PRO SPORTS / ELITE REHAB

Please Fill This Form Out Completely

Name:________________________DOB:________________Age:______Date:__________

Occupation:______________________ Height: ______________ Weight:__________

Pharmacy Name:________________________ Location or phone #:________________

Referring Physician:____________________Family Physician:__________________

Do you have an advance directive or living will? ( ) No ( ) Yes If yes, who____________________

History of Present Illness/Condition

Reason you are seeing the doctor today?:________________When did symptoms start?____________

Have you been treated previously or had an X-Ray/MRI for this problem? No ( ) Yes ( ) Where?:__________

Past Medical History

Are you **right** ( ) or **left** handed ( ) **Allergies to medications** No ( ) Yes ( ) please list__________________

Can you possibly be pregnant? No ( ) Yes ( )

Anemia	**No ( ) Yes ( )**	**Lung or Breathing Problems**	**No ( ) Yes ( )**
Arthritis	**No ( ) Yes ( )**	**Mental Illness**	**No ( ) Yes ( )**
Rheumatoid Arthritis	**No ( ) Yes ( )**	**Peptic Ulcer**	**No ( ) Yes ( )**
Asthma/Emphysema	**No ( ) Yes ( )**	**Psoriasis**	**No ( ) Yes ( )**
Bleeding Disorders	**No ( ) Yes ( )**	**Pulmonary Embolus**	**No ( ) Yes ( )**
Cancer	**No ( ) Yes ( )**	**Seizures**	**No ( ) Yes ( )**
Where?____________________		**Stroke**	**No ( ) Yes ( )**
Diabetes	**No ( ) Yes ( )**	**Venous Thrombosis**	**No ( ) Yes ( )**
Gout	**No ( ) Yes ( )**	**Pacemaker**	**No( ) Yes ( )**
Heart Disease	**No ( ) Yes ( )**	**Osteoporosis**	**No ( ) Yes ( )**
High Blood Pressure	**No ( ) Yes ( )**		
High Cholesterol	**No ( ) Yes ( )**		
HIV AIDS	**No ( ) Yes ( )**	**Other**______________________________	

Family History for any of the above conditions? _____ Yes _____ No relevant family history. If yes, please explain

____

Have you had any surgeries in the past? If yes, please list type and date of surgery:________________

____

Social History

Marital Status: S M W D Ethnicity:__________Race:_________Preferred Language:____________

Tobacco User Any Kind? No ( ) Yes ( ) If no, when did you quit?:______________________________

Drink Alcohol? _______never _______occasional _______ moderate to heavy _______family history

Drug Overuse? _______never _______present _______past problem

Reviewed with patient: ______________________________MD

PRO SPORTS/ELITE REHAB

Review of Systems

Patient Name: ______________________________ D.O.B.: ____________________

Date: ____________________

Please Check Each Item "Yes" Or "No"

CONSTITUTIONAL/GENERAL

WEIGHT LOSS	No ( ) Yes ( )
FEVER	No ( ) Yes ( )
CHILLS	No ( ) Yes ( )
NIGHT SWEATS	No ( ) Yes ( )
LOSS OF APPETITE	No ( ) Yes ( )
SKIN RASH	No ( ) Yes ( )

EYES/VISION

VISUAL CHANGES	No ( ) Yes ( )
CATARACTS	No ( ) Yes ( )
GLAUCOMA	No ( ) Yes ( )

EARS

HEARING LOSS	No ( ) Yes ( )
PAIN	No ( ) Yes ( )
RINGING	No ( ) Yes ( )
DIZZINESS/VERTIGO	No ( ) Yes ( )

NOSE

NOSE BLEEDS	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )
RUNNY NOSE	No ( ) Yes ( )
INJURY	No ( ) Yes ( )

THROAT

FREQ. SORE THROATS	No ( ) Yes ( )
DIFFICULTY SWALLOWING	No ( ) Yes ( )
HOARSENESS	No ( ) Yes ( )
FOREIGN BODY	No ( ) Yes ( )

HEART

HIGH BLOOD PRESSURE	No ( ) Yes ( )
CHEST PAIN	No ( ) Yes ( )
IRREGULAR HEART BEAT	No ( ) Yes ( )
PREVIOUS HEART ATTACK	No ( ) Yes ( )

LUNGS

BRONCHITIS	No ( ) Yes ( )
ASTHMA/WHEEZING	No ( ) Yes ( )
CONGESTION	No ( ) Yes ( )

Other past medical history not mentioned

____

GASTROINTESTINAL

INDIGESTION/HEARTBURN	No ( ) Yes ( )
ULCERS	No ( ) Yes ( )
GALLBLADDER	No ( ) Yes ( )
DIARRHEA	No ( ) Yes ( )
DIVERTICULITIS	No ( ) Yes ( )
NAUSEA/VOMITING	No ( ) Yes ( )

URINARY TRACT

KIDNEY PROBLEMS	No ( ) Yes ( )
PAINFUL URINATION	No ( ) Yes ( )
BLOOD IN URINE	No ( ) Yes ( )
PROSTATE PROBLEMS	No ( ) Yes ( )

MUSCULOSKELETAL

BACK PAIN	No ( ) Yes ( )
WEAKNESS	No ( ) Yes ( )
ARTHRITIS	No ( ) Yes ( )
JOINT SWELLING	No ( ) Yes ( )
JOINT PAIN	No ( ) Yes ( )
LIMITATION of MOTION	No ( ) Yes ( )

NEURO/PSYCHOLOGICAL

NUMBNESS	No ( ) Yes ( )
MIGRAINES	No ( ) Yes ( )
SEIZURES	No ( ) Yes ( )
CONVULSIONS	No ( ) Yes ( )
STROKE	No ( ) Yes ( )
DEPRESSION	No ( ) Yes ( )

ENDOCRINE

THYROID DISORDERS	No ( ) Yes ( )
DIABETES	No ( ) Yes ( )
MENOPAUSE	No ( ) Yes ( )
HORMONE REPLACEMENT	No ( ) Yes ( )

BLOOD DISORDERS

LOW BLOOD COUNTS	No ( ) Yes ( )
BLOOD CLOTS	No ( ) Yes ( )
HEPATITIS	No ( ) Yes ( )
HIV/AIDS	No ( ) Yes ( )
OTHER	No ( ) Yes ( )

Patient Signature:

____

Physician Signature: ____________________

PATIENT NAME: ______________________________

Please list below the previous doctors that you have seen for your main problem / complaint (MD, DO, Chiropractor, Pain Management, etc.)

PHYSICIAN	SPECIALTY	DATES	TREATMENT

Please indicate which diagnostic tests you have had in evaluation for your main problem and/or complaint.

TEST	DATE	TEST	DATE
PLAIN X-RAY		MRI	
BONE SCAN		EMG/NCV	
MYELOGRAM		DEXA SCAN	
CT SCAN		ARTHROGRAM	
DISCOGRAM		OTHER	

Please mark which treatments you have had for your main problem / complaint and indicate whether they were helpful.

ELECTRICAL STIM	YES NO	INJECTIONS	YES NO
T.E.N.S	YES NO	HOME EXERCISES	YES NO
ULTRASOUND	YES NO	MANIPULATION	YES NO
HOT PACKS	YES NO	ACUPUNCTURE	YES NO
COLD PACKS	YES NO	WHIRLPOOL	YES NO
OTHER (Please list)			

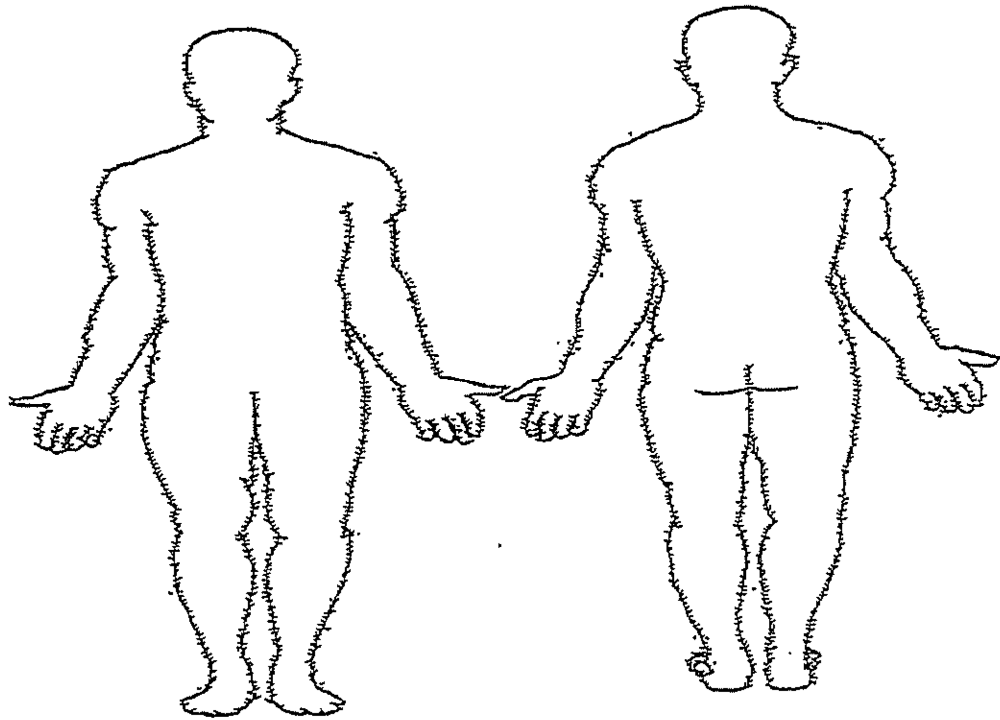
Mark ONLY the drugs that you have previously taken for your problem / complaint and if they helped.

ASPIRIN		MOTRIN		SKELAXIN	
CELEBREX		NAPROSYN		TYLENOL	
ELAVIL		NEURONTIN		ULTRAM	
FLEXERIL		PERCOCET		VICODIN	
IBUPROFEN		PREDNISONE		GABAPENTIN	
LORTAB		PROZAC		OTHER	
LYRICA		ROBAXIN			
MOBIC		SOMA			

PATIENT NAME: ____________________

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOU SYMPTOMS ON THE DIAGRAMS

XXXX = PAIN
OOOO = NUMBNESS
//// = ACHING
**** = PINS AND NEEDLES



IF YOU HAVE NECK PAIN, WHAT PERCENTAGE OF YOUR PAIN IN NECK_____%
WHAT PERCENTAGE IS THE PAIN IN YOUR ARM_____%

IF YOU HAVE BACK PAIN, WHAT PERCENTAGE OF YOUR PAIN IS IN YOUR BACK?_____%
WHAT PERCENTAGE IS LEG?_____%

TOTAL 100%

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MEDICATION LIST

PLEASE PRINT

Patient Name: ______________________________ D.O.B.: ____________________

Are You Allergic To Any Medications? :____

Please list below **all** medications that you are taking, include prescribed, supplements, herbals, dietary, nutritional and over the counter medications.

NAME OF MEDICATION	STRENGTH (MILLIGRAMS, GRAMS)	DOSAGE (HOW MANY TIMES A DAY?)	WHO PRESCRIBED?

If You Need More Space, Please Write "See List" And Attach A List.

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Demographics/New Problem

Patient Name: ______________________________ Social Security # _______________

Mailing Address: ________________________City_______________State______ Zip: __________

Seasonal Address: _______________________City_______________State______ Zip: __________

Home Telephone #: ______________________ Cellular #:___________________________

Email Address: ____

Employer: ____________________________ Employer Telephone #: ____________________

Emergency Contact: __________________________ Contact #:________________________

If Not Referred By a Physician, Who Referred You: _____________________________________

Issue being seen for today?:

_____Worker's Compensation _____Auto accident _____School athletic accident _____Other accident _____None

Date of Injury: _____/_____/______ Problem/injury: ___________________________

Attorney for injury? If yes name and phone number:_____________________________________

If no injury please describe your problem and date of onset:_____/_____/_____/ ________________

Any previous treatment for this problem? (X-Rays, MRI, etc.) _____ Yes _____No If yes, what facility? ____________

Insurance Information

We will need a copy of all insurance cards and a photo ID for our records.

Primary Insurance Carrier: ____

ID #: ___________________________ Group #: ____________________

Policy Holder's Name: ________________ S.S. #: ______________ DOB: __________

Secondary Insurance Carrier: ____

ID #: ___________________________ Group #: _________________________

Policy Holder's Name: ________________ S.S. #: _____________ DOB: _________________

Financially Responsible Person (If different from above)

Name: _____________________________ Social Security No: ________________________

Date of Birth: __________________Relationship to patient: ____________________________

Mailing address if different from above: ____

City: _______________________ State: ____________________ Zip code: ____________

Contact#: ____________________________Employer:______________________________

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INSURANCE AUTHORIZATION FORM

Patient Name: ______________________________ Date of Birth: ____________

Patient/Insurance Signature Authorization
Medicare and All Other Insurance

I consent to treatment necessary for the care of the above named patient.

I authorize Peter G. Wernicki, M.D, PA., Pro Sports, Ronald Robinson, M.D., Kent Smillie, M.D., Marcus J. Malone, M.D., Worthington Keville, PA-C and Elite Rehab to appeal any claims on my behalf to my insurance company.

I authorize the release of my medical records to the referring/family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records, if necessary.

All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as necessary function of their role.

I request that payment of authorized Medicare benefits and/or any other insurance carrier benefits be made on my behalf to Peter G. Wernicki, M.D., PA, Pro Sports, Ronald Robinson, M.D., Kent Smillie, M.D., Marcus J. Malone, M.D., and Elite Rehab. The Medicare provider agrees to accept the Medicare assignment and the patient is responsible for the deductible, co-insurance, and non-covered services. This authorization is to be a continued one, remaining in force until revoked in writing by the undersigned.

I acknowledge full financial responsibility for services rendered by ProSports & Elite Rehab and understand I am responsible to notify this office of any insurance changes and I have been advised that payment is due at the time of service. We do not accept any HMO plan. We are happy to submit claims for you, but ultimately the patient is responsible for payment for any charges incurred.

I understand that payment of the charges incurred, including copays, deductibles, or co-insurance is due at the time services are rendered unless prior financial arrangements have been made with our management. Any balances due beyond 30 days are subject to interest of 1.5%, which accumulates each month thereafter, in addition to the initial $15.00 administrative fee for balances not paid in full at the time services are rendered.

If I default on my account, I agree to pay all reasonable attorney fees, interest on account, and collections costs. The collection fees are 50% for current outstanding balances and 60% for balances greater than one year.

There will be a $25.00 fee for all returned checks. We can file your insurance as a courtesy.

I have read and fully understand the above and I consent to treatment, financial responsibility, release of medical information, and insurance authorization.

Patient Name:____DOB:______________

Patient Or Parent/Guardian Signature ______________________________ Date: __________

PRO SPORTS / ELITE REHAB

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ProSports & Elite Rehab are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. The terms of the privacy practices are to provide you with notice of its legal duties and privacy practices regarding your health information.
ProSports & Elite Rehab reserve the right to change our privacy practices (PHI) and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes.
ProSports & Elite Rehab may use or disclose as needed, your PHI to medical students that shadow the physicians for training. We may use a sign-in sheet at the registration desk for you to indicate your name and physician you are seeing. We may call you by name in the waiting room. We may leave a voicemail on your phone, unless otherwise notified by the patient, in case of any changes to your appointment.

I acknowledge receipt of the Pro Sports & Elite Rehab Notice of Privacy Practices. I understand that, by reading this consent form and signing, I am giving my consent to your use and disclosure of my Protected Health Information (PHI) to carry out treatments, payment activities and healthcare operations.

______________________________ ______________

Printed Name ID Number or SSN

______________________________ ______________

Signature Date of Notification

You may notify me of or my listed parties below of test results, appointment reminder, and other information regarding my health information to the phone numbers provided.

______ Message on answering machine

______ Message on voicemail/cell phone

Below please list the people that we are allowed to release/discuss your information to:

Name (please print) Relationship to patient

1.______________________________ ______________

2.______________________________ ______________

3.______________________________ ______________

PRO SPORTS / ELITE REHAB

Notice of Privacy Practices

ProSports & Elite Rehab are now required by Federal Law to provide you a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review this carefully.

ProSports & Elite Rehab are committed to protecting your medical information. These practices are required by law to maintain the privacy of your medical information. ProSports & Elite Rehab reserves the right to change the terms of this notice of privacy and to make any new notice by requesting that all patients read and sign a new and update notice of privacy practice (PHI).

For more information about our privacy practices, or for additional copies of this notice, please contact the office manager at 772-978-7808.

ProSports & Elite Rehab may access, use or share medical information about you for treatment, payment and healthcare operations;

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. You may revoke this in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Notification to Family and Friends: We may disclose your health information to notify or assist in notifying a family member, your emergency contact or any other person to the extent to help with your healthcare or with payment for your healthcare, but only if you agree that we do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personal under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of PHI of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages).

Your Rights: You have the right to look at or get copies of your health information, with limited exceptions. If copies are requested, there is a charge for copies. You must make a request in writing to obtain access to your health information. You may change or add information to your health record. The request must be in writing and it must explain why the information should be amended; HOWEVER, ProSports and ProSpine may not change the original documents.

Complaints: If you need more information, have complaints or feel that your privacy rights have been violated contact: Marcus Malone, M.D., 1355 37th Street, Suite 301, Vero Beach, FL 32960. If you are not satisfied with how ProSports & Elite Rehab handle your concern, you may submit a formal complaint to: DHHS Office of Civil Rights, 200 Independence Ave SW., HHH Building, Washington, DC 20201. If you file a complaint, we will not take any action against you or change our treatment of you in anyway.