

**JUAN CARLOS GALVEZ, MD, RMSK**  
Arthritis And Sports Medicine

**PATIENT DEMOGRAPHIC INFORMATION**

Chart #: \_\_\_\_\_  
Date of Appt: \_\_\_\_\_

Email: \_\_\_\_\_  
Cell : \_\_\_\_\_  
Home : \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt : \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital Status: S M D W Primary Language: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F Social Security: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Office: \_\_\_\_\_  
Orthopedic Problem: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_  
Type of Injury: Auto \_\_\_\_\_ Work \_\_\_\_\_ Slip & Fall \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_  
How did accident happen? \_\_\_\_\_  
Spouse/Parent Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

<b><u>Primary Insurance</u></b>	<b><u>Secondary Insurance</u></b>
Name of Insurance: _____	Name of Insurance: _____
Insured's Name: _____	Insured's Name: _____
Insured's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Insured's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Insured's Date of Birth: _____	Insured's Date of Birth: _____
Relationship to Insured: _____	Relationship to Insured: _____
Subscriber ID Number: _____	Subscriber ID Number: _____
Group Number: _____	Group Number: _____

**AUTO INSURANCE**

Date of Accident: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insured Person: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_  
Policy: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Phone: \_\_\_\_\_ Adjuster: \_\_\_\_\_  
: \_\_\_\_\_

**ATTORNEY INFORMATION**

Any pending litigation related to your injury? \_\_\_\_\_  
Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Attorney Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_



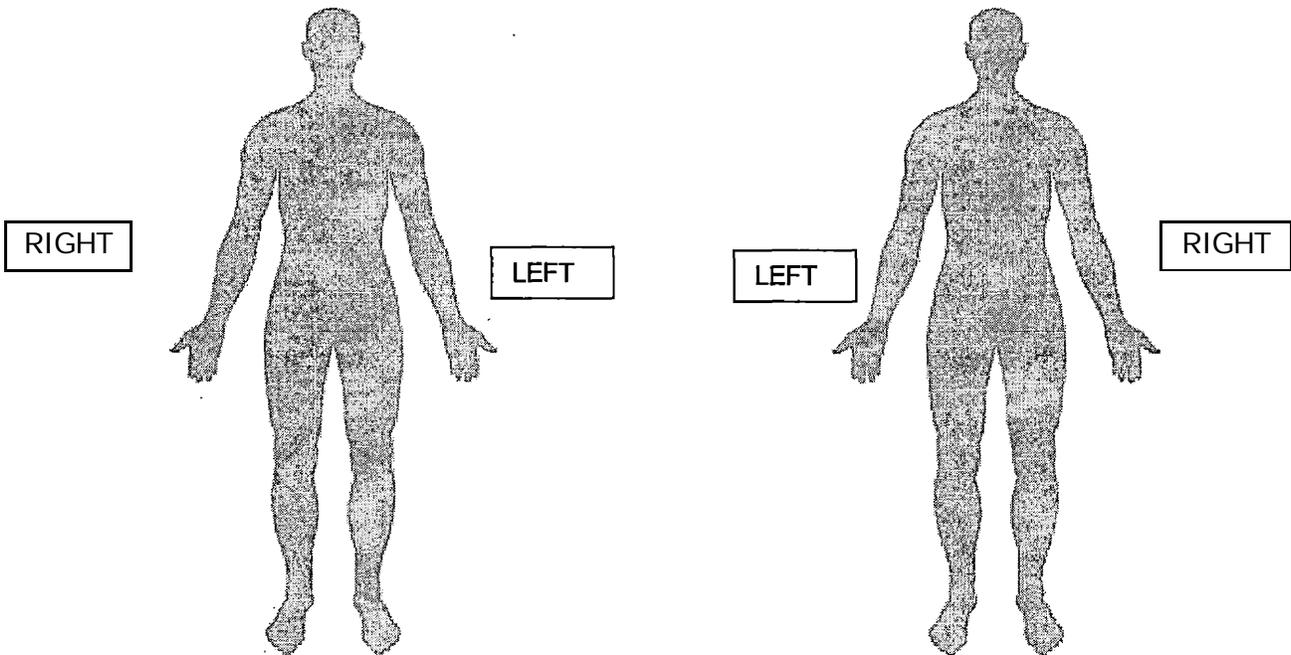
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- On the following diagrams, please show **where** you're experiencing **all** of your present complaints with the letter **X**:

**FRONT**

**BACK**



**Are you experiencing any of the following symptoms?**

- |  |   |
|--|---|
| <input type="checkbox"/> Arm/Shoulder pain   | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Neck pain/stiffness  |
| <input type="checkbox"/> Leg pain            | <input type="checkbox"/> Irritability         |
| <input type="checkbox"/> Stomach upset       | <input type="checkbox"/> Sleep difficulties   |
| <input type="checkbox"/> Anxiety/Depression  | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> Feet/Toe numbness   | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Back pain/stiffness | <input type="checkbox"/> Hand/Finger numbness |
|  | <input type="checkbox"/>                      |

**Circle the severity of your pain:**

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

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**X-RAY COPIES**

All X-rays taken by this office are the property of JUAN CARLOS GALVEZ, MD, RMSK. Under no circumstances can originals be taken out of this office. All originals will be maintained in this office at all times.

If copies are requested, at least a 24 hour notice will be required and there will be a \$10.00 per film charge for materials, payable in advance. Your consideration is appreciated

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\_\_\_\_\_  
Patient's Signature (If patient is a minor, signature of parent/guardian)

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**CANCELLATION FEE POLICY**

We value your time and patience when you come to visit the office. In return we ask that you please understand that we strive to serve you as efficiently as possible and need your help to do so. We ask that you please provide us with a 24 hour notice if you need to cancel or reschedule your appointment. This helps us to serve other patients who also require our services. In the event that you do not show and do not call to cancel/reschedule there will be a \$25 no show fee charged to you at your next visit.

We appreciate your understanding of this matter and look forward to serving you.

I, \_\_\_\_\_, have read and understood the above policy. I understand that I will be charged if I fail to provide a 24 hour notice of cancellation.

Signature: \_\_\_\_\_  
(patient/parent/conservator/guardian)

\_\_\_\_\_ Date

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**PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

I, \_\_\_\_\_, understand that as part of my healthcare, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provide with a notice of information practices that provide a more complete description of information used and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations

I understand that this facility is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I further understand that this facility reserves the right to change this notice and practices and prior implementation, in accordance with section 164.520 of the code of federal regulations. Should this facility change their notice they will send a copy of any revised notice to the address I've provided.

I understand that as a part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my information to another entity and I consent to such disclosure for these permitted uses including disclosures via fax

I authorize this facility to discuss my treatment, payment, and healthcare operations with the following person/people:

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I fully understand and accept/decline the terms of this consent.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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**NOTICE**

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NON-INSURED PHYSICIANS WHO FAIL TO SATISFY ADVERSE JUDGMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE IS PROVIDED PURSUANT TO FLORIDA LAW.

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PATIENT SIGNATURE

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DATE

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**NOTICE OF SMOKING CESSATION**

Doctors generally advise to quit smoking before and after operations because smoking decreases the level of blood flow. Smoking constricts the blood vessels. When the blood vessels are narrowed down, the oxygen supply to the cells gets reduced. Even the ability of the hemoglobin to move the oxygen lowers down. All these delay the wound healing, process.

Smoking which reduces the blood flow results in the loss of skin during the process of healing. Because smoking delays wound healing it causes death to the skin leaving bad and ugly scars. Smoking also increases the risk of coughing after the surgery. This may lead to unwanted bleeding.

It is important to understand the smoking affects the healing of bones. Bones are nourished by blood much like other organs and tissues in your body. Nutrients, minerals, and oxygen are all supplied to the bones via the blood stream. Smoking elevates the levels of nicotine in your blood and this causes the blood vessels to constrict. Because of the constriction of the vessels, decreased levels of nutrients are supplied to the bones. This in turn inhibits bone healing after surgery for fractures.

General anesthesia and surgery can cause stress. During surgery there is a possibility that the patient may experience pain. Changes may take place in his/her blood pressure. The patient may also suffer from loss of blood and other unfortunate events during surgery. Smoking should be avoided before surgery because smoking, apart from causing stress can compound the above problems too.

I have read and understand the effects and risks of smoking before and after surgery.

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Patient Signature

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Date

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**ELECTRONIC COMMUNICATION CONSENT FORM**

**Texting Consent:**

As part of our practice's communications with you, we can send you SMS (text) Messages directly to your phone.

- I **consent** and accept to receiving text **messages**. I understand I can withdraw my consent at any time. Please provide your cellular number: \_\_\_\_\_
  - I do not consent to receiving any text messages.
- 

**Email Consent:**

The use of email is limited to setting up or canceling appointments and for sending appointment reminders. Due to security, details of one's case cannot be discussed via email. Email may also not be used as a means of providing services. You also agree not to use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as our clinic cannot guarantee a rapid response via email.

By signing, you are also aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold our clinic or your service provider responsible for any breach of confidentiality that results from the use of the email addresses listed below.

- I **consent** and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.

Email: \_\_\_\_\_

- I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Print name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Patient Signature</b>
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