CENTRAL FLORIDA INJURY SOUTHWEST, INC.
882 S. Kirkman Rd., Ste. 101, Orlando, FL 32811
Phone: (407) 578-2350 Fax: (407)264-8300
Jerold Fadem Sr., M.D · Jerold Fadem Jr., M.D. · Ilka A. Fahey, M.D.

WELCOME TO OUR TREATMENT CENTER!

To help us provide you the best possible care, please fill out the following information.

Demographic Information:

Name: _____ DOB: _____ Gender: M or F

SSN: _____ How long have you lived in Florida? _____

Address: _____ Apt. Number: _____

City, State, Zip: _____

Home Phone: _____ Alternate Phone: _____

Employer: _____

Address: _____ City, State, Zip: _____

Email: _____

Accident Information:

Type of Accident (circle one): Auto Accident Slip & Fall W/C

Date of Accident: _____ Time of Accident: _____ AM PM

Location of Accident: _____

If Auto Accident: Were you the (circle one): Driver Passenger Seatbelt fastened? Yes ☐ No ☐

If Accident was a slip & fall or Worker's Comp, please describe: _____

_____

Auto Insurance:

Insurance Company Name: _____

Name of Insured: _____ Relationship to Patient: _____

Policy #: _____ Claim #: _____

Attorney Information:

Name of Firm: _____

Attorney's Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Medical Checklist:

Please list following:

Allergies to Medications: _____

Current Medications: _____

Previous Surgeries: _____

All medical conditions: _____

Previous orthopedic treatment: _____

Previous chiropractic treatment: _____

Primary Care Physician: _____ Phone: _____

When did you have your last medical check-up? _____

Do you…

Smoke tobacco? Yes ☐ No ☐ Drink alcohol excessively? Yes ☐ No ☐ Do illicit drugs? Yes ☐ No ☐

Have a family history of Diabetes or High Blood Pressure? Yes ☐ No ☐ If so, who? _____

Is it possible you could be pregnant? Yes ☐ No ☐

Additional Accident Information:

Describe the accident: _____

_____

_____

Was an accident report filled out? Yes ☐ No ☐

Make/model of vehicle you were occupying: _____

If you were the passenger, where were you sitting in the vehicle? _____

Was another vehicle involved? Yes ☐ No ☐ Make/model of other vehicle: _____

What speed was your vehicle traveling? _____ Were you accelerating? Yes ☐ No ☐

What was your vehicle doing immediately prior to impact? (i.e. changing lanes, stopped at a stop sign, turning at an intersection, etc.) _____

What was your vehicle's point of impact? (i.e. front/rear bumper, front fender, etc.) _____

What was the amount of damage to your vehicle? _____

Does your car have airbags? Yes ☐ No ☐ Did the airbags deploy? Yes ☐ No ☐

Did any part of your body strike any part of your vehicle due to the impact? Yes ☐ No ☐

Additional Accident Information (cont'd):

Describe your injuries: _____

_____

_____

Did you receive emergency care at the scene? Yes ☐ No ☐ If no, did you go to the hospital? Yes ☐ No ☐

If so, how did you get there? _____

Name of Hospital: _____

Did you have…

X-rays? Yes ☐ No ☐ CT scans? Yes ☐ No ☐ MRIs? Yes ☐ No ☐

Any other treatment? Yes ☐ No ☐ If yes, please explain: _____

Were you given any medications? Yes ☐ No ☐ If yes, which ones: _____

Did you miss any work? Yes ☐ No ☐ If yes, give dates: _____

If you did not go to the hospital, where did you go immediately after the accident? _____

Who referred you to our office?/ How did you hear of our office? _____

_____

May we thank them for referring you? Y N May we send a copy of your initial evaluation? Y N

I HEREBY STATE THAT THE INFORMATION PROVIDED IS TRUE TO THE BEST OF MY KNOWLEDGE.

Printed Name: _____ Date: _____

Signature: _____

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PATIENT HISTORY QUESTIONNAIRE

Name _____ Date _____
History reviewed by _____M.D. Date _____

REVIEW OF SYSTEMS:
If you are **currently** having any problems in the following areas, please check.

○ Fevers/Nightsweats	○ Frequent headaches	○ Nausea/Vomiting	○ Rashes
○ Shaking Chills	○ Cough	○ Stomach pain	○ Anxiety
○ Recent weight loss	○ Shortness of breath	○ Blood in stool	○ Depression
○ Bleeding gums	○ Coughing up blood	○ Loose stools	○ Calf cramps
○ Frequent nosebleeds	○ Hoarseness	○ Loss of appetite	○ Joint pain/swelling
○ Visual problems	○ Chest pain	○ Difficulty urinating	○ Neck pain/stiffness
○ Hearing problems	○ Abnormal heartbeat	○ Burning on urination	○ Back pain/stiffness
○ Dizziness/Fainting	○ Ankle swelling	○ Blood in urine	○ Arm or leg weakness
○ Loss of consciousness	○ Leg pain	○ Incontinence	○ Numbness/tingling

Please use box below for other conditions not listed or additional comments

Patient's Signature _____ Date _____

Established patients ONLY – If it has been more than 6 weeks since you have seen the doctor have there been ANY changes in your health or the above?

○ **No, there has NOT been any change in my health.**

○ **YES, there has been a change in my health. Please explain below:**

_____
_____
_____
_____

Patient's Signature_____Date_____

ACKNOWLEDGEMENT OF LIABILITY
ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, hereby acknowledges personal responsibility and liability for all the medical services which are provided by Central Florida Injury Southwest, Inc. This personal obligation is not affected by any obligation of insurance companies to pay health care costs. If an insurance company pays, the payment(s) shall be credited to your account. If no insurance payment is received, you are completely responsible to pay for all medical treatments. In addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, the undersigned hereby assigns to the physician or facility named above the following rights, power, and authority.

CONSENT FOR TREATMENT: The undersigned hereby consents to provision of examination, fitness evaluations, treatment, therapies, medical and laboratory procedures, and drugs and supplies to the patient as ordered by the patient's healthcare provider Central Florida Injury, their physicians, nurse practitioners, physical therapist, certified athletic trainers or staff and acknowledges that no guarantee or assurance has been made to the results of such treatments, procedures or examinations.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the Physician and or Facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable rights. Any cause of action that exists in my favor against any insurance company or other person or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company or other person or entity. I, as the patient and or responsible party further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy and my information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: As to any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility names above, you are hereby tendered the right to demand payment in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patient(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a secured interest (lien) against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician facility named above power of attorney to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered by physician facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of patient and/or responsible party:

Patient Signature: _____ Date: _____

Print Name: _____ Date of Accident: _____

Relationship to Patient: _____

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AUTHORIZATION FOR MEDICAL INFORMATION (HIPAA compliant)

I,_____, hereby authorize use or disclosure of protect health information about me as described below.

The following specific person, class of persons or facility is authorized to make the requested disclosure: _____

_____

_____

Please release information to CENTRAL FLORIDA INJURY SOUTHWEST, INC: 882 S. Kirkman Rd., Ste. 101, Orlando, FL 32811:

1. The specific information to be disclosed is:

   Full and complete medical records and reports concerning the undersigned's medical or physical condition. This authorization includes but is not limited to reports, x-rays, diagnostics, laboratory reports, in-patient records, out-patient records emergency records.

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

3. I may revoke this authorization by notifying the above named recipient in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

4. This authorization expires on year from the date of execution and a photocopy of this authorization shall be valid as the original.

_____ _____

Patient Signature Representative Capacity, if applicable

_____ _____

Print Name Date of Authorization

_____ _____

Date of Birth (optional) Social Security Number

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Authorization of Signature

I, _____, hereby authorize Central Florida Injury to affix my signature for endorsement of checks made payable to me and Central Florida Injury for medical payment.

Patient Signature: _____ Date: _____

Printed Name: _____

Authorization of Signature

To Whom It May Concern:
This authorizes Central Florida Injury & Rehabilitation Centers, of their agent/designee to sign and or submit health claim forms to the no-fault insurance carrier, health insurance carrier, supplemental insurance carrier, Medicare or any supplemental form of health insurance that I have. Please accept this as your authorization to accept this signature as if I signed the claim forms individually.
A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Patient Signature: _____ Date: _____

Printed Name: _____

Insurance Release Authorization

I, _____, hereby authorize Central Florida Injury to obtain any and all insurance information needed for verification purposes. This includes deductible amounts, med-pay limits and any other information deemed necessary by Central Florida Injury for medical billing purposes.

Patient Signature: _____ Date: _____

Printed Name: _____

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Patient Consent to X-ray

I, _____, authorize the performance of diagnostic x-ray examination of myself which the above doctor or his/her associates may consider necessary or advisable in the course of my examination and treatment.

Patient Signature: _____ Date: _____

Consent to X-ray a Minor Child

I, _____, authorize the performance of diagnostic x-ray examination of myself which the above doctor or his/her associates may consider necessary or advisable in the course of my examination and treatment. The patient is a minor, ___ years of age.

Patient Signature: _____ Date: _____

Verification of NOT Pregnant

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor or his/her associates have my permission to perform diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of Last Menstrual Period: _____

Patient Signature: _____ Date: _____