

Date: _____

Patient Name: _____ Date of Birth: ___ / ___ / ___

SS#: _____ Race: _____

Ethnicity: _____ Language: _____

Home Address: _____

City: _____ State: _____ Zip: _____ 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: _____ Relationship to Patient: _____

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

PATIENT QUESTIONNAIRE — ORTHOPEDIC VISIT INTAKE Page 2

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

1. CHIEF COMPLAINT & BODY PART

Body part (check up to 2):

- Neck
- Elbow
- Knee
- Low Back
- Wrist / Hand
- Foot / Ankle
- Shoulder
- Hip
- Other: _____

Side: Right Left Bilateral **Most painful area today:** _____

2. ONSET & DURATION

Date problem began: _____

Problem type:

- New problem (less than 6 weeks)
- Chronic (more than 3 months)
- Subacute (6 weeks – 3 months)
- Re-injury / flare-up

Caused by an injury? No Yes

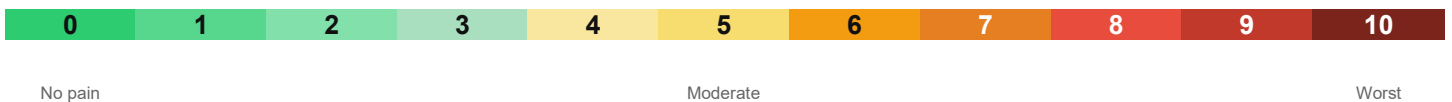
Date of injury: _____ Location where injury occurred: _____

Mechanism of injury:

- Fall
- Throw
- Motor vehicle accident
- Lift
- Pull
- Exercise / sports
- Twist
- Collision / contact
- Other: _____

3. PAIN LEVEL TODAY

Circle the number that best describes your pain today: 0 = No pain at all → 10 = Worst pain imaginable



4. BRIEF DESCRIPTION OF THE PROBLEM

What is bothering you most today?

5. PRIOR EVALUATION & TREATMENT HISTORY — CHECK ALL THAT APPLY

Anti-inflammatory / Pain Medications:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen (Advil / Motrin) | <input type="checkbox"/> Naproxen (Aleve) |
| <input type="checkbox"/> Indomethacin | <input type="checkbox"/> Meloxicam | <input type="checkbox"/> Celecoxib (Celebrex) |
| <input type="checkbox"/> Diclofenac | <input type="checkbox"/> Tylenol / Acetaminophen | <input type="checkbox"/> Opioid / Narcotic pain medication |

Other medication(s): _____ Duration of use: _____

Physical Therapy:

Yes No **Duration:** _____ **Where / Provider:** _____

Activity Modification:

Yes — reduced physical activities (sports, exercise, stairs, walking) No

Assistive Devices:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Bracing / Brace | <input type="checkbox"/> Cane | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Weight loss program |
| <input type="checkbox"/> Other: _____ | | |

Injections:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Cortisone / Corticosteroid | <input type="checkbox"/> Hyalgan | <input type="checkbox"/> Synvisc / Euflexxa |
| <input type="checkbox"/> PRP (platelet-rich plasma) | <input type="checkbox"/> Other: _____ | |

Number of injections: _____ Most recent date: _____ Provided by (doctor / office): _____

Prior Surgery:

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthroscopic (scope) surgery | <input type="checkbox"/> Open surgery | <input type="checkbox"/> Joint replacement |
| <input type="checkbox"/> Spinal surgery | <input type="checkbox"/> Fracture surgery | <input type="checkbox"/> Other: _____ |

Surgeon name: _____ Date(s): _____ Hospital / Facility: _____

Prior Consultation with Another Physician for This Problem:

No Yes

Physician name: _____ Phone: _____

Recommended treatment / determination given by that physician:

Have you ever undergone joint replacement?

No Yes

If yes — which joint: _____ Date: _____

6. EMERGENCY ROOM VISIT FOR THIS PROBLEM

No Yes

Date: _____ Hospital: _____

7. ADMINISTRATIVE QUESTIONS

Attorney involved? No Yes **Workers' compensation claim related to this problem?** No Yes

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

1. CURRENT MEDICATIONS

No current medications

List all current medications below (bring a list if needed):

Medication Name	Dose	How Often

2. PAST MEDICAL HISTORY — CHECK ALL THAT APPLY

No medical history to report

- | | |
|---|---|
| <input type="checkbox"/> Hypertension / High blood pressure | <input type="checkbox"/> Heart disease / Heart attack |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Lung disease / COPD | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Arthritis (osteoarthritis) |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Blood clots (DVT / PE) | <input type="checkbox"/> Blood thinners (Coumadin / Plavix / aspirin) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver disease / Hepatitis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stomach ulcer / GI bleeding |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mental health condition | <input type="checkbox"/> Alcohol use disorder |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Other: _____ | |

3. PAST SURGICAL HISTORY — CHECK ALL THAT APPLY

No surgical history to report

- | | |
|---|--|
| <input type="checkbox"/> Cardiac / Heart surgery | <input type="checkbox"/> Carpal tunnel — Left wrist |
| <input type="checkbox"/> Carpal tunnel — Right wrist | <input type="checkbox"/> Arthroscopy — Left shoulder |
| <input type="checkbox"/> Arthroscopy — Right shoulder | <input type="checkbox"/> Arthroscopy — Left elbow |
| <input type="checkbox"/> Arthroscopy — Right elbow | <input type="checkbox"/> Arthroscopy — Left hip |
| <input type="checkbox"/> Arthroscopy — Right hip | <input type="checkbox"/> Arthroscopy — Left knee |
| <input type="checkbox"/> Arthroscopy — Right knee | <input type="checkbox"/> Arthroscopy — Left ankle |
| <input type="checkbox"/> Arthroscopy — Right ankle | <input type="checkbox"/> Left knee replacement |
| <input type="checkbox"/> Right knee replacement | <input type="checkbox"/> Left hip replacement |
| <input type="checkbox"/> Right hip replacement | <input type="checkbox"/> Spinal fusion |
| <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Fracture surgery |
| <input type="checkbox"/> Other surgery: _____ | |

4. FAMILY HISTORY — PLACE MARK IN APPLICABLE BOXES

Unknown family history

Condition	Father	Mother	Sibling
Heart attack / Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension / High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder / Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's / Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. SOCIAL HISTORY

Employer: _____ Job title: _____

Work status:

Regular duty Light duty Not working Disabled Retired

Tobacco use:

Never Current — packs per day: _____ Former — quit year: _____

Alcohol use:

Never Occasional Daily

Drug use:

Never Past Current

Hand dominance:

Right-handed Left-handed

Marital status:

Married Single Divorced Widowed **Living alone?** Yes No

Females only:

Could you be pregnant? Yes No Currently menstruating? Yes No

6. ALLERGIES — MEDICATIONS AND SUBSTANCES

No known drug allergies

Check all allergies:

<input type="checkbox"/> Codeine	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulpha drugs	<input type="checkbox"/> Iodine / Shellfish
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Keflex / Cephalosporins
<input type="checkbox"/> Novocaine / Lidocaine	<input type="checkbox"/> Latex	<input type="checkbox"/> IVP / X-ray dye	<input type="checkbox"/> Metal / Nickel
<input type="checkbox"/> Egg / Avian (bird)	<input type="checkbox"/> NSAIDs (Advil / Naproxen)	<input type="checkbox"/> Vantin / Septra	<input type="checkbox"/> Depakene / Dilantin

Other allergies: _____

7. REVIEW OF SYSTEMS — CHECK CURRENT ISSUES ONLY

None of the following

Constitutional:

- Fever / chills
- Weakness
- Weight loss / gain
- Fatigue

Cardiovascular:

- Chest pain
- Calf cramps / leg swelling
- Palpitations / irregular heartbeat
- Has pacemaker
- Shortness of breath

Musculoskeletal:

- Joint pain
- Muscle pain
- Stiffness
- Muscle weakness

Neurological:

- Numbness
- Dizziness
- Tingling
- Seizures
- Headache
- Loss of sensation

Gastrointestinal:

- Nausea / vomiting
- Heartburn
- Abdominal pain
- GI bleeding

Respiratory:

- Cough
- Wheezing
- Difficulty breathing

Genitourinary:

- Urinary frequency
- Burning urination
- Blood in urine

Skin:

- Rash
- Bruising
- Swelling of extremities

Psychological:

- Anxiety
- Depression
- Mood changes

Ear / Nose / Throat:

- Hearing loss
- Frequent sore throats
- Nosebleeds

Pharmacy name: _____ Pharmacy phone: _____

I certify that the above information is correct to the best of my knowledge. Signature: _____ Date: _____

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

OFFICE POLICY INFORMATION Page 4

Patient Name:

Patient Name: _____ Date of Birth: _____

OUR OFFICE POLICY

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 Compensation 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.
Communication	I give permission to Dr. Michael Messieh, MD to receive and make any unauthorized calls and/or text messaging through his cell phone to discuss any and all medical care directly with the patient and any other medical doctor regarding the treatment and 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.

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. 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: _____

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY Page 5

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 minor or unable to sign): _____

Relationship of Patient Representative: _____

I have chosen to receive a copy of the Privacy Act: Yes No

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

PATIENT AUTHORIZATION TO DISCLOSE AND RELEASE HEALTH INFORMATION Page 6

841 Oakley Seaver Dr. Ste 1B | Clermont, FL 34711 | Fax# 352-243-6855

Name: _____ DOB: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Individual or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

For the following purpose(s):

- Continuing Medical Care
- Information for insurance carrier
- Other (please specify): _____
- Personal Use
- Information for Attorney

My authorization for release includes my personal health information consisting of:

- Initial Evaluation
- Progress / Office Notes
- X-ray Only
- Non-Messieh Orthopedics films
- Operative Reports
- Discharge Summary
- X-ray report only
- All of the Above
- Medical Status
- Work Status
- Both X-ray films/disc and Report
- Other (specify): _____

Delivery method:

- 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 _____ Authorization revoked on (date): _____

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

VIDEO / PHOTO RELEASE FORM Page 7 — Messieh Orthopedics

I, _____, hereby grant permission to Messieh Orthopedics / Michael Messieh, MD, the rights of my image, in video or still, and of the likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration.

I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears.

Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations Courses Online / Internet Videos Media News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the session listed on this document only.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name: _____

Phone #: _____

Signature: _____

Date: _____ DECLINED RELEASE: _____

MESSIEH ORTHOPEDICS | Michael S. Messieh, M.D.

PRISMA DATA EXCHANGE CONSENT FORM Page 8

Practice Name: Focus Orthopedics, Michael Messieh MD

EMR System: eClinicalWorks with PRISMA Health Information Exchange

PURPOSE OF CONSENT

Focus Orthopedics participates in the PRISMA Data Exchange Network, a secure, HIPAA-compliant system that allows healthcare providers to access and share your medical information electronically with other participating organizations. This helps improve coordination of your care by allowing your treating providers to view relevant medical records such as test results, imaging, medications, allergies, and prior visit summaries.

HOW YOUR INFORMATION IS PROTECTED

All data exchanged through PRISMA is encrypted and transmitted securely. Access is restricted to authorized healthcare professionals involved in your care, in accordance with federal and state privacy laws including the Health Insurance Portability and Accountability Act (HIPAA).

INFORMATION THAT MAY BE SHARED

- | | |
|--|--|
| <input type="checkbox"/> Medical history, diagnoses, and treatment summaries | <input type="checkbox"/> Laboratory and imaging results |
| <input type="checkbox"/> Medications and allergies | <input type="checkbox"/> Surgical and procedural history |
| <input type="checkbox"/> Vital signs, progress notes, and care plans | <input type="checkbox"/> Immunizations and problem lists |

This exchange may include information obtained from hospitals, specialists, primary care providers, pharmacies, laboratories, and other healthcare facilities that also participate in PRISMA.

YOUR RIGHTS

- You have the right to opt out of PRISMA data sharing at any time by notifying our office in writing.
- Choosing to opt out will not affect your ability to receive care at Focus Orthopedics.
- If you choose to participate, your information may be viewed by authorized providers for treatment, payment, and healthcare operations purposes.

CONSENT STATEMENT

I understand and consent to allow Focus Orthopedics to electronically access and share my medical information through the PRISMA Data Exchange Network to support coordination of care among my healthcare providers. I have had an opportunity to ask questions and understand that I may withdraw this consent at any time.

Patient Name: _____ Date of Birth: _____

Signature:

Date: _____