

**JOHANNES V. BLOM, MD**  
Board Certified Orthopedic Surgeon  
Adult Reconstructive Surgery & General Orthopedics

**PATIENT DEMOGRAPHIC INFORMATION**

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

Cell #: [ ] [ ] - \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Home #: [ ] [ ] \_\_\_\_\_  
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 \_\_\_\_\_ l \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_  
How did accident happen? \_\_\_\_\_  
Spouse/Parent Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: [ ] [ ] -

**INSURANCE INFORMATION**

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
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 #: [ ] [ ] -  
: \_\_\_\_\_



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<b>Have you had or presently have any of the following health problems?</b>			Height: _____ Weight: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> High cholesterol	Allergies: _____ _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatoid OA	<input type="checkbox"/> Migraine	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Gastritis	
<input type="checkbox"/> Asthma/ Bronchitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Prostatitis	
<input type="checkbox"/> Vascular problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Cancer	
<input type="checkbox"/> Gout	<input type="checkbox"/> Panic/ Anxiety	<input type="checkbox"/> Other (please specify)	
<input type="checkbox"/> Urination disturbance	<input type="checkbox"/> Nervous System Disorder		
<input type="checkbox"/> Psychological Disturbance	<input type="checkbox"/> HIV exposure		
<input type="checkbox"/> Swallowing difficulties	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Ulcers/ Stomach ulcers	<input type="checkbox"/> Depression		
<input type="checkbox"/> Broken Bones: _____			
<b>Do you have a pacemaker?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Can you take Aspirin?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<b>Medication:</b>	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

<b>Pharmacy Name:</b>	<b>Pharmacy Phone Number:</b>
_____	_____
_____	_____

<b>Surgeries:</b>	<b>Date:</b>	<b>Surgeons:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

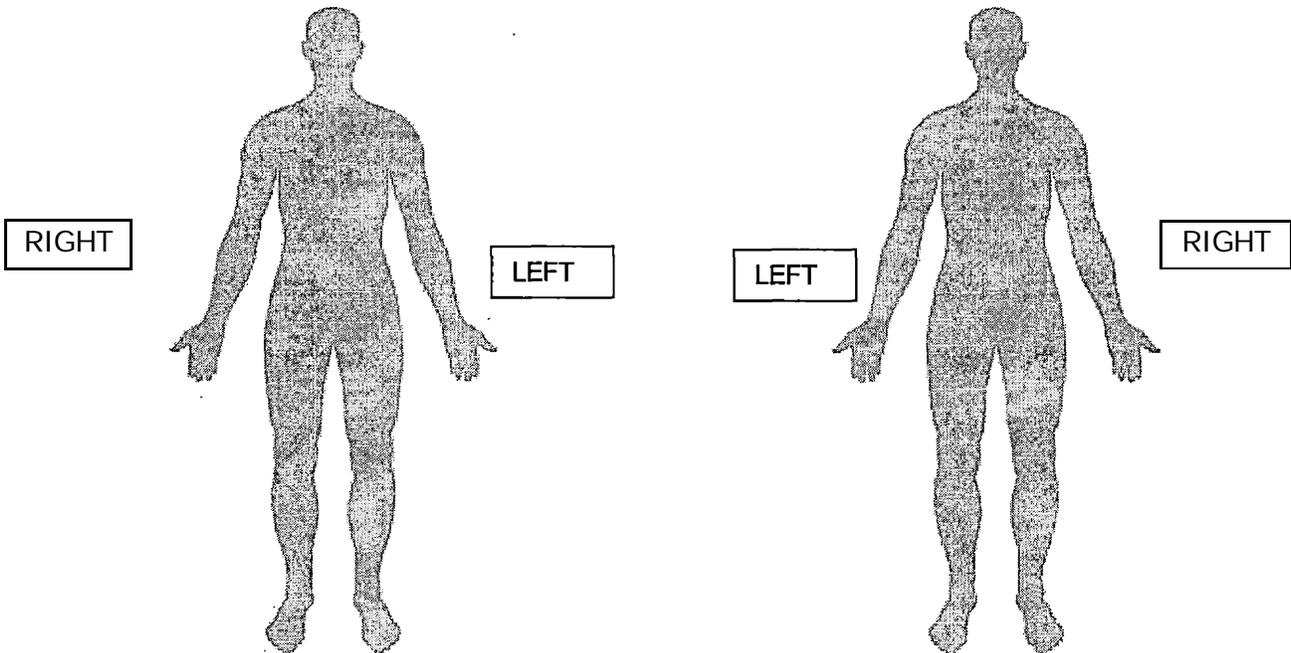


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- On the following diagrams, please show **where** you're experiencing **all** of your present complaints with the letter **X**:

**FRONT**

**BACK**



<b>Are you experiencing any of the following symptoms?</b>	
<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"/>
<b>Circle the severity of your pain:</b>	
(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 JOHANNES V. BLOM, MD, PA. 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

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

**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: \_\_\_\_\_ Date \_\_\_\_\_  
 (patient/parent/conservator/guardian)



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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 OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT OF RECEIPT**

By signing this form, you acknowledge receipt of the NOTICE OF PRIVACY PRACTICE OF JOHANNES V. BLOM, MD, PA. Our NOTICE OF PRIVACY PRACTICE provides information about how we may use and disclose your protected health information. We encourage you to read it in full

If you have any question about our Notice of Privacy Practices, please contact our Compliance Officer at:

3702 Washington Street, Suite 202  
 Hollywood, FL 33021  
 (954) 964-6114

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at the above address.

I acknowledge receipt on the Notice or Privacy Practices of Johannes V, Blom, MD, PA.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (Patient/parent/conservator/guardian)

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained:

Signature of provider representative: \_\_\_\_\_ Date \_\_\_\_\_

An acknowledgement was not obtained because:

- Patient refused to sign.
- Patient was unable to sign or initial because:  
 \_\_\_\_\_
- There was a medical emergency (the staff member will attempt to obtain acknowledgment at the next available opportunity).

Other reason(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Johannes V. Blom, MD

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### AUTHORIZATION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_, Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_,  
Authorize to release my medical records to:

To release to: \_\_\_\_\_  
Name of Hospital, Physician or Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Phone# Fax#

Any medical information concerning my treatment, including psychological, psychiatric, drug abuse, alcoholism, AIDS, Aids testing and care of hospitalization which may be in your care.

\_\_\_\_\_  
Date

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



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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: \_\_\_\_\_

**Patient Signature**