PATIENT INTAKE FORM

Disclaimer: Thank you for your interest in being a patient of Lucas J. Bader MD. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

Patient Details

First Name: _____ Last Name: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other
☐ (check if mailing address is the same as picture ID otherwise, please fill out)

Street Address: _____
City: _____
State: _____ ZIP Code: _____

Home Phone: _____
Mobile Phone: _____
E-Mail:_____
Weight: _____ Height: _____
Primary Language: ☐ English ☐ Spanish ☐ Other:

Emergency Contact

Emergency Contact Name: _____
Relationship: _____
E-Mail: _____
Home Phone: _____
Mobile Phone: _____

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Miami Ortho Institute

Patient Name: _____ **Today's Date:** _____

DOB: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female **Height:** _____

Occupation: _____ **Weight:** _____

Who referred you to see me today? _____ **Dominant Hand:** right ☐ left ☐

Body part to be examined: ☐ Right ☐ Left

☐ Shoulder ☐ Knee ☐ Elbow ☐ Hip ☐ Other _____

Past Medical History: Have you ever had any of the following? Check all that apply and specify as indicated.

General:
☐ Cancer _____

Head-Ears-Eyes-Nose-Throat:
☐ Sleep apnea

Cardiac:
☐ High blood pressure
☐ Coronary artery disease
☐ Coronary stent/angioplasty
☐ Heart attack
☐ Mitral valve prolapse

Pulmonary:
☐ Asthma
☐ Emphysema
☐ COPD
☐ Pneumonia
☐ Tuberculosis

Endocrine:
☐ Diabetes
☐ Hypothyroid
☐ Hyperthyroid

Genitourinary:
☐ Bladder infections
☐ Venereal disease
☐ Kidney disease

Gastrointestinal:
☐ Ulcer disease
☐ GERD
☐ Gallstones
☐ Diverticulitis

Skin:
☐ Eczema
☐ MRSA/Staph infection
Date Treated: _____

Musculoskeletal:
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Osteoporosis
☐ Fibromyalgia
☐ Ankylosing spondylitis
☐ Scoliosis

Neurological:
☐ Seizures
☐ Balance problems
☐ Headaches
☐ Migraines
☐ Peripheral neuropathy
☐ History of stroke
☐ Multiple sclerosis

Hematologic:
☐ Bleeding Disorder
☐ History of DVT/PE
☐ Blood clots

Infectious Disease:
☐ HIV
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

Psychiatric:
☐ Depression
☐ Bipolar
☐ Anxiety
☐ Manic
☐ History of drug dependency
☐ History of alcohol dependency

☐ **NONE**
☐ Other _____

Surgical History: Check any surgeries that you have had. *Please indicate the year of surgery to the best of your knowledge.*

☐ NONE ☐ Appendectomy ☐ Gall Bladder ☐ Vascular Bypass… Where? _____
☐ Heart Surgery ☐ Hysterectomy ☐ Tonsillectomy
☐ Arthroscopic Surgery: ☐ Shoulder ☐ Knee ☐ Hip ☐ Other: _____
☐ Total Joint Replacement: ☐ Shoulder ☐ Knee ☐ Hip
☐ Back Surgery: specify: _____
☐ Fracture Repair: specify: _____
☐ Other: _____
If you have had any problems with anesthesia, explain: _____

Social History: Please mark every area.

Tobacco use: ☐ Yes ☐ No ☐ Former ☐ Cigarettes ☐ Cigar ☐ Chewing ☐ Pipe ☐ Smokeless
Cigarettes: Pack(s) per day _____ How many years: _____ If you quit, when? _____
Other tobacco use: Amount per day: _____ How many years: _____ If you quit, when? _____
Alcohol use: ☐ Yes ☐ No If yes, how many drinks per week? _____
Are you currently able to work? ☐ Yes ☐ No If not, when was your last day of work? _____
Sports and Recreational Activities: _____

Review of Systems: Check any illnesses you currently have.

General:
☐ Fevers
☐ Weight loss or gain
☐ Difficulty sleeping
☐ Night sweats

Pulmonary:
☐ Shortness of breath
☐ Cough

☐ **NONE**

Genitourinary:
☐ Urinary frequency
☐ Urinary retention
☐ Urinary incontinence

Gastrointestinal:
☐ Nausea
☐ Vomiting

Cardiac:
☐ Chest pain

Neurological:
☐ Numbness or weakness
☐ Difficulty walking

Head-Ears-Eyes-Nose-Throat:
☐ Difficulty swallowing
☐ Difficulty breathing
☐ Vision loss or change
☐ Hearing loss or change
☐ Tinnitus (ringing in ears)

Family History: Has anyone in your family had any of the following problems?

☐ No significant past family history ☐ Unknown family history

Disease	Mother	Father	Brothers	Sisters	Daughters	Sons
High blood pressure/hypertension						
Heart attack/Heart surgery						
Diabetes						
Stroke						
Cancer (please specify)						
Arthritis						
Other (please specify)						

Medications: Use the back of this page if additional space is needed. Include antibiotics, blood thinners, insulin, and heart medications.

☐ **NONE**

Allergies or Drug Reactions: Check all that apply.

☐ **NO KNOWN DRUG ALLERGIES** ☐ Codeine ☐ Morphine ☐ Demerol
☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ NSAID's
☐ Adhesive Tape ☐ Latex ☐ Iodine ☐ Other:_____

Primary Care Physician: _____

Telephone #: _____ **City:** _____

Cardiologist: _____

Telephone #: _____ **City:** _____

***Please provide your pharmacy information. This will allow us to send medications to your pharmacy. ***

Pharmacy: _____
Address: _____
City: _____
Telephone: _____

Miami Ortho Institute

Dr. Lucas Bader

Miami Ortho Institute
12550 Biscayne Blvd Suite
405 North Miami, FL 33181

Tel- 786-539-2421 Fax-786-619-3366

INFORMED CONSENT TO ORTHOPEDIC/ SURGICAL CARE

I hereby request and consent to the performance of orthopedic care and other procedures, including various modes of therapy on *me* (or on the patient named below, for whom I am legally responsible) by the doctor named above and/or other licensed doctors who now or in the future will treat *me* while employed by, working, or associated with, or serving as back-up for the doctor named above, including those working at the clinic or office listed below or any other office or clinic.

I have had the opportunity to discuss ·with the doctor(s) named above and/or with other office or clinic personal the nature and purpose of orthopedic visit and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of orthopedics there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to *me* the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the' above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient:

Print Patient's Name

Signature of Patient

Date Signed

To be completed by patient's representative, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated:

Print Name of Patient

Print Name of Patient's Representative

Signature of Patient's Representative

As: _____
Relationship or Authority of Patient's Representative

Date Signed

To be completed by doctor or staff:

Witness to patient's signature

Translated By

Treating facility and provider:

Miami Ortho Institute
12550 Biscayne Blvd Suite 405
North Miami, FL 33181
Tel-786-539-2421 Fax-786-619-3366

RECORD RELEASE AUTHORIZATION

To: _____

_____
Doctor and Office

_____
Address

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Dr. Lucas Bader
Miami Ortho Institute
12550 Biscayne Blvd Suite 405
North Miami, FL 33181
Tel-786-539-2421 Fax-786-619-3366

THE COMPLETE RECORDS AND X-RAYS IN YOUR POSSESSION, CONCERNING MY
ILLNESS AND/OR TREATMENT DURING THE PERIOD OF _____ TO _____

NAME _____ DATE OF BIRTH ___/___/___

ADDRESS _____ CITY _____

STATE _____ ZIP _____

SIGNATURE _____ DATE ___/___/___

WITNESS _____

Miami Ortho Institute

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE
UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS.

SIGNATURE DATE

DO NOT DETACH