Scott D. Kazdan, D.O., LLC
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GENERAL INFORMATION

PATIENT NAME: ____DATE:_________________________

ADDRESS: _______________________________CITY:___________________STATE:________ZIP:______

HOME PHONE: _________________________WORK:____________________

CELL______________________

DATE OF BIRTH: _____________________ AGE: _________ GENDER: M / F

EMAIL ADDRESS: ____

SOCIAL SECURITY#______ /______ /_______

MARITAL STATUS: M S D W

SPOUSE'S NAME: ______________________________PHONE #:_____________________________________

EMPLOYER'S NAME: ______________________________________

EMPLOYER'S ADDRESS: ____

EMPLOYERS PHONE: ____

OCCUPATION: ____

REFERRED BY:

DOCTOR/ATTORNEY /INSURANCE/OTHER/INTERNET:

____

INSURANCE INFORMATION

IS THE PROBLEM RELATED TO:

WORK: YES ☐ NO ☐ INJURY DATE: ____/_____/_____ CLAIM#:______________

AUTO ACCIDENT: YES ☐ NO ☐ INJURY DATE: ____/_____/_____ CLAIM#:______________

PRIMARY INSURANCE NAME: ______________________________

ID/MEMBER#: ______________________ GROUP#: ______________________

INSURED/POLICY HOLDER:______________________ DOB: ______________________

RELATIONSHIP TO INSURED: ______________________________

***IF SECONDARY INSURANCE IS APPLICABLE, PLEASE FILL OUT THE FOLLOWING INFORMATION:

SECONDARY INSURANCE NAME: ______________________________

____

ID/MEMBER#: ______________________ GROUP#: ______________________

INSURED/POLICY HOLDER: ______________________ DOB:

____

RELATIONSHIP TO INSURED: ______________________________

It is the policy of this office to collect all copayments, deductibles and coinsurance indicated as the patient's responsibility by their insurance company. We cannot waive or reduce any patient's responsibility as per our contract with your insurance company. As a courtesy to the patient we verify your health insurance prior to your appointment. Any quote of patient responsibility is an estimate and may not reflect the actual amount due from the patient for service rendered. Any additional amounts due will be billed to the patient upon receipt of the explanation of benefits from the insurance company. We reserve the right to add a late payment charge of 1.5% to all outstanding balances not paid within 30 days. In addition, unless separate arrangements are made with our office manager, balances outstanding for ninety (90) days or more are delinquent and will be forwarded to a Professional Collection Firm. By signing below, you hereby agree to pay our costs and/or fees, including attorney's fees, related to the collection of any delinquent balance. It being acknowledged and understood that such costs and/or fees could equal an additional 35% of the total delinquent account.

SIGNATURE: ______________________________ DATE: ______________________

MEDICAL HISTORY

Please Respond to all Lines and Questions

Primary/Family Doctor: ____

CHIEF COMPLAINT:

Please describe your present symptoms and the date of onset:______________________________________

____

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____

____

PAST MEDICAL HISTORY:

Are you currently, or have you been treated in the past for any of the problems listed below? Describe briefly.

- Heart Disease______________________
- Heart Attack ______________________
- High Blood Pressure __________________
- Stroke ___________________________
- Diabetes _________________________
- TB ______________________________
- Arthritis _________________________
- Gout ____________________________
- Ulcers ___________________________
- Intestinal Bleeding ___________________
- Prostate Trouble _____________________
- Poor Circulation _____________________
- High Cholesterol _____________________
- Bleeding Easily ______________________
- Asthma ___________________________
- Cancer ____________________________
- Broken Bones _______________________
- Other _____________________________

FAMILY HISTORY:

Have parents or siblings had?	No	Yes	Family Member:	Age	Alive?	Specify Diseases:
Stroke/Headache/Seizure			Father			
Emphysema			Mother			
Heart Condition/Hypertension			Brother			
Cancer			Sister			
Diabetes or Thyroid Disease			Other:			

PAST SURGICAL HISTORY:

TYPE YEAR

____

____

____

____

CURRENT MEDICATIONS (NAME DOSAGE):

____

____

____

____

____

Allergies to Medications:

____

PHARMACY NAME: ________________________ ***PHONE #:*** __________________

SOCIAL HISTORY:

- Tobacco Use Amount: ______________
- Recreational Drugs Amount: _________
- Alcohol Use Amount: ______________

Patient: ______________________________ **Date:** ___________________________

Review of Systems

Do you now have had any problems related to the following systems? Circle Yes or No

Constitutional Syptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Otrher		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Cardiovascular

Chest Pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other		

Muscoloskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus problem	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Otrher		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other		

Psychologic

Severely depressed	Y	N
Considered suicide?	Y	N
Other		

PATIENT NAME: ____ DOB: _________________

Please read and initial each line

_______ I authorize payment of medical benefits to Scott Kazdan, D.O., LLC. I understand that I will be responsible for any and all services not covered by my insurance. I hereby irrevocably assign my benefits under any insurance policy to Scott Kazdan, D.O., LLC.
______ I authorize the release of my protected health information to carry out treatment, payment activities, insurance claim processing and health care operations.
______ Your doctor has decided not to carry medical malpractice insurance. This is permitted under Florida Law subject to certain conditions.
______ I authorize the office of Scott Kazdan, D.O., LLC to leave messages/voicemails regarding appointment information. I give permission to share appointment, medical and billing information with the listed the person(s) below:

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____

____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

____ I acknowledge that I have received a copy of the Notice of Privacy Practices.
You have the right to read our notice of privacy practices before you decide to sign this consent. You have the right to revoke this consent at anytime by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to continue treating you if you revoke this consent.

______________________________ ______________________________
PRINT NAME SIGNATURE

____
DATE

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.
While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country-claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU
We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.
We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO
We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action. We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean ________________________.
"Physician" shall be understood to mean "Scott Kazdan, D.O.".

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/ guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Academy of Orthopedic Surgeons.

In further consideration for this, Physician agrees to the same stipulations.

______________________________ Physician

______________________________ Patient/Guardian

______________________________ Effective from Date of Treatment

______________________________ Date of Signature

YOUR ORTHOPEDIC AILMENT AND YOUR DAILY ACTIVITIES

At Western Orthopedics and Rehabilitation we strive to provide the highest quality orthopedic care and treatment. As many orthopedic injuries and ailments may affect your ability to perform your job or activities of daily living, please be advised that:

1. Documentation related to your medical condition provided by this office will describe restrictions and limitations to your daily activities that are medically appropriate for your medical condition. We cannot exaggerate any patient's medical condition or recommended restrictions/limitations.

2. Completion of documentation related to Medical Leave, including Forms requested or required by FMLA, are extremely time consuming. There is $25.00 charge, to be paid in advance, for all such medical forms completed by Western Orthopedics and Rehabilitation.

3. Your orthopedic medical condition may prevent you from performing certain daily activities, which may include certain aspects of your job description. However, this does not mean we can provide documentation to put you out of work. Any documentation related to your medical condition that is requested or required to be provided will be limited to the specific medical condition and its related treatment. For example, a significant injury to the right lower extremity could prevent a patient from driving, however, this will not necessarily result in a medical recommendation for a "no work" status.

4. Western Orthopedics & Rehabilitation cannot require an employer to (i) accommodate any limitations or restrictions that may be recommended in connection with your orthopedic medical condition or (ii) allow you to return to work until the recommended limitations or restrictions no longer apply. However, this will not affect the physician's obligation to accurately document your medical condition.

5. If you believe that your orthopedic medical condition is so severe that you cannot work, you may seek an independent evaluation for a job disability screening. We can provide you with contact information to obtain such screening if desired. Please be advised (i) there are additional financial obligations and billing related to these services and (ii) seeking such additional independent services this will not impact your care at Western
Orthopedics and Rehabilitation.

6. Does your visit to the office today present any work related issues? YES/NO (If yes, please explain)

____
____
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____________________	____________________
Signature	Date