Paul Meli Orthopedic Surgery

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Native American/Alaskan ☐ Pacific Islander ☐ Other _
☐ Unknown ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline to Answer

Preferred Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other _____

Preferred Pharmacy: _____

Date of your appt.: _____ Doctor your appt. is with: _____

Chief Complaint

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Annual Follow Up Other: _____

Shoulder	☐	Right ☐	Left	Pelvis	☐	Right ☐	Left	Neck	☐
Upper Arm	☐	Right ☐	Left	Hip	☐	Right ☐	Left	Upper Back	☐
Elbow	☐	Right ☐	Left	Thigh	☐	Right ☐	Left	Mid Back	☐
Forearm	☐	Right ☐	Left	Knee	☐	Right ☐	Left	Low Back	☐
Wrist	☐	Right ☐	Left	Lower Leg	☐	Right ☐	Left	Buttocks	☐
Hand	☐	Right ☐	eft	Ankle	☐	Right ☐	Left	Tail Bone	☐
Thumb	☐	Right ☐	Left	Foot	☐	Right ☐	Left		
Index	☐	Right ☐	Left	Great Toe	☐	Right ☐	Left		
Middle	☐	Right ☐	Left	2nd Digit	☐	Right ☐	Left		
Third	☐	Right ☐	Left	3rd Digit	☐	Right ☐	Left		
Little	☐	Right ☐	Left	4th Digit	☐	Right ☐	Left		
				5th Digit	☐	Right ☐	Left		

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident
☐ Sport Injury ☐ Prior Surgery ☐ Surgery Complication

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ☐ Acute (sudden) ☐ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ☐ Yes ☐ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ☐ Yes ☐ No

3. Have you had a problem like this before? ☐ Yes ☐ No

Describe: _____

_____

4. Have you been seen in an ER for this problem? ☐ Yes ☐ No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

☐ 0 ☐ 1 ☐ ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Do the symptoms wake you from sleep?

☐ Yes ☐ No

7. Please describe the symptoms:

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting

8. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes and goes)

9. Is the problem getting better or worse?

☐ Getting better ☐ Getting worse ☐ Unchanged

10. What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in bed
☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead

11. Are there any other symptoms associated with this problem?

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking
☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

☐ None ☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG/NCV) ☐ Bone Scan

Have you had any prior treatment for this problem? ☐ Yes ☐ No

Type of treatment	Status of symptoms after treatment (select only those that apply)						Date of treatment
Ice	☐	Improved	☐	Worsened	☐	Unchanged	
Heat	☐	Improved	☐	Worsened	☐	Unchanged	
Rest	☐	Improved	☐	Worsened	☐	Unchanged	
NSAIDs	☐	Improved	☐	Worsened	☐	Unchanged	_____
Muscle Relaxers	☐	Improved	☐	Worsened	☐	Unchanged	_____
Chiropractor	☐	Improved	☐	Worsened	☐	Unchanged	_____
Physical Therapy	☐	Improved	☐	Worsened	☐	Unchanged	_____
Home Exercise Program	☐	Improved	☐	Worsened	☐	Unchanged	_____
Surgery	☐	Improved	☐	Worsened	☐	Unchanged	_____
Injections	☐	Improved	☐	Worsened	☐	Unchanged	_____
Bracing	☐	Improved	☐	Worsened	☐	Unchanged	_____
TENS unit	☐	Improved	☐	Worsened	☐	Unchanged	_____

Other/Comments: _____

_____

_____

 Patient Name: _____

Select all previous hospitalizations/surgeries: ☐ None

☐ Aneurysm (Brain) Surgery	☐ Hysterectomy
☐ Aortic Bypass / Vascular Surgery	☐ LAP Band / Gastric Bypass Surgery
☐ Appendectomy	☐ Lumpectomy
☐ Cataract (Eye) Surgery	☐ Mastectomy
☐ Cholecystectomy (Gallbladder)	☐ Malignancy/Cancer
☐ Heart Surgery	☐ Stents
☐ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	☐	☐
Arthroscopy: Shoulder	☐	☐
Carpal Tunnel Release	☐	☐
Rotator Cuff Repair	☐	☐
Total Hip Replacement	☐	☐
Total Knee Replacement	☐	☐
Total Shoulder Replacement	☐	☐
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Uses a CPAP ☐ Snores

Are you taking blood thinners? ☐ Yes ☐ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

☐ None for all

				None	Comments
1) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐	_____
2) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐	_____
3) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐	_____
4) CV	☐ Chest Pain	☐ Palpitations		☐	_____
5) RS	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐	_____
6) GI	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐	_____
7) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐	_____
8) SK	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐	_____
9) NEU	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness		_____
	☐ Change in Bowel	☐ Change in Bladder	☐ Dizziness		
10) PSY	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐	_____
11) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats		
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐	_____

 Patient Name: _____

Family History

Have any direct relatives had any of the following disorders? ☐ **None for all**

Father	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments (ex. cancer type) _____			
Mother	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments (ex. cancer type) _____			
Sibling	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension
	☐ Bleeding Problems	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy
	☐ Stroke	☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? ☐ Current, every day smoker ☐ Current, some day smoker ☐ Former smoker ☐ Never
☐ Heavy tobacco smoker ☐ Light tobacco smoker

Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Are you currently working? ☐ Yes ☐ No ☐ Retired ☐ Disabled If no, what date did you last work? _____

Please list work restrictions, if any: _____

Occupation: _____ **Employer:** _____ ☐ **Student**

Do you have any allergies: ☐ Yes, if so list below ☐ No

Please list current Medications and strength below

_____
_____
_____
_____
_____

Do you have a history of:

☐ Aneurysm	☐ Emphysema	☐ Kidney Disease
☐ Angina	☐ Epilepsy	☐ Kidney Stones
☐ Arthritis	☐ Heart Attack	☐ MRSA
☐ Asthma	☐ Hepatitis	☐ Pacemaker
☐ Bone Infection	☐ HIV/AIDS	☐ Blood Clots
☐ Cancer	☐ High Cholesterol	☐ Embolism
☐ COPD	☐ Hypertension	☐ Seizures
☐ Diabetes	☐ Hyperthyroidism	☐ Stroke

PAUL MELI ORTHOPEDIC
2122 W. CYPRESS CREEK ROAD, SUITE 202, FORT LAUDERDALE, FL 33309

**** DEMOGRAPHICS ****

DATE: _____

PATIENT NAME (PRINT):_____DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED RACE/ETHNICITY: _____

LOCAL ADDRESS:_____ APT #: _____

CITY: _____ ST: _____ ZIP CODE: _____

MAILING ADDRESS:_____ APT #: _____

CITY: _____ ST: _____ ZIP CODE: _____

HOME #:_____ CELL #: _____

*** **PREFERRED PHONE #:** _____

EMAIL ADDRESS (FOR APPOINTMENT PURPOSES ONLY): _____

EMPLOYER'S NAME:_____ OCCUPATION: _____

IS THIS DUE TO AN ACCIDENT? ☐ NO ☐ YES IF YES, DATE OF ACCIDENT: _____

IS THIS A WORK OR AUTO ACCIDENT? ☐ WORK ☐ AUTO ☐ OTHER (PLEASE LIST): _____

*** EMERGENCY CONTACT: _____ PHONE #: _____ RELATIONSHIP: _____

PRIMARY MEDICAL INSURANCE:_____ID _____

SECONDARY MEDICAL INSURANCE:_____ID _____

SUBSCRIBER/POLICY HOLDER:_____SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER: _____

WHO WERE YOU REFERRED BY: _____

YOUR PRIMARY CARE PHYSICIAN:_____ PCP PHONE #:_____

PRIMARY PHARMACY/ADDRESS:

PHARMACY PHONE:

PAUL MELI ORTHOPEDIC
2122 W. CYPRESS CREEK ROAD, SUITE 202, FORT LAUDERDALE, FL 33309

CANCELLATION POLICY

Our cancellation policy states that any scheduled appointment (either an office visit or procedure) must be canceled with a 24 hour advanced notice during normal operating hours (Monday through Friday; 8:00 AM. – 4:00 PM.) An "untimely cancellation" is noted as a cancellation provided to our office with less than a 24 hour notice of the scheduled appointment. **These missed appointments are labeled as a "no show."**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work of family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Please be informed that it is the policy of **Paul Meli Orthopedic** monitor and manage appointment "no shows."

Patient's who fail to arrive for a scheduled appointment, without 24 hour advanced notice, will be considered a "no show."

Patient's who consistently fail to arrive for more than (1) scheduled appointment are considered a CHRONIC "no show."

"No show" appointments will incur the following fees

- **Follow up appointment: $30.00**
- **Procedure appointment: $150.00**

Please note: This fee will not be covered by your insurance company. You MUST pay this fee in full balance before a future appointment can be made. Chronic "no show" patients are subject to dismissal from the Practice.

By signing below, I have reviewed the above, fully understand and agree with the terms provided herein.

Patient Signature:_____ Date: _____

Printed name: _____

PAUL MELI ORTHOPEDIC SURGEON

PLEASE READ AND SIGN BELOW

In the event insurance is filed for surgery or other services rendered to me, I hereby authorize this office to request information to my insurance company and assign benefits directly to **PAUL MELI ORTHOPEDIC.**

1. MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process a claim or any related claims for my physician, or to my attorney. As well as releasing any medical records to Dr. Paul Meli regarding my care.

2. INSURED PATIENTS (*THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENT'S*)

I have been notified by my physician that my insurance is likely to deny payment for certain items (i.e., injections, x-rays, office visit durable medical equipment, etc.) If my insurance denies payment, I agree to be personally and fully responsible for payment.

3. SIGNATURE ON FILE/LIFETIME AUTHORIZATION

I request that payment of authorized medical benefits be made to my physician for services rendered and any information needed to determine these benefits for any related services.

4. By appointing **Paul Meli, MD.** to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize **Paul Meli, MD.** to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance, or request.

5. By signing below, I acknowledge that I have received/or viewed a copy of the **Paul Meli Orthopedic** notice of privacy practices.

6. PAYMENT POLICY: Payment is due at the time services are rendered. *PLEASE NO EXCEPTIONS*

7. With my signature I agree that Paul Meli Orthopedic and its collections department/agency may contact me at any of the phone numbers I have provided to discuss all balances to my account. Paul Meli Orthopedic also has permission to contact me via email if any of my phone numbers have been changed or disconnected.

8. Any unpaid balances after 90 days will be forwarded to collections.

PRINT NAME (PLEASE PRINT): _____

SIGNATURE: _____ **DATE:**_____

Please save to your computer and email to jrojas@paulmeli.com