Steve V. Nguyen, MD Na, Dinh, MD Sergio Martinez, DO
Amanda Rogan, PA Marilyne Etienne, PA Kelsey L Calamaro PA-C
5979 Vineland Road Suite 101, Orlando, Fl 32819
5555 E SR-44 Unit 2, Wildwood, Fl 34785
Phone: 407-355-3120 Fax: 407-355-3119

TREATMENT CHECKLIST

Body Part: ☐ **Knee** ☐ **Hip** ☐ **Left** ☐ **Right**

Current pain: (No pain 0- 10 Severe pain): ___/10 **Worst Pain:** __/10

How long have you been experiencing pain? _____

Check the box next to the treatments you have tried			**Did it help?**
☐	ANTI-INFLAMMATORY MEDICATIONS	If yes, circle which ones: **Aspirin, Ibuprofen, Naproxen, Indomethacin, Meloxicam,** Other: _____	• NO RELIEF • MILD • MODERATE • SIGNIFICANT
☐	CORTISONE INJECTIONS	If yes, **how many times?** _____ **Date of your last injection:** _____	• NO RELIEF • MILD • MODERATE • SIGNIFICANT
☐	GEL INJECTIONS	If yes, **how many times?** _____ **Date of your last injection:** _____	• NO RELIEF • MILD • MODERATE • SIGNIFICANT
☐	PHYSICAL THERAPY	If yes, **for how long?** _____ **When?** _____	• NO RELIEF • MILD • MODERATE • SIGNIFICANT
☐	ASSISTIVE WALKING DEVICES	If yes, circle which: **Cane, Walker, Crutches, Wheelchair**	
☐	KNEE BRACE	If yes, circle which: **Over the Counter** or **Prescribed**	☐ NO RELIEF ☐ MILD ☐ MODERATE ☐ SIGNIFICANT
☐	PRP/STEM CELL INJECTIONS	If yes, **how many times?** _____	☐ NO RELIEF ☐ MILD ☐ MODERATE ☐ SIGNIFICANT
☐	HOME EXERCISE	**What kind of exercise?** _____	
☐	WEIGHT LOSS	**If yes, how many lb lost?** _____	

Check the box next to surgeries you've had on the body part		**Date**	**Surgeon Name**
☐	ARTHROSCOPY (SCOPE SURGERY)		
☐	JOINT REPLACEMENT		
☐	ORIF FOR FRACTURE		
☐	OTHER: _____		

SIGNATURE: _____ **DATE**:_____

Steve V. Nguyen, MD Na, Dinh, MD Sergio Martinez, DO
Amanda Rogan, PA Marilyne Etienne, PA Kelsey L Calamaro PA-C
5979 Vineland Road Suite 101, Orlando, Fl 32819
5555 E SR-44 Unit 2, Wildwood, Fl 34785
Phone: 407-355-3120 Fax: 407-355-3119

FALL RISK ASSESSMENT

Patient Name: _____ DOB: _____

1. Feels unsteady when standing or walking?	☐ Yes	☐ No
2. Worries about falling?	☐ Yes	☐ No
3. Has fallen in the past?	☐ Yes	☐ No
4. Are you Wheelchair or home bound?	☐ Yes	☐ No

SIGNATURE: _____ **DATE**:_____

Steve V. Nguyen, MD Nam, Dinh, MD Sergio Martinez, DO
Amanda Rogan, PA Marilyne Etienne, PA Kelsey L Calamaro PA-C
5979 Vineland Road Suite 101, Orlando, Fl 32819
5555 E SR-44 Unit 2, Wildwood, Fl 34785
Phone: 407-355-3120 Fax: 407-355-3119

PATIENT INFORMATION

First Name: _____ Middle: _____ Last Name: _____

DOB: _____ SSN: _____ Marital Status: _____

Gender: _____ Race: _____ Ethnicity: _____

Spoken Languages: _____ Cell Phone: _____ Home Phone: _____

Address/City/State/Zip code: _____

Height: _____ Weight:_____

PRIMARY CARE DOCTOR

Physician Name: _____ Phone Number: _____ Fax Number:_____

Address/City/State/Zip code: _____

EMERGENCY CONTACT

Contact Name: _____

Relationship to patient: _____ Cell Phone: _____

MEDICATION ALLERGIES

- ☐ No known allergies
- ☐ I have allergies. Please, specify which one(s_____

FAMILY HISTORY

- ☐ No known family history
- ☐ Has any person, related by blood, had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
Alcohol abuse				Heart disease			
Alzheimer's disease				Hypercholesterolemia			
Anemia				Hypertensive disorder			
Anxiety disorder				Kidney disease			
Arthritis				Liver problem			
Asthma				Malignant hyperthermia			
Attention deficit hyperactivity disorder				Malignant neoplasm of uterus			
BRCA1 mutation carrier detection test				Malignant neoplastic disease			
BRCA2 mutation carrier detection test				Malignant tumor of breast			
Back problem				Malignant tumor of cervix			
Blood coagulation disorder				Malignant tumor of colon			
Cerebrovascular accident				Malignant tumor of lung			
Chronic obstructive pulmonary disease				Malignant tumor of ovary			
Dementia				Mental disorder			
Depressive disorder				Migraine			
Diabetes mellitus				Multiple sclerosis			
Disease of liver				Myocardial infarction			
Disorder of cardiovascular system				Obesity			
Disorder of lung				Osteoporosis			
Disorder of musculoskeletal system				Pulmonary embolism			
Disorder of nervous system				Seizure disorder			
Disorder of thyroid gland				Sleep disorder			
Endometrial carcinoma				Substance abuse			
Epilepsy				Other			
Headache							

SOCIAL HISTORY

Activities of Daily Living

- Are you able to walk?
  - ☐ Yes: Walks without restrictions
  - ☐ Yes: Walks with assistive device(s)
  - ☐ Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility
  - ☐ No: Confined to chair
  - ☐ No: Independent in wheelchair
  - ☐ No: Requires minimal help in wheelchair
  - ☐ No: Dependent on helper pushing wheelchair
  - ☐ No: Unable to walk
  - ☐ No: Unable to initiate walking
  - ☐ No: Bed-ridden

- Which of your hands is dominant?

  ☐ Right ☐ Left ☐ Bilateral

Substance use

- Do you or have you ever smoked tobacco?
  - ☐ Never smoker
  - ☐ Former smoker
  - ☐ Current everyday smoker
  - ☐ Current some days smoker
  - ☐ Smoker- current status unknown
  - ☐ Unknown if ever smoked
  - ☐ Not tolerated

- Do you or have you ever used any other forms of tobacco or nicotine?
  ☐ Yes ☐ No

- What was the day of your most recent tobacco screening: _____

- Has tobacco cessation counseling been provided?
  ☐ Yes ☐ No

- What is your level of alcohol consumption?
  ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

- Do you use any illicit or recreational drug?
  ☐ Yes ☐ No

- What is your level of caffeine consumption?
  ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Advance Directive

- Do you have an advance directive?
  ☐ Yes ☐ No

- Do you have a medical power of attorney?
  ☐ Yes ☐ No

SURGICAL HISTORY

What operations have you had in the past? If so, when?

_____
_____
_____

IMPLANT HISTORY

Have or had you ever had an implant? If so, which and when?

_____
_____
_____

PAST MEDICAL HISTORY OF THE PATIENT

Have you ever had or have any of the following?;

	Yes	No		Yes	No
ADD/ ADHD			Heart Disease		
AIDS/ HIV			Heart Problems		
Abuse/ Domestic Violence			Hepatitis		
Allergies/ Hayfever			Hernia		
Anemia			High Cholesterol		
Anesthesia Complications			Hospitalizations		
Anxiety Disorder			Hypertension		
Anxiety/ Depression			Hyperthyroidism		
Arthritis			Hypothyroidism		
Asthma			Infertility		
Autism Spectrum Disorder (ASD)			Kidney Disease		
Bedwetting			Kidney Stones		
Birth Defect or Inherited Disease			Liver Disease		
Bladder or Kidney Problems			Lung Disease		
Bleeding Disorder			MRSA exposure		
Blood Clot			Meniere's disease		
Blood Diseases			Mental Disorder		
Blood Transfusion			Mental Illness		
Breast Cancer			Migraines		
Breast Problem			Muscle, Joint, or Bone Problems		
COPD			Obesity		
Cancer			Orthotics		
Chicken Pox			Osteoporosis		
Chronic Ear Infections			Other		
Congestive Heart Failure (CHF)			Ovarian Cancer		
Constipation			Pacemaker		
Coronary Artery Disease			Peripheral Vascular Disease		
Depression			Polyps		
Developmental or Behavioral Disorders			Pre-Eclampsia		
Diabetes			Pulmonary Embolism		
Difficulty Swallowing			Reflux/GERD		
Diverticulitis			Rheumatoid Arthritis		
Ear or Hearing Problems			Seizures/Epilepsy		
Eating Disorder			Skin Problems		
Eczema			Stroke		
Endometriosis			Thrombophilias		
Fibromyalgia			Thyroid problems		
GI Problems			Tuberculosis		
Gout			Ulcers		
Headaches			Varicosities		
Heart Attack (IM)			Vision or Eye problems		

CONSENT FOR EXAMINATION AND TREATMENT ASSIGNMENT OF INSURANCE AND RECORDS AUTHORIZATION

I consent to examination and treatment as deemed necessary by your physicians. I also authorize Optimotion Orthopaedics to provide information about my relevant medical history (including, but not limited to, the highly confidential information listed above) to any of the following: other health care providers involved in my care, insurance companies, attorneys, and adjusters. I hereby assign to Optimotion Orthopaedics all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amounts not covered by insurance.

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to provide services to an individual when the individual is located at a different location than the provider; and I hereby give my consent to the providers of Optimotion Orthopaedics to provide me with health care services via telemedicine. I understand that the laws protecting the privacy and confidentiality of medical information also apply to telemedicine. As always, your insurer will have access to your medical records for quality review and audit purposes. I understand that I will be responsible for any copayments or coinsurance that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent for the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent verbally or in writing at any time by contacting Optimotion Orthopaedics at (407) 355-3120. As long as this consent is in effect (has not been revoked), Optimotion Orthopaedics may provide me with health care services via telemedicine without my signing another consent form.

MEDICAL AUTHORIZATION

I _____, authorize Optimotion Orthopaedics to release any or all of my patient health information,
including highly confidential information, to the person(s) listed below. (Example: Spouse or family members may be involved in billing and insurance inquiries or medication refills.)

Signature:_____ Date: _____

Name	Relation the patient	Telephone

PRIVACY NOTICE

Inspecting and Copying Your Protected Health Information (PHI): You have the right to inspect and copy your protected health information that may be used to make decisions about your health care, with the exception of psychotherapy notes. If you wish to view or copy your health information, you must submit your request in writing to the Site Privacy Coordinator or Optimotion Orthopaedics Privacy Officer. If you request copies of information, the cost will be $1.00 per page for the first 25 pages and then $0.25 per page. You may also access your patient records through your patient portal at no cost.

In accordance with the Health Information Portability and Accountability Act (HIPAA), Optimotion Orthopaedics patients have the right to privacy regarding their health-related information as provided under applicable law. Optimotion Orthopaedics will endeavor to ensure that patient information is used only for purposes authorized to the patient and as required by law. Upon request, we can provide you with a complete copy of our Privacy Policies.

In addition, patients have the right to review and submit comments regarding their medical records during regular business hours upon reasonable notice. Please review our Full Notice of Privacy Practices on our website at www.optimotion.com or at our clinic locations.

CANCELLATION POLICY

If you are unable to keep your appointment, we kindly ask that you provide at least 24 hours notice to avoid a $25.00 no-show fee.

Co-pays, deductibles, and insurance are collected prior to treatment. If payment is received at the time of services, the patient will receive 3 statements regarding the outstanding balance. If your account remains past due, your account will be sent to a collection agency.

Signature: _____ Date: _____