PAUL A. DOWDY, M.D.
Orthopedic Center for Sports Medicine

Paul A. Dowdy, M.D.
Board Certified in Orthopedic Surgery
Specializing In Sports Medicine, Arthroscopic Surgery, Reconstruction of the Shoulder & Knee and Regenerative Medicine

105 Park Place Blvd • Suite A • Davenport, FL 33837
Phone (863) 421-7411 • Fax (863) 547-9514

Todays Date _____

PATIENT INFORMATION

PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____
Apellido *Nombre* *Inicial del segundo nombre*

Date of Birth _____ Age _____ Phone (_____) _____ Social Security # _____-_____-_____
Fecha de cumpleaños *Años* *Teléfono* *Seguro social*

Local Mailing Address _____ City _____ State _____ Zip _____
Local Dirección postal *Ciudad* *Estado* *Código postal*

Permanent Mailing Address _____ City _____ State _____ Zip _____
Permanente Dirección postal *Ciudad* *Estado* *Código postal*

Messages regarding my appointment or medical condition may be left at the numbers listed below:
Mensajes con respecto a mi cita o condición médica pueden dejarse en los números que se indican a continuación

Phone (_____) _____ Phone (_____) _____
Teléfono *Teléfono*

In case of an emergency you may contact the listed person(s) below:
En caso de una emergencia puede comunicarse con la persona(s) se enumeran a continuación

Name _____ Name _____
Nombre *Nombre*

Address _____ Address _____
Dirección *Dirección*

Phone (_____) _____ Relationship _____ Phone (_____) _____ Relationship _____
Teléfono *Relación* *Teléfono* *Relación*

Race (select one or more)
Raza (seleccione uno o más)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian/White
- ☐ Filipino
- ☐ Hispanic or Latino
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other
- ☐ Multi-racial
- ☐ Undetermined
- ☐ Do not wish to respond

Ethnicity
Etnia

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Do not wish to respond

Preferred Language
Idioma preferido

- ☐ English
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Spanish
- ☐ Creole
- ☐ Mandarin
- ☐ Vietnamese
- ☐ Other
- ☐ Do not wish to respond

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Todays Date _____

PATIENT PROBLEM QUESTIONNAIRE

PLEASE PRINT

Name _____ Age _____ Date of Birth _____

E-mail Address _____ Sex ☐ M ☐ F

1. What part of the body are you being seen for today? _____ Shoulder _____ Elbow _____ Wrist _____ Hand
Please specify - R for Right L for Left B for Both _____ Hip _____ Knee _____ Ankle _____ Foot
_____ Other: _____

2. Is your problem the result of an injury? ☐ Yes ☐ No *(If "No", then proceed to question #7)*

3. What was the date of your injury? _____ Time of injury: _____ AM / _____ PM

4. How were you injured? ☐ Sports - please specify the sport_____
☐ Car accident ☐ Motorcycle accident ☐ A fall
☐ Other: _____

5. Where were you injured? ☐ Work ☐ School ☐ Home ☐ Other: _____

6. How did the injury occur? _____

7. How long have you had this problem? *(Please specify a number)* _____ Days _____ Weeks _____ Months _____ Years

8. How would you describe the pain that you are experiencing? *(Please check all which apply)*

Duration:	☐ Lasts for minutes	☐ Lasts for hours	☐ Constant
Timing:	☐ Pain with exercise or activity	☐ Pain at rest	☐ Pain at nighttime
Context:	☐ Pain is getting worse	☐ Pain is staying the same	☐ Pain keeps recurring
Quality:	☐ Sharp	☐ Dull	☐ Throbbing
Severity:	☐ Mild	☐ Moderate	☐ Severe
Modifying factors:	☐ Better with rest	☐ Better with ice	☐ Better with limb elevation
Associated symptoms:	☐ Numbness	☐ Tingling	☐ Limb feels cold

9. What types of treatment have you had for this problem?

☐ Anti-inflammatory medications ☐ Surgery ☐ Cortisone injections
☐ Physical therapy ☐ No treatment ☐ Other: _____

10. How were you referred to us?

☐ Advertisement ☐ Health Fair ☐ Primary Care Physician ☐ Website
☐ Emergency Room ☐ High School ☐ Other: _____

11. Who is your Primary Care Physician? _____

12. Are you right or left handed? _____

13. DO YOU HAVE A PACEMAKER? ☐ Yes ☐ No

MEDICAL HISTORY

Patient Name _____ Date of Birth: _____

What pharmacy do you use? _____

HEALTH HISTORY OF THE PATIENT

	Yes	No
Stroke	☐	☐
Diabetes	☐	☐
Kidney Trouble or Stones	☐	☐
Alcoholism	☐	☐
Phlebitis	☐	☐
Liver Trouble	☐	☐
Cancer	☐	☐

type: _____

	Yes	No
Seizures	☐	☐
Arthritis	☐	☐
Bleeding Disorders	☐	☐
Lung Disease	☐	☐
Anemia	☐	☐
Thyroid Trouble	☐	☐
Mental Illness	☐	☐

explain: _____
(i.e. anxiety, depression, Alzheimer's, bipolar)

	Yes	No
High Blood Pressure	☐	☐
Gout	☐	☐
Stomach Ulcers	☐	☐
Tuberculosis	☐	☐
Heart Trouble	☐	☐
Serious Injuries	☐	☐
Other Illnesses	☐	☐

explain: _____

explain: _____

explain: _____

Surgical Procedures *(include aprox. dates)*

_____

_____

MEDICATIONS

List **all prescription** and **non-prescription** medications and supplements. **NONE** ☐

Name of Medication	Strength/Dose	Frequency

ALLERGIES

Indicate **all** allergies you have to **medications or metals**. **NONE** ☐

Allergy	Reaction to Allergy	Allergy	Reaction to Allergy

SOCIAL HISTORY

Do you work? Yes ☐ No ☐

Occupation: _____

Presently Living Alone? Yes ☐ No ☐

Married ☐ Single ☐ Divorced ☐

Number of Children Living: _____

Number of Pregnancies: _____

Are you currently pregnant or breastfeeding? Yes ☐ No ☐

Smoke? No ☐ Yes ☐ _____ packs/day

Alcohol? Never ☐ Socially ☐ Daily ☐

Illicit Drug Use? None ☐ Presently ☐ Past Problem ☐

FAMILY HISTORY

	Yes	No
Stroke	☐	☐
Diabetes	☐	☐

	Yes	No
Heart Trouble	☐	☐
High Blood Pressure	☐	☐

	Yes	No
Cancer	☐	☐
Mental Illness	☐	☐

	Living	Deceased
Mother	☐	☐
Father	☐	☐

REVIEW OF SYSTEMS

Have you recently had or do you now have:

	Yes	No
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Chills or Fever	☐	☐
Alcoholism	☐	☐
Chest Pain	☐	☐

	Yes	No
Abnormal Heartbeat	☐	☐
Decreased Appetite	☐	☐
Nausea or Vomiting	☐	☐
Weight Loss	☐	☐
Frequent Headaches	☐	☐

	Yes	No
Blood in Bowel Movements	☐	☐
Frequent Loose Bowel Movements	☐	☐
Frequent Constipation	☐	☐
Rectal Bleeding	☐	☐
Lightheadedness	☐	☐

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OUR OFFICE POLICY

Patient Name _____ Date of Birth: _____

BASIC POLICY **Pay for service is due in full at the time service is provided in our office.**

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also file most secondary insurance companies for you. **Copayments and deductibles are due at the time of service.** Since your agreement with your insurance carrier is a private one, we do not 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, professional fees are due and payable in full from you. HMO patients, it is your responsibility to obtain authorization from your PCP prior to being seen and to provide our office with the name and address of your PCP.

MEDICARE PATIENTS We will bill Medicare for you. **All copayments or deductibles are due and payable at the time service is provided.** We will file secondary insurances, for your reimbursement, as a courtesy.

SURGERY FEES **All copays, deductibles, and payments for noncovered surgical procedures are due prior to your surgery.** Prior authorization may be required by your carrier. Self pay surgeries require 50% deposit prior to scheduling surgery.

NONCOVERED SERVICES **Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided.**

AUTO ACCIDENT CASES If you are injured in an auto accident, we will need the claim number and insurance carrier. **Deductible and copay are due and payable at the time services are rendered.**

WORKER'S COMPENSATION If your injury is work-related, we will need a copy of notice of injury, the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

MEDICAL RECORDS FAX I authorize Orthopedic Center for Sports Medicine to transmit my medical records electronically. If they are received by another party in error, I absolve Orthopedic Center for Sports Medicine of any and all liability relating to such submission of said records.

PATIENT PRIVACY In order to protect the privacy of our patients and the confidentiality of medical information, we are implementing procedures to restrict access to patient information. Any request for copies of a patient's chart will need a written request from the patient and an address of where the copy of this patient's record is going. Anyone calling for information from a patient's appointment record, work status, or any information pertaining to a patient must first identify the patient with the date of birth and social security number of the patient. Patients needing x-rays taken in this office will be charged a minimal fee for copies of the x-rays, therefore the original x-ray will remain a permanent record in this office. These procedures are keeping with standards set by the HIPAA guidelines.

Signature: _____ Date:_____

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

I hereby give consent to Orthopedic Center for Sports Medicine to provide whatever treatment 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 Orthopedic Center for Sports Medicine to submit a claim to my insurance carrier, or its intermediaries for all covered services rendered by the physician(s). I also authorize my insurance carrier, or its intermediaries to issue payment directly to the physician(s). A photocopy of this assignment is considered to be as valid as an original.

I hereby authorize Orthopedic Center for Sports Medicine to furnish complete information requested by my insurance carrier, or its intermediaries regarding services rendered.

I further agree that I am responsible for payment of any remaining balance after insurance payments have been made, including any collection costs (Collection Agency fee is 30%) or legal fees incurred to collect these balances.

Signature of Patient: _____ Date:_____

Signature of Responsible Person: _____ Date:_____
(If Other Than Patient)

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UPDATE TO OFFICE POLICIES REGARDING APPOINTMENTS SCHEDULED

▲ Your appointment time is tailored for you. If the need arises to reschedule or cancel your appointment, please provide us at least 24 notice. This policy also applies to emergencies and situations beyond your control. This means if you have an appointment on a Monday, you will have to notify us during office hours the Friday before to avoid being charged a fee. If there are holidays before your appointment where the office is closed for a consecutive number of days, then you must notify the office on whatever the previous working day is to avoid being charged the fee! Without adequate notification, we will not be able to give your reserved time to another patient in need of orthopedic care. ***There is a $50.00 broken appointment fee for any failed appointments.***

▲ Effective December 1st 2015, if you have given us your email address to set up your patient portal, you will receive notification of your appointments at the time they are scheduled. You will no longer receive a call reminding you of your appointment.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Per HIPPA guidelines, please list any family members or persons who may be privileged to your records.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you have any questions, we would appreciate your prompt inquiry.

_____ _____
Patient's Name Date

_____
Patient's Signature

_____
Office Initials and Date