Patient Name: _____

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Headaches	○ Dizziness	○ Seizures	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? ○ Y ○ N If Yes, packs per day _____ ○ Quit

Alcohol use? ○ Y ○ N ○ Quit

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ Y ○ N ○ Retired ○ Disabled If no, when did you last work? _____

Are you currently on any work restrictions? ○ Y ○ N If Yes, what are they? _____

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

_____ _____

Signature **Date**

Patient Name: _____

PAST MEDICAL HISTORY

List all previous hospitalizations : ○ **None** **YEAR**

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking, or have you ever taken, blood thinners? ○ Y ○ N If Yes, which one? _____

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control):

○ None	**Medication**	**Reason**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_ _____	_____

Are you allergic to any medications? ○ Y ○ If Yes, please list below:

Medication	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies? ○ Y ○ N If Yes, what are they? _____ **Latex allergy?** ○ Y ○ N

Do you have a personal history or any of the following? ○ **NONE**

○ Excessive or Prolonged Bleeding	○ Rheumatic Fever	○ HIV / AIDS	○ Stroke
○ Blood Clots	○ Diabetes Type: _____		○ Circulatory Problems
○ Asthma	○ Reaction to Anesthesia Type: _____		○ Heart Disease /Defect
○ Stomach Ulcers	○ Cancer Type: _____		○ Chemotherapy /Radiation
○ Birth Defects	○ Arthritis Type: _____		○ Continuous Seizures
○ Problems with Wounds Healing	○ Hepatitis	○ Fractures /Joint Dislocations	○ Epilepsy
○ Emphysema	○ Bone or Joint Infections	○ Tuberculosis	○ Lung Disease
Are you Pregnant? ○ Y ○ N	○ Abnormal Blood Pressure	○ Chemical Dependency	○ Psychiatric Care
Claustrophobic? ○ Y ○ N	○ Pacemaker	○ Sleep Apnea	**Use a C PAP?** ○ Y ○ N

MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Age: _____ **Sex:** ○ M ○ F **Height:** _____ **Weight:** _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Referring Physicians Name: _____

Part of the body being seen for today: ○ R ○ L _____

In this section, selct the option which best describes how your problem started.

○ **NO INJURY** Was the onset ○ Gradual ○ Sudden
Onset Date: _____

○ **INJURY** ○ Accident ○ Sport
Date of injury: _____

○ **INJURY AT WORK** Date of work injury: _____

○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive

○ **AUTO ACCIDENT** Date of auto accident: _____

Description of Injury / Accident

_____
_____
_____
_____
_____
_____
_____
_____

Have you had a problem like this before? ○ Y ○ N

Were you seen in the E.R. for this problem? ○ Y ○ N if yes, Which E.R.? _____

What tests have you had for this problem? ○ X-rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve (EMG / NCV)

On a scale of 0-10 (10 is the worst) how severe is your pain?

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

What is the quality of pain? ○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning

The pain is ○ Constant ○ Intermittent (comes & goes)

Does the pain wake you from your sleep? ○ Y ○ N

I experience: ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of control bowel or bladder

○ Locking / Catching ○ Giving way ○ Pain ○ Stiffness Other _____

Since my problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

What makes your symptoms worse: ○ Standing ○ Walking ○ Lifting ○ Twisting ○ Stairs

○ Exercise ○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Bending ○ Lying in bed

What makes your symptoms better?: ○ Rest ○ Elevation ○ Ice ○ Heat Other:_____

PERSONAL VALUABLES

I acknowledge that its practice/ facility do not accept responsibility for any personal property. I accept the risk of loss or damaged to any of my personal property.

USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALCARE OPERATIONS

I, understand that as part of my health care, JOSEPH I. FERNANDEZ, M.D., P.A. and SAM ASH, M.D., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that JOSEPH I. FERNANDEZ, M.D., P.A., is not required to agree to the restriction requested.

I understand that I may revoke this consent in writing. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that JOSEPH I. FERNANDEZ, M.D., P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should JOSEPH I. FERNANDEZ, M.D., P.A. or any of its providers change their notice, I have the right to obtain a copy of any revised notice.

I understand that as part of this practice's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I acknowledge that I have read and reviewed the NOTICE OF PRIVACY PRACTICES and I am in agreement of such.

I acknowledge that this form has been fully explained to me and that I have read and understand each of the provisions appearing on this form, and that by signing this form, I consent to these provisions individually and collectively

X

_____

Patient's Signature Date

_____

OFFICE USE ONLY

- Consent received by _____on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical records on _____.

CONSENT AND DISCLOSURE FORM

ASSIGNMENT OF INSURANCE BENEFITS
I authorize payment of Medicare, Medicaid or other insurance benefits otherwise payable to me for medical service rendered to me or my child directly to
JOSEPH I. FERNANDEZ, M.D., P.A.
SAM ASH, M.D.
These benefits are not limited to Individual Policies, Group Policies, Workers Compensation, Liability, PIP or any other policy that may cover healthcare benefits.

Where MEDICARE/MEDICAID BENEFITS are applicable. I certify that the information given by me in applying for payment under Title XVII or XVI of the Social Security Act is correct, and request that these payments of authorized be made directly to myself and/or JOSEPH I. FERNANDEZ, M.D., P.A. or any of its providers.

THIRD PARTY BENEFITS COLLECTIONS
I authorize JOSEPH I. FERNANDEZ, M.D., P.A., or any of its providers, to act in my behalf as attorney in fact in the collection of benefits form any responsible third party payer through whatever mean may be deemed necessary, and in the endorsement of benefit checks made payable to myself and/or JOSEPH I. FERNANDEZ, M.D., P.A. or any of its providers.

RELEASE OF INFORMATION
I authorize JOSEPH I. FERNANDEZ, M.D., P.A., or any of its providers to release copies of information in their possession, acquired in the course of my or my child's examination and/or treatment, to my insurance carriers in connection with my treatment for the purpose of any insurance, Medicare and Medicaid payments

- This facility and its affiliates
- Physicians (Attending and Consulting)
- Utilization review agencies or auditors
- Other allied health professionals

USE OF INFORMATION
I authorize JOSEPH I. FERNANDEZ, M.D., P.A. and its affiliates and authorized agents to use the information acquired in the course of my or my child's examination and treatment to provide me with information about JOSEPH I. FERNANDEZ, M.D., P.A., and its affiliates and other matters that may be of interest to me regarding my or my child's healthcare.

GUARANTEE OF PAYMENT
I herby understand that I am financial responsible for payment to JOSEPH I. FERNANDEZ, M.D., P.A., for any charges not covered or allowable by my Insurance Company, and all deductibles, co-insurance, co-payments, and for any balances remaining after payment has been made by my Insurance Company. This include any denials of payment due to lack of medical necessity of pre-certification/ authorization, lack, lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage. I further understand and agree that is this account is placed for collection; I will be responsible for paying the balance owed to the physician plus the cost of collection fees, and/or including reasonable attorneys fees if/when applicable.

CONSENT TO TREATMENT
I consent to all medical and surgical procedures and treatment, including but no limited to surgery, medical treatment, radiological examination, anesthesia, laboratory procedures, and medications that may be performed, administered or rendered by or under specific or general instructions of my physician or designated health care provider. I herby voluntarily consent to rendering of medical treatment by JOSEPH I. FERNANDEZ, M.D., P.A., and SAM ASH, M.D., and/or the medical staff, which may include routine diagnostic and/or surgical procedures, x-rays, administration of injections, therapy and/or any other such medical treatment deemed necessary for the treatment and improvement of the patient's condition.

OPEN DOOR POLICY
Due to the nature of the practice, JOSEPH I. FERNANDEZ, M.D., or any of its providers, have an open door policy. Treatment areas are kept open and examining room doors may be kept open. If you have any questions or objections to this policy, please inform the physician or the designated health care provider.

APPOINTMENT AND PATIENTS REMINDERS
Acknowledge that this practice/facility may call for appointment reminders and/or cancellations. I authorize the use or enclosure of medical information to contact myself as a reminder. This contact may be by phone, in writing, e-mail, or otherwise and may involve leaving a message on an answering machine or any other device available. If you have any questions and/or objections to this policy, please inform us.
I authorize JOSEPH I. FERNANDEZ, M.D., P.A., and its affiliates to take pictures of my (or my child) medical or surgical procedure(s) and condition(s) and to the use of such picture for treatment, scientific, educational or research purposes.

MIAMI SPORTS MEDICINE

Joseph I. Fernandez, M.D., F.A.C.S. ● Sam Ash, M.D.
Ralph Doerner, M.S., P.A.C. ● Matthieu Myers, M.S., P.A.C.

MEDICAL MALPRACTICE INSURANCE ACKNOWLEDGEMENT

Dear Patient:

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. The notice is pursuant to Florida Law.

Estimado Paciente:

Bajo la ley de la Florida, los medicos por lo general, deben llenar el requisito de tener un seguro que cobra cualquier reclamo o demuestre responsabilidad financiera para cubrir cualquier reclamo que se trate de negligencia pro parte del medico. SU DOCTOR HA DECIDIDO NO TENER SEGURO CONTRA RECLAMOS DE NEGLIGENCIA. Esto es permitido bajo la ley de la Florida sujeto a ciertas condiciones. La ley de la Florida impone penas contra medicos que no esten asegurados y que no satisfagan juicios que provienen de reclamo de negligencia. Esta noticia se prove de acuerdo con los requerimientos de la ley de la Florida

Date/Fecha:_____

Patient's Signature:_____

If minor, Parent/Guardian's Signature: _____

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: (Apellido)	First: (Primer Nombre)	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) (Estado Civil) Single / Mar / Div / Sep / Wid
Race: (Raza) Ethnicity:(Etnicidad)	Preferred Language (Idioma preferido)	Social Security no. (Seguro Social)	Birth date: (Fecha de nacimiento) / /		Sex: (Sexo) ❑ M ❑ F
Cell no.: (Cellular)	Other phone no.:	Email: (Correo Electronico)			
Street address: (Direccion)	City: (Cuidad)	State: (Estado)	ZIP Code: (Codigo Postal)		
Occupation: Ocupación	Employer: Empleador	Employer phone no.: Telefono de el Empleador ( )			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

Primary Insurance Name: _____ Self Pay Worker's Compensation

Policy no: _____ Group no.: _____ Phone no.:_____

Policy Holder: _____ Date of Birth: _____ Social Security: _____

Secondary Insurance Name: _____

Policy No.: _____ Group no.: _____ Phone no.: _____

Policy Holder: _____ Date of Birth: _____ Social Security: _____

- **(Please give the receptionist your insurance card and picture ID)**

PHARMACY INFORMATION

Pharmacy Name: _____ (Farmacia) Location: _____ (Direccion) Phone no.: _____ (Telefono)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Joseph I. Fernandez, M.D. DBA Miami Sports Medicine or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*