PATIENT INFORMATION

_____/_____/_____

Last Name, First Name **Date of Birth** **Social Security #**

_____/_____/_____/ _____

Gender **Age** **Marital Status** **Email address**

_____/_____/_____/_____

Street Address (including Apt#) **City** **State** **Zip code**

_____/_____/_____

Primary Contact number **Alternate Phone Number**

_____/_____/_____

Emergency Contact Name **Relation** **Telephone Number**

_____

Referred by (How did you hear about us)

PRIMARY CARE INFORMATION

_____/_____/_____

Name of primary Care Physician (Or Medical Center Name) **Phone Number** **Fax Number**

PHARMACY INFORMATION

_____/_____

Pharmacy Name **Phone Number**

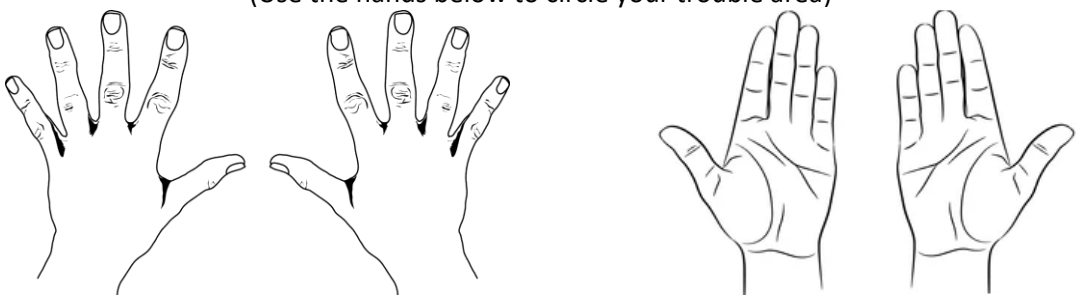
REASON FOR TODAY'S VISIT

Today's Date: _____

[circle] **Pain / Injury / Mass / Deformity / Weakness / Numbness / Tingling / Other:**_____

When did the symptoms/injury start (date)? _____ **What is your dominant hand?** _____

(Use the hands below to circle your trouble area)



Left Right Left Right

CURRENT MEDICATIONS

NAME	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY: (Check all that apply)

- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Hypertension
- ❑ Coronary Artery Disease
- ❑ Heart Attack or Stent
- ❑ COPD/Asthma
- ❑ Stroke/TIA
- ❑ Sleep Apnea
- ❑ Rheumatoid Arthritis
- ❑ Other Autoimmune Disorder
- ❑ Chronic Pain
- ❑ Spinal Stenosis/Radiculopathy
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Liver Disease/Hepatitis
- ❑ Bleeding Disorder
- ❑ High Cholesterol
- ❑ GERD/Gastritis
- ❑ Obesity
- ❑ Depression/Anxiety
- ❑ Bipolar/Schizophrenia
- ❑ Vascular Disease
- ❑ Thyroid Disease
- ❑ Cancer (specify) _____

PAST SURGICAL HISTORY AND HOSPITALIZATIONS

Date	Surgery / Hospitalizations	Complications?	Anesthesia?

FAMILY MEDICAL HISTORY

❑ Heart Attack ❑ Coronary Artery Disease ❑ COPD/Asthma ❑ Stroke/TIA ❑ Cancer (specify) _____ ❑ Hypertension	❑ Dementia ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Other Autoimmune Disorder ❑ Diabetes

SOCIAL HISTORY

Occupation: _____ Living Conditions (circle): Alone / Spouse / Family / Aide

Smoking/Tobacco: No / Yes: Packs/day _____ How many years ____ Quit (year) _____

Marijuana: No / Yes: Medicinal / Recreational Occasional / Weekly / Daily / Quit

Alcohol: No / Yes: Occasional / Weekly / Daily / Quit

Recreational Drugs: No / Yes: If yes explain: _____

ALLERGIES

Medications: No ____ Yes ____ if yes explain: _____

Non medication related allergies: Yes ____ No ____ if yes explain: _____

Review of systems (Circle all that apply)

General/Constitutional
Fever, sweats, chills, fatigue, other: _____

Head/Eyes/Ears/Nose/Throat
Blurry or double vision, hearing loss, runny nose, sore throat, allergies, other: _____

Skin
Rash, eczema, psoriasis, cancer, non-healing wounds, other: _____

Musculoskeletal
Arthritis, weakness, cramps, back pain (upper/lower), use cane or walker, other: _____

Respiratory
Asthma, COPD, shortness of breath, cough, sleep apnea, other: _____

Lymphatics
Swollen or tender nodes, lymphoma, lymphedema, other: _____

Endocrine
Hot/Cold flashes, weight change, thyroid problems, other: _____

Cardio-Vascular
Chest pain, arrhythmia, blood clot, swelling in extremities, pain with walking, pacemaker, defibrillator, stents, Other: _____

Neurologic
Headache, seizure, stroke/TIA, numbness, tingling, tremors, weakness, loss of memory, fibromyalgia, chronic pain, Other: _____

Psychological
Anxiety, depression, suicidal ideation, hallucinations, PTSD, ADHD, Other: _____

Gastrointestinal
Irritable bowel, diverticulitis, diverticulosis, cirrhosis, Other: _____

Hematologic
Bleeding disorder, bruising, clots, history of pulmonary embolism (PE), other: _____

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as guardian, agent or as patient that in consideration of the services rendered to the patient, he/she herby individually obligates himself/herself to pay the account, or "your part" of the charges of the physician at the time of services. Interest shall be charged beginning 45 days after date of service until, paid and will accrue at the rate of 12% per annum. Should the account be referred to an attorney or collection, the undersigned shall pay the reasonable attorney's fees and collection expenses. Your signature below indicated that you understand and accept this policy. Further, your signature authorizes payment of medical benefits to the doctor when an assigned claim is filed. Finally, your signature authorizes **Aventura Hand Center** to submit a request of payment to the undersigned for services denied or not covered by the provided insurance. For your convenience we accept Visa, MasterCard, American Express, Discover, Cash and Checks made payable to **Aventura Hand Center**.

_____	_____	_____
Patient Name (print)	**Patient Signature**	**Date**

NO SHOW POLICY AND AGREEMENT

When you schedule an appointment with Aventura Hand Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible prior to your scheduled appointment to respect the time of other patients and providers. Any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office **within 24 hours** will be considered a **No Show** and will be charged a **$30.00 fee**. If a patient No Shows for **three (3)** separate appointments, Aventura Hand Center reserves the right to **dismiss** the patient from the practice.

_____	_____	_____
Patient Name (print)	**Patient Signature**	**Date**

CONSENT FOR TREATMENT

I, _____, give permission and request **Aventura Hand Center** to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in the judgment of the provider in attendance that are deemed necessary and advisable. I understand that I have the right and will have the opportunity to refuse any recommended treatment. Any and all diagnostic and/or therapeutic procedures and treatments provided will be so with my consent only.

_____	_____	_____
Patient Name (print)	**Patient Signature**	**Date**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Example: Medical Records and/or Notes from previous treatments)

Patient's Full Name: _____ Date of Birth: _____

I request and authorize _____
to release healthcare information of the above-named patient to:

Aventura Hand Center
20895 East Dixie Hwy
Aventura, FL 33180
786-519-4263 (phone)
305-454-9390 (fax)

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:
_____
_____

☐ All Healthcare information

☐ Other:
_____
_____

I authorize the release of my Medical Records to be released to **Aventura Hand Center**

☐ Yes ☐ No

Patient Signature: _____ Date Signed: _____