MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.
DEMOGRAPHICS/INSURANCE INFORMATION

Date:_____

Patient name:_____Date of Birth:___/___/_____

SS#:_____Race:_____

Ethnicity:_____Language:_____

Home address:_____

City:_____State:_____Zip code:_____Email:_____

Home phone#_____Cell#:_____Work#:_____

Family/Primary Care Doctor:_____Phone#:_____

Who/How were you REFERRED to our office? Physician or Person's Name:_____

PRIMARY INSURANCE INFORMATION

Primary Insurance Carrier Name:_____
Are you covered by additional Insurance?_____Yes _____No

Additional Insurance Carrier Name:_____
PLEASE PROVIDE THE OFFICE STAFF WITH YOUR INSURANCE CARDS AND PHOTO ID SO THAT WE ARE ABLE TO COPY, SCAN AND PLACE IN YOUR MEDICAL RECORD

EMERGENCY CONTACT INFORMATION

In case of an emergency who should be notified? Please list up to 4 names, phone numbers & relationship

Name of Emergency Contact	Telephone Number	Relationship to Patient

May we release your medical information to the above names? _____Yes _____No

ADDITIONAL INFORMATION

In the event that Messieh Orthopedics may need to contact me at my home or on any of the numbers I have provided above, I authorize the office to leave a message on my machine, voicemail or with anyone who answers: _____Yes _____No

The office staff may only leave a message and/or speak with anyone listed under my emergency contacts: _____Yes _____No

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____
Please print name of Patient, Guardian or Personal Representative **Relationship to Patient**

Patient Name:_____DOB:___/___/_____Age:_____Height:_____Weight:_____
Sex: ( )F ( )M

What are you seeing the doctor for? Please explain your reason for this visit. (Up to 2 body parts per visit) Circle your answer.

Neck	**Low Back**	**If more than one body part, list most painful below**
Right Shoulder	**Left Shoulder**	
Right Knee	**Left Knee**	
Right Hip	**Left Hip**	
Right Elbow	**Left Elbow**	
Right Wrist/Hand	**Left Wrist/Hand**	
Right Foot/ankle	**Left Foot/ankle**	**Date Problem began:_____**

Describe your current problem below:
_____new injury or problem (less than 6 weeks duration)
_____sub- acute problem (6 weeks to 3 months duration)
_____chronic problem (problem has been treated over time period of more than 3 months)
_____re-injury (you injured this same area before, received treatment, had no problems until new injury occurred)

Is your problem a result of an injury? _____Yes, Date:_____ _____No

****If your problem is a result of an injury, where did it occur? Please circle below****

HOME WORK MOTOR VEHICLE EXERCISE OTHER:_____

What caused your injury/problem?
___fall ___fighting
___lifting ___twisting
___throwing ___collision/contact
___pulling ___other/specify_____
Explain in your own words how this injury or problem occurred:

****Have you talked to a lawyer concerning you injury: _____Yes _____No**

****Are you receiving or have you applied for Worker's Compensation concerning your injury? _____Yes _____No**

****Have you received previous treatment for your current problem? _____Yes, specify below _____No**
Circle if applies below:
Medicine Physical Therapy Surgery Injections Other_____

Did you go to the Emergency Room? _____Yes, date of ER visit:_____ _____No
ON A SCALE OF 0-10 (WITH 10 BEING THE WORST PAIN IMAGINABLE), HOW WOULD YOU SCORE YOUR PAIN TODAY?
___0 ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10

MEDICAL HISTORY INFORMATION

Patient:_____ **DOB:**_____/_____/_____

MEDICAL HISTORY: Do you have or have you ever had any of the following? (Check all that apply)

___Stroke
___Heart trouble
___Hypertension
___Diabetes
___Arthritis
___Gout
___Seizures
___Mental Illness
___Cancer
___Bleeding disorder
___Alcoholism
___Lung Disease
___TB
___Phlebitis
___Anemia
___Stomach Ulcer
___Liver Disease
___Thyroid Disease
___Other/Specify _____
_____if none apply please initial

PAST SURGICAL HISTORY:

_____ _____ _____

_____ _____ _____

MEDICATIONS: Please list below your current medications, both prescription and over the counter; or please supply a list.

**Pharmacy Name:_____Location:_____Phone#:_____

**Name:_____Dosage:_____Name:_____Dosage:_____

**Name:_____Dosage:_____Name:_____Dosage:_____

**Name:_____Dosage:_____Name:_____Dosage:_____

**Name:_____Dosage:_____Name:_____Dosage:_____

******ALLERGIC TO ANY MEDICATIONS? _____ YES, LIST ALLERGIES:_____. _____ NO ALLERGIES***

FAMILY HISTORY:

	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Unknown
Father	( )	( )	( )	( )	( )	( )
Mother	( )	( )	( )	( )	( )	( )
Paternal Grandfather	( )	( )	( )	( )	( )	( )
Paternal Grandmother	( )	( )	( )	( )	( )	( )
Maternal Grandfather	( )	( )	( )	( )	( )	( )
Maternal Grandmother	( )	( )	( )	( )	( )	( )
Siblings	( )	( )	( )	( )	( )	( )

Employer: _____Job title:_____

Current Work Status: ( ) Regular ( ) Light Duty ( ) Not working now ( ) Disabled ( ) Retired

SOCIAL HISTORY:

Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widow/Widower Are you currently living alone? ( ) Yes ( ) No

Do you use tobacco? ( ) Yes ( ) No If yes, # of packs per day: _____ ( ) past history of smoking, how long ago?_____

Do you have children? ( ) Yes ( ) No if yes, # of children: _____, # of pregnancies_____

Alcohol use? ( ) Yes ( ) No if yes, how often: #_____drinks per year, #_____per day

Alcohol misuse? If more than 6 how often on one occasion? _____never, _____less than monthly,____monthly,____weekly,_____daily

Drug overuse? ( ) Yes, current ( ) past problem ( ) Never used

REVIEW OF SYSTEMS (do you have or have you ever had) please check ALL that APPLY:

____Chills ____Fever ____Headache ____Cough ____Reading glasses _____Difficulty swallowing ____Breathing problems

____Wheezing ____Chest pain ____Change in bowel habits ____Stomach problems ____Anemia ____Arthritis ____Swollen joints

____ Weakness ____Cold extremities ____Rash ____Dizziness

OUR OFFICE POLICY

Patient Name:_____Date of Birth:_____/_____/_____

BASIC POLICY: Payment is due in full at the time of service.

PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also file to most secondary insurance carriers for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, occasional fees may be due and payable in full from you. HMO patients, it is your responsibility to obtain authorization from your Primary Care Physician (PCP) prior to being seen and to provide our office with the name and address of your PCP.

MEDICARE PATIENTS: We bill Medicare for you. All Co-payments and/or deductibles are due at the time of service. We will also file to your secondary insurance carrier for you.

SURGERY FEES: All co-pays, deductibles and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required from your carrier. Self- pay surgeries require 50% deposit prior to scheduling surgery.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

AUTO ACCIDENT CASES: WE DO NOT ACCEPT ANY AUTO ACCIDENT CASES.

WORKER'S COMPENSTATION CASES: WE DO NOT ACCEPT ANY WORKER'S COMPENSATION CASES.

MEDICAL RECORDS FAX: I authorize Messieh Orthopedics, Inc./Dr. Michael S. Messieh, to transmit my medical records electronically. If they are received by another party in error, I absolve Messieh Orthopedics, Inc of any and all liability relating to such submission of said records. I give permission for Messieh Orthopedics, Inc to send my records to my primary care physician.

APPOINTMENT FORMS: 24 hour notice is required for all appointment cancellations. Multiple failures to notify the office of cancellation and/or no show of appointments may result in a cancellation fee and/or your termination of care.

CONSENT FOR TREATMENT AND LIFETIME AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I hereby give consent to Messieh Orthopedics, Inc., Dr. Michael S. Messieh, to provide whatever treatment he/they deem necessary to the patient. I certify that the information I furnish is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

I hereby authorize Messieh Orthopedics, Inc., Dr. Michael S. Messieh to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician. I also authorize my insurance carrier, or it's intermediaries to issue payment directly to the physician. A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize Messieh Orthopedics, Inc., Dr. Michael S. Messieh to release any medical information in connection with these services to any person or corporation which is or may be liable for any or any portion of the charges, including insurance companies, health care plans, worker's compensation carriers, adjusters or attorneys to the extent necessary to obtain. Also, to the patient's personal physician, referring physicians or primary care physician. I am aware that any/all information contained within my medical records/chart is property of Messieh Orthopedics, Inc., Dr. Michael S. Messieh. I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs or legal fees occurred to collect these balances.

BINDING ARBITRATION

I AGREE THAT any dispute will be resolved by binding arbitration. When the patient and the physician agrees to arbitration, they agree to give up their constitutional rights to have a potential medical malpractice claim resolved in court. Binding arbitration means that the physician and the patient agree to litigate outside the court system any claims that may arise from rendering or failing to render medical care and treatment before an arbitration panel. The arbitration panel is required to follow the state law and their decision is binding upon the parties. The patient has had an opportunity and ability to know and understand the terms of the agreement before signing and agree that the terms are reasonable and fair. I understand that a video from FPIC explain the purpose and fundamentals of the arbitration agreement is available for viewing.

Signature of Patient:_____Date:_____

Signature of Responsible Person (if other than patient):_____Date:_____

Michael S. Messieh, M.D.

Acknowledgement of Receipt of Notice of Privacy

Notice

Messieh Orthopedics, Inc reserves the right to modify the privacy practices outlined in the notice.

Signature

I have read and understand the Notice of Privacy Practices for (Messieh Orthopedics, Inc)

_____

Name of Patient (print)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative

I have chosen to receive a copy of the Privacy Act: _____ Yes _____No

MESSIEH ORTHOPEDICS
MICHAEL S. MESSIEH, M.D.
841 Oakley Seaver Dr. Ste 1B
Clermont, FL 34711
Fax# 352-243-6855

PATIENT AUTHORIZATION TO DISCLOSE AND RELEASE HEALTH INFORMATION

Name:_____DOB:____/____/_____SS#_____

Address:_____

City:_____State:_____Zip:_____

I hereby consent to the release and disclosure of my personal health information from:

(Individual or Organizaiton):_____

Address:_____

City:_____State:_____Zip:_____

For the following purpose (s):
____Continuing Medical Care ____Personal Use
____Information for insurance carrier ____Information for Attorney
____Other (please specify)_____

My authorization for release includes my personal health information consisting of:
____Initial Evaluation ____Operative Reports ____Medical Status
____Progress/Office Notes ____Discharge Summary ____Work Status
____Xray Only ____Xray report only ____Both Xray films/disc and Report
____Non-Messieh Orthopedics Inc films _____Other (please specify)_____
____All of the Above

____Mail to above address _____Fax to above fax# _____Call when records are ready

I understand that the information outlined in this release will be disclosed according to the instructions of this release within five (5) business days of Messieh Orthopedics having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and is no longer protected by the Privacy Regulations (45 C.F.R. 164). This authorization will expire one year from the date of this request. This authorization is not valid if not filled out completely.

Patient Signature:_____Date:_____

For Office use only:
Document flow: _____patient's medical record scanned This authorization was revoked on_____(date).