Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Dr. Frederick McClimans, D.O. Megan Kise, PA-C Leah Petit, APRN

Appointment Date:________________________________ Time:____________________

Requirements prior to your appointment:

- ✓ Obtain pertinent medical records prior to your appointment.
  - o Medical records may include:
    - Diagnostic reports (x-ray, MRI, CT, nerve conduction study)
    - Operative reports
    - Physician office notes
- ✓ If a referral is required, please request from your PCP ahead of time and confirm receipt with our office prior to your appointment.
- ✓ Auto accident and Slip & Fall injury patients require an approved a "Letter of Protection" from your attorney prior to your appointment.

Items required for your appointment:

- ✓ Completed paperwork
- ✓ X-rays, if any
- ✓ Photo ID
- ✓ Health Insurance Cards
- ✓ Form of payment for co-pay, co-insurance and/or deductible
- ✓ Auto insurance claim information, if applicable

Please remember:

- ✓ Arrive **30 minutes** prior to your appointment time.
- ✓ Please call if you are running late, need to reschedule or cancel. There is a $75.00 "no show" fee.
- ✓ Co-pays are collected at time of service.

In order for Tampa Bay Bone & Joint Center to ensure all patients receive quality care in a time efficient manner we ask that you address no more than 2 body parts of concern per visit.

Failure to be prepared for your appointment may result in rescheduling.

Dr. McClimans and the TBBJ staff look forward to seeing you!

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Date:________________

PATIENT INFORMATION

PATIENT NAME: FIRST MIDDLE LAST

PATIENT ADDRESS: NUMBER & STREET APT#	CITY	ST	ZIP

HOME PHONE #	MOBILE #	WORK #
DATE OF BIRTH: SOCIAL SECURITY #	SEX ☐MALE ☐FEMALE	MARITAL STATUS ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED ☐OTHER:

RACE
☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐BLACK, AFRICAN AMERICAN ☐HAWAIIAN OR OTHER PAC. ISLAND. ☐ WHITE ☐DECLINE

ETHNICITY: ☐HISPANIC OR LATINO ☐NOT HISPANIC OR LATINO ☐DECLINED

PREFERRED LANGUNAGE: ☐ENGLISH ☐SPANISH ☐DECLINED

PHARMACY USED (NAME, ADDRESS, PHONE #)	DO WE HAVE CONSENT TO RETRIEVE YOUR PRESCRIPTION HISTORY? ☐ YES ☐NO

MAY WE LEAVE CONFIDENTIAL MESSAGES ON: EMAIL: ☐YES ☐NO ANSWERING MACHINE/VOICEMAIL: ☐YES ☐NO DO YOU MAKE YOUR OWN MEDICAL DECISIONS? ☐YES ☐NO IF NO, WHO DOES?______________	EMAIL ADDRESS

EMPLOYER NAME	EMPLOYER ADDRESS	EMPLOYER PHONE #

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: FIRST MIDDLE LAST

HOME PHONE #	WORK PHONE #	RELATIONSHIP TO PATIENT

PRIMARY/REFERRING PHYSICIAN

PHYSICIAN NAME:	PHONE #

HEALTH INSURANCE INFORMATION

IS YOUR VISIT RELATED TO: ☐WORKER'S COMP? ☐AUTO ACCIDENT? ☐LIABILITY CASE? IF SO, PLEASE STOP AND SEE THE FRONT DESK.

PRIMARY INSURANCE COMPANY NAME:	ID #	GROUP #	PHONE #
POLICY HOLDER NAME:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	
SECONDARY INSURANCE COMPANY NAME:	ID #	GROUP #	PHONE #
POLICY HOLDER NAME:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Patient Name: ______________________ DOB:____________ Date:__________________

Height:____________ Weight:________lbs. Hand Dominance:__________________

Chief Complaint: ____

Please complete one sheet per complaint. If you have more than one complaint, please ask the front desk for an additional form.

Please circle all that apply to your current complaint.

- **Location:** left , right , bilateral , anterior , posterior , medial , lateral , deep , superficial
- **How does it feel?** aching , burning , gnawing , stabbing , throbbing , sharp , dull , superficial , deep , occasional , frequent , constant , worsening , improving , not changing, ________________________________
- **How severe is it?:** no pain , mild , moderate , severe , pain level ___/10 , worst pain ___/10
- **How long ago did the pain begin? :** date of onset ___ days , ___ weeks , ___ months , ___ years , continuous since onset,____
- **Reason pain began:** cannot identify ,fall , bending , lifting , twisting , sports injury , work injury , MVA , assault, overuse , atraumatic , laceration,____
- **What makes it better?:** nothing helps , sitting , standing , lying down , position change , heat ,ice , rest , elevation , exercise , stretching , limited weight bearing , PT/OT , chiropractic care , ESI , OTC medication, narcotics, NSAIDs, cortisone injection, vicosupplement injection(e.g. synvisc) orthotics, previous surgery , brace, crutches , cane , wheelchair , walker,__________
- **What makes it worse?:** cannot identify, sitting, standing, lying down, walking, lifting, carrying, twisting , bending/squatting , pushing/pulling , ROM , weightbearing , exercise , previous surgery, changing clothes , getting out of bed , going from sit to stand , upstairs , downstairs , morning , daytime , nighttime , cold weather , damp weather,____
- **Associated Symptoms:** weakness , numbness , tingling , swelling , redness , warmth , ecchymosis , catching/locking , popping/clicking , buckling , grinding , instability , radiation down leg , drainage , fever, chills, weight loss , change in bowel/bladder habits,________________________________
- **Previous Surgery on chief complaint:** none , surgical procedure:____________________ , date:_______
- **Prior Imaging on chief complaint:** none , no recent studies , x ray , MRI , CT scan , bone scan , EMG
- **Prev. Steroid/Cortisone Injections:** none, did not help, helped a little, helped temporarily, helped significantly.
- **Total Number of Injections given:**__________Date last injection was given:_________Helped for:__________
- **Previous physical therapy:** none, did not help, helped a little, helped temporarily, and helped significantly.
- **Last date of treatment:**____
- **Work Related:** no , yes, ____
- **Working:** no , regular duty , modified duty,________________________________

Comments: ____

____

____

____

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

New Patient Health Questionnaire

Name:______________________________ Date:______________________________

DOB: ______________ Age:_________ New Patient____ Established____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office.

Information contained here will not be released to any person except when you have authorized us to do so.

What is your chief complaint? ____

Have you ever had a similar injury? ____

Occupation: (if retired, previous occupation)____________________If disabled, check here:__ Nature of disability:__________

Do you exercise routinely? ☐No ☐Yes If Yes, what exercise/how often?______________________________

Medical Information

Medications (Please list all medications you are currently taking. Include over the counter, herbal or natural remedies.)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Females Only: Are you pregnant, planning a pregnancy or nursing a child? ☐No ☐Yes

Have you ever had or been diagnosed to have: (check all that apply)

Cataracts		Heart Disease		Stomach Ulcers		Diabetes		Depression	
Glaucoma		Heart murmur		IBS		Anemia		Bipolar	
Asthma		High Blood Pressure		Diverticulosis		Bleeding Disorder		PTSD	
Pneumonia		High cholesterol		Hemorrhoids		Arthritis		Frequent Infection	
TB/Lung Disease		Pacemaker		Kidney Disease		Osteoporosis		MRSA	
COPD		Stroke (date)		Kidney Stones		Cancer (type)		HIV	
Sleep Apnea		Cardiac stents		TIA		Rheumatic Fever		Syphilis	

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Pleurisy		Heart Attack (date)		Thyroid disorder (Hypo/Hyper)		Chicken Pox	
Prostate Enlargement		Jaundice or Liver DZ		German Measles		Multiple Sclerosis	
Claustrophobia		Hepatitis (circle) A B C		Seizures/Epilepsy		Myasthenia Gravis	
Fibromyalgia		Alzheimer's/Dementia		Parkinson's		Latex Allergy Reaction:	

Medical Illnesses or Conditions: (list any other chronic conditions which you have been diagnosed to have)

____

____

Allergies: Are you allergic to any medications? ☐ No known drug allergies ☐ Yes If yes, please list below.

Name & reaction: ______________________________

____

Operations: (list any surgery and approximate year)

____

____

____

____

Do you have any metal in your body? ☐ No ☐ Yes If Yes, please explain: ______________________________

____

Hospitalizations: (Other than operations)

Year	Reason	Hospital

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Family History	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Asthma
Daughter							
Father							
Son							
Mother							

Social History

Do you drink alcohol? ☐No ☐Yes If Yes, circle:

How often within the past year:	Never	Monthly	2-4x/month	2-3x/week	>4x/week
# of drinks per occasion:	1-2	3-4	5-6	7-9	>10
How often >6 drinks in one day	Never	< Monthly	Monthly	Weekly	Daily

Have you ever smoked? ☐No ☐Yes Cigar Pipe Cigarettes If Yes: #packs/day_____________ #years _____

Do you still smoke now? ☐No ☐Yes If No, when did you quit? _____________

If current smoker, Circle: Do you smoke? Every day Some days

How soon after you wake up do you smoke? 5 mins 6-30mins 31-60 mins >60 mins

Are you interested in quitting? Ready to quit Thinking about quitting Not ready

Do you currently use marijuana? (Circle one) Recreational Medical

Do you currently use cocaine, heroin, speed, crack or other inhalants? ☐No ☐Yes

History of drug use? ☐No ☐Yes If Yes, explain ____

Systems Review: Please indicate those items that have been recurrent or a recent signific

Yes	No	
		Constitutional Symptoms
___	___	Good health lately
___	___	Recent significant weight change
___	___	
___	___	Frequent headaches
		Eyes
___	___	Change in vision
___	___	Blurred or double vision
___	___	Eye disease or injury
___	___	Wear glasses?
___	___	Wear contact lenses?
		Ears/Nose/Mouth/Throat/Neck
___	___	Do you wear hearing aids?
___	___	Hearing loss or
___	___	Ringing in ears?
___	___	Earaches or drainage?
___	___	Chronic sinus problems or runny nose
___	___	Nose bleeds
___	___	Mouth sores
___	___	Bleeding gums
___	___	Sore throat/hoarseness or voice change
___	___	Lumps or swollen glands in neck

Yes	No	
___	___	Difficulty swallowing
___	___	Neck pain or stiffness
		Cardiovascular
___	___	Heart trouble
___	___	Chest pain or angina pectoris
___	___	Palpitations
___	___	Shortness of breath with walking or lying flat
___	___	Swelling feet, ankles, or hands
___	___	Waking at night with shortness of breath
		Respiratory
___	___	Chronic or frequent cough
___	___	Coughing or spitting up blood
___	___	Shortness of breath
___	___	Asthma or recurrent wheezing
		Gastrointestinal
___	___	Loss of appetite
___	___	Nausea or vomiting
___	___	Change in bowel movements
___	___	Constipation
___	___	Frequent diarrhea

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Yes	No	
___	___	Rectal bleeding or blood in stool
___	___	Stomach/abdominal pains or heartburn
___	___	Heartburn
___	___	Black or tarry stools?
		Genitourinary
___	___	Frequent urination
___	___	Burning or pain on urination
___	___	Blood in urine
___	___	Change in force or strain when urinating
___	___	Incontinence or dribbling of urine
___	___	Sexual difficulties
___	___	Men: testicular pain
___	___	Women: painful periods
___	___	Irregular Periods
___	___	Recurrent vaginal discharge

Number of pregnancies (including miscarriages):___________

_______ # Deliveries _______# Miscarriages

Method of birth control (if applicable)___________________

Menopausal, since when: _______________

Date of last menstrual period: ___________

Date of last pap smear: _______________

Date of last mammogram: _______________

Yes	No	
___	___	**Musculoskeletal**
___	___	Joint pain(s)
___	___	Joint stiffness/swelling or warmth
___	___	Weakness of muscles or joints
___	___	Muscle pain or recurrent cramps
___	___	Back pain
___	___	Cold hands or feet
___	___	Difficulty walking
		Hematologic
___	___	Slow to heal after cuts or wounds
___	___	Bleeding or bruising tendency
___	___	Recurrent anemia
___	___	Swelling, warmth or tenderness of veins or history of phlebitis

Yes	No	
___	___	**Integumentary (Skin/Breast)**
___	___	Rashes
___	___	Itching
___	___	Change in skin color or moles
___	___	Change in hair or nails
___	___	Varicose veins
___	___	Breast pain
___	___	Breast lump
___	___	Breast discharge or rash
		Neurological
___	___	Frequent, recurring or increasing headaches
___	___	Light- headedness or dizziness
___	___	Convulsions, seizures or spasms
___	___	Numbness or tingling sensations
___	___	Tremors
___	___	Paralysis
___	___	Stroke
___	___	Head injury
		Psychiatric
___	___	Memory loss or confusion
___	___	Nervousness
___	___	Insomnia
___	___	Depression
		Endocrine
___	___	Glandular or hormone problem
___	___	Heat or cold intolerance
___	___	Excessive skin dryness
___	___	Excessive thirst or urination
___	___	Change in hand or glove size
		Allergic/Immunologic
___	___	History of skin reaction or other adverse reaction to: ______________
___	___	Penicillin or other antibiotic: describe reaction:___________________
___	___	Morphine, Demerol or other narcotics reaction:___________________
___	___	Novocain or other anesthetics reaction: ___________________
___	___	Aspirin or other pain remedies reaction: ___________________
___	___	Tetanus antitoxin or other serums
___	___	Iodine, methiolate or other antiseptic
___	___	Other medications:_________________
___	___	Other known food allergies_____________

Patient's Name: ____
(Please Print)
Patient or (Legal Guardian's) Signature: ______________________________ Date: ___________
If Legal Guardian, Relationship to Patient: ______________________________

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Financial Policy

This is an agreement between Tampa Bay Bone and Joint Center, as creditor, and the Patient/Debtor named on this form.
By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders, cashier's check, Visa, MasterCard, Discover, and American Express. We collect co pay, coinsurance and any deductible at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will file insurance claims **only** for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front and back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All co pay, coinsurance and deductibles are due at the time services are rendered.

If your insurance requires a referral and/or preauthorization, you are responsible for obtaining the first referral. Failure to obtain the referral and/or preauthorization may result in your appointment being rescheduled. We will assist you in obtaining any subsequent referrals or authorizations required.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Cancellation Policy: Failure to cancel or reschedule an office visit **24 hours** prior to the scheduled appointment will result in a **$75.00** charge to the patient.

Collection Fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned Checks: There is a fee currently of **$29.00** for any checks returned by the bank. Payment made on a returned check must be made in cash, money order, or credit card.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($10.00 for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization if we retrieve the chart from storage. You authorize us to include all relevant information, including payment history. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Permission for Treatment

I do hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to Tampa Bay Bone & Joint to administer and perform all examinations, treatments, diagnostic procedures and surgeries needed now or in the future. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. Photocopy of this consent is to be considered as valid as the original.

My signature below certifies that I have read (or the form as been read to me) and I understand the contents on this form.

Patient's Name: ______________________________ Date: ______________
(Please Print)

Patient or (Legal Guardian's) Signature: ______________________________

If Legal Guardian, Relationship to Patient: ______________________________

Tampa Bay Bone & Joint Center

11809 N. Dale Mabry Hwy.
Tampa, FL 33618
Phone: (813) 960-3228 Fax: (813) 960-0440

Patient Name:________________________________ DOB:___________________ Date:____________________

Assignment of Rights, Benefits and Causes of Action

I hereby assign all insurance rights, benefits, and causes of action, available to me under any policy of insurance to, Tampa Bay Bone and Joint Center (Assignee). This assignment specifically applies only to the extent of services, supplies or durable medical equipment rendered or provided to me by Assignee as a result of the subject accident.

Adequate consideration has been received for this assignment. The Assignee is authorized to bill the insurance companies responsible for payment of the services provided to me as a result of the subject accident and to file any lawsuits necessary for payment of my available insurance benefits.

Patient's Signature: ____ Date: ____________

Patient Consent for use and disclosure of Protected Health Information

Tampa Bay Bone and Joint Center will not release information to anyone unless we have written authorization to do so.

I authorize the office of Tampa Bay Bone and Joint Center to disclose protected health information to the following:

LIST NAMES OF THOSE WITH WHOM YOU WANT US TO SHARE YOUR HEALTH INFORMATION

Name	Relationship
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

Patient Signature:__________________________________ Date:________________________________

Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of Tampa Bay Bone and Joint Center's Notice of Privacy Practices as required by law.

Patient Signature:__________________________________ Date:__________________________

Please note that making an appointment and/or completing the documentation including past health history, insurance and billing information, advising as to chief medical concerns, and providing other preliminary information, does not create a Doctor-Patient Relationship. You do not become a patient of the practice until you have been notified that you have been accepted as a patient following your initial appointment.