AVI JADHAV MD, FAAOS, FRCS, MCh

Board Certified, Fellowship Trained Orthopedic Surgeon
Joint Replacements, Trauma and Pediatric Orthopedics
17222 Hosp Blvd, Ste 322, Brooksville FL 34601

NEW PATIENT FORM

Date___/_____/2024

Thank you for choosing us for your health care needs. In order to provide you the outstanding medical care that you deserve **fill this form completely and accurately; BOTH PAGES - FRONT AND BACK; and sign and date it.** **THIS IS A LEGAL REQUIREMENT WITHOUT WHICH WE CANNOT PROVIDE YOU CARE. Thank You.**

Where did you hear about us? ☐my PCP ☐Emergency room ☐Google ☐Hernando Sun ☐Friend/family ☐5&Dine

First Name _____Last Name _____ ***(Attach front and back of drivers license)***

Date of Birth(DOB)_____ SS#:_____Gender: ☐M ☐F, Race: _____

Home Phone _____ Cell Phone _____ Work Phone_____

Email Address: _____ Height_____Weight_____lbs

Primary Address:

Street _____City _____State _____Zip_____

Secondary Address (If applicable):

Street _____City _____State _____Zip_____

EMPLOYMENT: Job Title: _____Employer:_____

Phone_____ Fax:_____ Address _____

Emergency Contact Name: Relationship: Phone:

INSURANCE INFORMATION: ***(Attach copies of front and back of all your insurance and pharmacy cards)***

Your Current	Primary Insurance	Secondary Insurance
Insurance name:		
Plan name:		
Policy or ID#:		
Group #:		
Is it HMO or PPO?:		
Subscriber: Write 'me' if its you		
Your CoPay for this visit:		
Your Outstanding Deductible:		

If Patient is a minor: Legal Guardian Name & Relation_____

Address: Phone:

PHARMACY Name_____ Phone #: _____

Address: Fax#

PRIMARY CARE PHYSICIAN: Name_____ Phone # _____

Address _____Fax #_____Last seen date_____

List other medical providers involved in your care: (for example.: Cardiologist, Neurologist, Pain Dr, Vascular Dr)

Name _____Specialty_____Phone_____Fax _____

PLEASE TURN THE PAGE OVER, FILL FORM CONTINUED ON BACK SIDE AND SIGN

CONSENTS, AGREEMENTS, ACKNOWLEDGEMENTS, AUTHORIZATIONS, ASSIGNMENTS

By signing below, I, the undersigned,

1. voluntarily authorize and give consent to Dr. Avinash Jadhav and his staff:
    a. to provide and perform such medical procedure(s) and/or services as deemed advisable and necessary for the diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me regarding result of my treatment or examination.
    b. to release or request my personal and medical records to or from any medical provider for continuity of medical care or authorization of required services
    c. to release to any third party any information needed for collection of charges incurred. I request and authorize that payments from insurance, payments of benefits and any payments related to crossover medigap insurers be made on my behalf directly to Orthopedic Specialist MD.
    d. to communicate with me by mail, email, phone, or text messages, and leave detailed voicemail regarding my medical information if I am not available to pick up the phone.
    e. to disclose my Protected Health information (PHI) to individuals listed below. I understand that I am not required to list anyone, and I can change this list at any time by submitting the request to this office in writing.

    *Name*_____*Relationship* _____ *Phone Number* _____ *Email*_____
2. agree to following NARCOTIC AGREEMENT which states that if I am prescribed narcotic pain medications by this facility, I agree:
    a. not to increase the dosage or frequency to take the medication without getting prior approval from my physician.
    b. I will not receive any other controlled substance (potentially addicting or sedating medication) at the same time. If this is offered by another doctor, I am obligated to inform to, this and the other physician, of all the drugs I am currently taking.
    c. that there will be no early refills. If medications are stolen, I will complete a police report, and provide copy to this office.
    d. that if I show signs/symptoms of substance abuse I will be immediately referred to pain management /addiction specialist.
    e. that if I violate this agreement, my care by this facility will be immediately terminated with subject to clause 9.
3. agree to following FINANCIAL AGREEMENT which states that:
    a. It is my responsibility to provide a proof of my valid current health insurance coverage and confirm that this office participates with my specific insurance plan for each and every service that I receive. If I am not insured by a plan that this office participates with, or if my insurance benefits are not valid or current or cover any service that I receive; I understand that I will be billed at the 'self pay rate' and NOT any 'contracted insurance rate which may be subsidized', and agree to pay the entire cost of the services immediately. I understand and agree that this payment will be non-refundable even if I obtain retroactive insurance at a later date. If I am unable to make the full payment, then this office will have no obligation to provide me any further services and it will be entirely my responsibility alone to immediately find another provider to continue my remaining health care. In such instance, my responsibility to make 'due payments' for services received is not released and this office may engage any third party to collect the payments due.
    b. Copays, deductibles and co-insurance are part of my contractual agreement with my insurance company and these payments are due at the time of the service received. I will pay any balance received in the billing statement or Explanation of Benefits immediately upon receipt of that statement. After the visit no payment can be refunded irrespective of the outcome of the visit.
    c. It is MY RESPONSIBILITY to know which services are covered by my insurance and if I receive non-covered services, I will make full payment for these services when the services are rendered. I understand that THERE ARE NO GUARANTEES, i.e. the doctor may not be able to help my problem as per my expectation or the treatment may not be successful. However, after the visit, FULL PAYMENT OF ALL THE SERVICES RENDERED IS DUE IMMEDIATELY AND NO PART OF PAYMENT IS REFUNDABLE irrespective of the result of the visit or treatment.
    d. I agree to pay fee of $25 to $100 for completing any forms by the doctor (as insurance doesn't pay for this service), and $35 for every returned check or/and each appointment cancelled without notification 3 full business days prior to the appointment.
    e. I understand that ultimately, I am financially responsible for all charges regardless of my insurance coverage and in the event of default, I agree to pay all costs of collections and reasonable attorney's fees.
    f. I certify that the information I have reported regarding my insurance coverage is correct.
    g. I accept that if I am unable to pay my outstanding bill, this office has right to refuse services effective immediately after which I would be solely responsible for all consequences and for continuing my health care elsewhere.
4. agree to inform this office of any changes to my health status as well as health insurance coverage as soon as they occur.
5. understand and agree that this office can provide care only for my Orthopedic problems of extremities related to chief complaint in today's encounter and it is my sole responsibility to obtain care from other health care provider for all other health problems and any problems that this office cannot provide care of. Particularly, it is my responsibility to obtain Home Health care, Physical Therapy, Braces, Imaging, labs, EMG-NCV studies, medications, pain management, approvals and authorizations from PCP and /or insurance etc. when required for my treatment, without which optimal outcome cannot be achieved.
6. agree that my care at this office will be ***'by appointment ONLY'*** and when this facility is closed or this provider is not available, it will be my sole responsibility to find another provider and/or facility to get necessary treatment including that for emergencies.
7. agree to comply with all instructions (including showing up for all appointments) given by this office regarding my treatment.
8. understand and accept that if I cannot speak English competently as deemed necessary by the provider, it is my responsibility to provide adequately competent interpreter, failing which this office may deny services to me.
9. understand and accept without any reservations that this office may terminate my care for any cause, including but not restricted to failure to comply (clause 2, 7, 8) and failure to pay for the services, as deemed appropriate by this office unilaterally, effective immediately after which I alone will be solely responsible to immediately find another provider to continue my remaining health care. In such circumstances I release Dr Jadhav and his company of ALL LIABILITY related to my healthcare effective immediately.
10. acknowledge that a copy of the Notice of Privacy Practices and the Florida Patient Bill of Rights has been provided to me. I understand and agree that this practice may use and disclose my health information as described in a Notice of Privacy Practices; and this practice reserves the right to make changes to their Privacy Notice copies of which will be available on request.
11. permit a copy, in electronic or paper format, of these consents, agreements, acknowledgements, authorizations and assignments, to be used in place of the original.
12. agree that all above consents, agreements, acknowledgements, authorizations and assignments will remain in effect until revoked by me in writing and submitted to this office.

X _____ _____ **/ ____/2024**

Name and Signature of Patient/Parent of Minor/Legal Representative **Date of Birth** **Today's Date**

Patient Name: **Date of Birth:**

HISTORY FORM: ***Answer questions below by Checking ALL that applies AND writing ALL details.***

Is anyone with you today? ☐No ☐Yes. ●Name:_____ ●Relation: _____

Are you currently ☐Retired___yrs ago ☐Disabled ☐unemployed ☐Working ☐can't work due to current pain ☐Student

What is /was your Occupation?_____●How long you did it? _____

List your hobbies/sports you enjoy: _____

Which is your Dominant Hand? ☐Right ☐Left

Where is your pain? _____●Left or Right?_____●Did you have injury? ☐Yes ☐No

Is your injury or Pain related to: ☐Accident ☐employment ☐NONE ●Do you have a lawsuit: ☐Yes ☐No

Give approximate Start of pain / date of injury: _____

How did the pain Start/injury occur? _____

How severe is the pain on a scale of 1 to 10, with 10 being the most severe? _____

What makes the pain worse?: ☐activity using painful part ☐weight Bearing ☐Walking ☐Working ☐Other_____

What makes the pain better?: ☐Rest ☐Non-weight Bearing ☐Elevation ☐Ice ☐Heat ☐Medication_____

Do you have: ☐Popping ☐clicking ☐numbness ☐Tingling ☐Weakness ☐Stiffness ☐Walking Difficulty ☐Other____

Which activities you cannot do due to your pain? _____

What investigations you had so far? ☐Nothing ☐XRay ☐MRI ☐CT scan ☐Ultrasound ☐EMG-NCV ☐Labs____

Have you received any **TREATMENT SO FAR**? ☐No ☐Yes: **If yes**: ●What date? _____

●Where? ☐Emergency Room ☐PCP ☐Urgent Care ☐Other Specialist (Name:_____

●What? ☐Medication (Name:____ _____●Did it help? ☐Yes ☐No ☐Partially

☐Injection in Joint (Name:_____ _____●Did it help? ☐Yes ☐No ☐Partially

☐PT_____mths, ●When? _____☐ Splint / Brace

☐Surgery _____●When, Where? _____

List your current prescription MEDICATIONS (with dose & frequency): ***OR attach list of medications you take***

Name of the Medicine	*Problem for which you take this medicine*	*Dose (mg)*	*Frequency*
Blood Thinner:			
Narcotic:			
Other:			

List your 'Over The Counter' medications and supplements: _____

_____

List ALLERGIES to medications if any and briefly describe the allergic reaction (example: itching, nausea, fainting etc)

PAST MEDICAL/FAMILY HISTORY: Please check below (all that applies) if you / your family member has /had

	You	Mom	Dad	Sibling		You	Mom	Dad	Sibling
1. Osteoarthritis	☐	☐	☐	☐	2. Diabetes	☐	☐	☐	☐
3. Broken Bone (Fracture)	☐	☐	☐	☐	4. High blood pressure	☐	☐	☐	☐
5. Rheumatoid arthritis	☐	☐	☐	☐	6. Heart Attack/disease	☐	☐	☐	☐
7. Osteoporosis	☐	☐	☐	☐	8. Stroke/ Brain disease	☐	☐	☐	☐
9. Other Bone/Joint disease	☐	☐	☐	☐	10. Lung disease	☐	☐	☐	☐
11. Bleeding problem	☐	☐	☐	☐	12. Liver Disease	☐	☐	☐	☐
13. Vascular disease	☐	☐	☐	☐	14. Gastrointestinal Disease	☐	☐	☐	☐
15. Nerve injury/disease	☐	☐	☐	☐	16. Kidney Disease	☐	☐	☐	☐
17. Muscle disease	☐	☐	☐	☐	18. Urinary Infection	☐	☐	☐	☐
19. Cancer	☐	☐	☐	☐	20. Endocrine Disease	☐	☐	☐	☐
21. Back or Neck Pain	☐	☐	☐	☐	22. Autoimmune Disease	☐	☐	☐	☐
23. Blood clot in lungs/veins	☐	☐	☐	☐	24. Dental caries	☐	☐	☐	☐
25. Other_____	☐	☐	☐	☐	26. MRSA infection	☐	☐	☐	☐

Give details of anything that you have checked above with corresponding #

_____

_____

_____

PAST SURGICAL HISTORY: Please List all surgical procedures you had starting with most recent:

Date ***Surgery*** ***Surgeon*** ***Hospital, City, State, Phone #, Fax #***

_____

_____

_____

_____

SOCIAL HISTORY & HABITS:

Marital Status	*Use of Alcohol*	*Use of Tobacco*	*Living Situation*
❑ Single	❑ Never	❑ Never	❑ With family (Specify:_____
❑ Married	❑ Rarely	❑ Previously, quit on_____	❑ With friends (Name:_____
❑ Divorced	❑ Moderate	❑ Current: _____ packs a day	❑ Alone
❑ Widow	❑ Daily		❑ Other (Specify:_____

Illicit Drug use: ☐ No ☐ **Yes:** Give Details: _____

REVIEW OF SYSTEMS: Check the boxes opposite any symptoms below you have ***at present***. (Check all that applies)

☐ Eye discharge	☐ Ear pain	☐ Breathing difficulty	☐ Chest pain	☐ Heart burn
☐ Skin Rash	☐ Bleeding tendency	☐ Burning urination	☐ Constipation	☐ Diarrhoea
☐ Anxiety	☐ Depression	☐ Excessive Thirst	☐ Numbness	☐ Weakness

☐ Anything else:_____

I confirm that I have answered all the questions on this form correctly and completely. I understand that providing incorrect or incomplete information can be dangerous to my health and detrimental to my treatment. I understand that it is my responsibility to inform the doctor of any changes to my medical status and I agree to do so promptly. If I fail to do so, I will be solely responsible for all consequences and release Dr Jadhav and his company of ALL LIABILITY related to it.

X _____ _____/_____/**2024**

Name and Signature of Patient/Parent of Minor/Legal Representative **Date of Birth** **Today's Date**

PLEASE TURN THE PAGE OVER, FILL FORM CONTINUED ON BACK SIDE AND SIGN