Back Surgery _____	Hysterectomy _____	Mastectomy _____
Cataract Removal _____	Prostate Surgery _____	Arterial Stents _____

Other: _____

FAMILY MEDICAL HISTORY

Mother: Alive / Deceased / Unknown Father: Alive / Deceased / Unknown

Who in your immediate family has ever had the following: (M) mother / (F) Father / (B) Brother / (S) Sister

Cancer _____	High Blood Pressure _____	Alcoholism _____
Diabetes _____	Coronary Artery Disease _____	Bleeding Tendency _____
Crohn's Disease _____	Rheumatoid Arthritis _____	Leukemia _____
Stroke _____	Heart Attack _____	Hypothyroidism _____
Asthma _____	Seizure Disorder _____	

Other: _____

SOCIAL HISTORY:

Alcohol: Do you drink alcohol ☐ Y ☐ N

If so how many drinks per occasion _____ how many drinks per week _____

Tobacco:

Do you now or have you ever used tobacco products?

☐ I have never used them

( ) I have quit using them and did so in _____

☐ I am a current user of ☐ Cigarettes ☐ Smokeless tobacco ☐ Cigars

On average I use: 1 2 3 packs/cans/cigars per day.

Do you now or have you ever used any of the following?

☐ Marijuana ☐ Cocaine ☐ Prescription ☐ Other

Medical Review:

Please indicate if you currently have any of the following:

Symptom		Comments
Fever	☐ Yes ☐ No	_____
Change in appetite	☐ Yes ☐ No	_____
Weight Gain	☐ Yes ☐ No	_____
Weight Loss	☐ Yes ☐ No	_____
Bruise easy	☐ Yes ☐ No	_____
Rashes	☐ Yes ☐ No	_____
Slow healing wound	☐ Yes ☐ No	_____
Difficult Seeing	☐ Yes ☐ No	_____
Double vision	☐ Yes ☐ No	_____
Blurred Vision	☐ Yes ☐ No	_____
Hearing Changes	☐ Yes ☐ No	_____
Difficulty Swallowing	☐ Yes ☐ No	_____
Sore Throat	☐ Yes ☐ No	_____
Nose Bleeds	☐ Yes ☐ No	_____
Chest Pain	☐ Yes ☐ No	_____

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Symptom		Comments
Irregular Heartbeat	☐ Yes ☐ No	
Heart Murmur	☐ Yes ☐ No	
Swelling in Legs	☐ Yes ☐ No	
High Blood Pressure	☐ Yes ☐ No	
Cough	☐ Yes ☐ No	
Wheezing	☐ Yes ☐ No	
Shortness of Breath	☐ Yes ☐ No	
Abdominal Pain	☐ Yes ☐ No	
Nausea	☐ Yes ☐ No	
Vomiting	☐ Yes ☐ No	
Diarrhea	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Blood in Urine	☐ Yes ☐ No	
Painful Urination	☐ Yes ☐ No	
Urinary Tract Infections	☐ Yes ☐ No	
Joint Pain	☐ Yes ☐ No	
Swollen Joint	☐ Yes ☐ No	
Stiffness	☐ Yes ☐ No	
Muscle Pain	☐ Yes ☐ No	
Fracture	☐ Yes ☐ No	
Muscle Weakness	☐ Yes ☐ No	
Numbness / Tingling	☐ Yes ☐ No	
Migraines	☐ Yes ☐ No	
Memory Loss	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Sleep Disturbances	☐ Yes ☐ No	

Print Name: _____ Signature: _____ Date: _____

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First Point of Contact Screening

Patient Name _____ Date _____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? ☐ Yes ☐ No

   If yes, please circle the symptoms you have now, or have had, over the past seven days?
   - **Fever**
   - **Night sweats**
   - **Sneezing or runny nose**
   - **Cough**
   - Severe headache
   - Stiff neck
   - Muscle or joint pain (circle one or both)
   - New rashes or open sores on your skin or in your mouth
   - Redness, swelling, or discharge of your eyes (pink eye)
   - Unexplained bleeding
   - Vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? ☐ Yes ☐ No

   If yes please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? ☐ Yes ☐ No

   If yes, pleas list where: _____

Thank you for your help and support in caring for our patients and community.

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by: _____

Action taken:

☐ No action taken

☐ Isolate

☐ Cough hand washing etiquette provided

☐ Mask provided

☐ PM/ Lead clinical notified

Thank you for trusting us with your healthcare!

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Consent for Treatment and Payment Agreement

Kendall Orthopedic, Surgical, and Pediatric Specialists Consent for Treatment and Payment Agreement I hereby authorize Kendall Orthopedic, Surgical, and Pediatric Specialists to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable In the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, al. of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Kendall Orthopedic, Surgical, and Pediatric Specialists of benefits otherwise payable to me, I hereby acknowledge the release of my medical records to third party Insurers of authorized persons to whom disclosures necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible tar charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given In advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services, I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your Insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Kendall Orthopedic, Surgical, and Pediatric specialists, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: ____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information, given to me in applying for payment under Title XV11 of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim, I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign tie benefits payable for services to Kendall Orthopedic, Surgical, and Pediatric Specialists. Patient Initial: ____

I request this authorization also apply to all other insurance. Patient Initial: ____

I acknowledge that I have been given Kendall Orthopedic, Surgical, and Pediatric Specialists Notice of Privacy Practices. I understand that if I have questions or complaints that should contact the Facility Privacy Official. Patent initial: ____

RELEASE OF MEDICAL INFORMATION

I give permission for my protected heath information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Release info Allowed in exam room Authorized to receive information	Release info (Please mark with an X)	Allowed in exam room (Please mark with an X)

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature _____ Date _____ Patient Date of Birth _____

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Radiology Financial Release Form

The radiologist invoice is separate from the invoice from Kendall Surgical/Orthopedic and Pediatric Specialists. The radiology bill from Intellirad covers reading and interpretation of the X-Ray whereas our bill will cover the physical taking on the X-Rays

By signing this document you acknowledge you understand there are two components that will be billed from these services.

La facture del radiólogo es aparte de la facture de Kendall Surgical/Orthopedic and pediatric Specialist. La facture de los radiologos de Intellirad abarca la lectura e interpretacion de los rayos-X y la nuestra abarca la toma fisica de las radiografias.

Al firmar este docuento afirma la compression que hay dos components independientes por los que seran facturados.

Patient Name (Nombre): _____

Date of Service (Fecha): _____

Signature (Firma): _____

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CONTROLLED SUBSTANCE AGREEMENT

PATIENT NAME: _____ DOE: _____

The purpose of this Agreement is to enter a mutual contract regarding certain medicines (controlled substances) you will be taking or could be taking in the future. Prescription of controlled substances is strictly monitored by state and federal law so strict accountability is necessary

- **I understand that this Agreement is based on the trust and confidence** necessary in a provider/patient relationship and that my provider will manage controlled substances based on this agreement. ____ Pt. Initials

- **I understand that if I break this Agreement**, my provider will stop prescribing these controlled substances. ____Pt. Initials

- **I agree to notify my provider of any and all controlled substances or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur within two (2) weeks, or sooner if I have an encounter with my provider, following receipt of prescription. If I fail to alert my provider I understand I may be discharged from the practice. ____ Pt. Initials

- **I understand that someday my provider may recommend weaning me partially or totally from controlled substances** if he/she determines that, in the long run, this is likely to be in my best interests, In st.t.:11 situations other medications or therapies will likely' be suggested as part of my new treatment plan. I agree to respect my provider's opinion in such circumstances and comply with the new treatment plan or discuss pursing other treatment venues. ____ Pt. Initials

- **I understand that if I am suspected of diverting or distributing my controlled substances, my provider will immediately cease prescribing** the medications. In this case, my provider will be required to comply with local state and/or federal reporting requirements and investigation. ____ Pt. Initials

- **I agree to consider to follow my provider's recommendation** to seek psychiatric treatment, psychotherapy, psychological treatment or referral to pain management specialist/addictionologist if my provider deems necessary. ____ Pt. Initials

- **If the controlled substances are prescribed to treat pain symptoms, I agree to communicate fully and honestly with my provider** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. ____ Pt. Initials

- I**f the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.** I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. ____ Pt. Initials

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CONTROLLED SUBSTANCE AGREEMENT

- **I understand the combination of opiates or pain medications with anti-anxiety medications such as Valium or Xariax may increase the likelihood of side effects such as stopping breathing and/or abnormal heart rhythms which may result in injury or death.** ____ Pt. Initials

- **I understand that controlled substances which I may be prescribed have potential risks and side effects, including the risk of addiction.** An over-dosage with a controlled substance may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, reduced sexual **function,** seizures, coma, and/or aspiration. ____ Pt. Initials

- **I will not use any recreational mind-altering or illicit (i.e. marijuana, cocaine, methamphetamine, etc.) substances.** Avoid use of alcohol as I understand alcohol may accentuate or exacerbate side effects associated with legal CS. ____ Pt. Initials

- **I will not share, sell or trade my medication with anyone nor will I take other individual's prescribed CS.** ____ Pt. Initials

- **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other provider unless that provider is co-managing care with my current provider.** ____ Pt. Initials

- **I will inform my provider of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. ____ Pt. Initials

- **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed.** Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted, Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to injury or death. ____ Pt. Initials

- **I understand that suddenly stopping some medications** (including opioids and sedatives} can cause substantial discomfort including psychological distress, extreme achiness and fatigue, nausea, trembling, etc. ____ Pt. Initials

- **I understand the abruptly stopping chronic higher dose use of benzodiazepines** can cause serious risk to my health and that weaning instructions must be followed explicitly. ____ Pt. Initials

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CONTROLLED SUBSTANCE AGREEMENT

- I will avoid withdrawal symptoms by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out of medication is not grounds for insisting on an 'emergency or urgent appointment. ____ Pt. Initials

- I will safeguard my controlled substances from loss or theft Lost or stolen medicines will not be replaced. ____ Pt. Initials

- I agree that refills of my prescriptions for controlled substance will be made only at the time of an office visit or during regular office hours, No refills will be available during evenings or on weekends. ____ Pt. Initials

- I agree that prescriptions for controlled substances will not be refilled earlier than the agreed upon renewal date. ____ Pt. Initials

- **(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this/these medication, I will immediately call my obstetric provider and prescribing prescriber/provider to inform them.** ____ Pt. Initials

I agree to use _____ Pharmacy,

Located at _____

Telephone number _____, for filling

prescriptions for ***all*** of my controlled substance(s)

- **If I chose to have my medications filled by a new pharmacy not listed above,** I will be required to sign a new Controlled substance Contract at my next appointment with my updated pharmacy information ____ Pt. Initials

- **I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law.** Forged prescriptions and/or forged provider's signatures are also against the law. If any of these instances occur, it will result in an immediate termination from this practice. ____ Pt. Initials

- I **authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances.** If requested, I authorize my provider to provide a copy this Agreement to my pharmacy or to the requesting government agency. I agree waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. ____ Pt. Initials

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- I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of controlled substance. Tests may include screens for illegal substances, and my cooperation is required. **Refusal of such testing may subject me to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from this practice**.
  ____ Pt. Initials

- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time and possible termination of care.** ____ Pt. Initials

- I will bring all unused controlled substances to every office visit. ____ Pt. Initials

- **I understand that any serious misbehavior** such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice. ____ Pt. Initials

- **I agree to follow the guidelines that have been fully explained to me**. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. ____ Pt. Initials

This agreement is entered into on this _____ day of _____, 20____

Patient/Responsible party signature:

_____ Date: _____ Time: _____

Prescriber/provider signature:

_____ Date: _____ Time: _____

Medication(s) prescribed

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Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I wish to designate the following individual to pick up a prescription order on my behalf.

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/Representative Initials) I do not want to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____