

Integrity Medical Group, LLC

S&F

Confidential Patient Case History

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take the time and answer each question as completely as possible. Please sign each page.

Patient Information

TODAY'S DATE: ____/____/____ MALE / FEMALE AGE: _____

FIRST NAME: _____ MI _____ LAST NAME: _____

DOB: ____/____/____ SOC.SEC# ____/____/____ MARITAL STATUS: Married/Single/Divorced/Widow

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ NUMBER OF CHILDREN: _____

OCCUPATION: _____ EMPLOYER: _____ WORK#: (____) _____

EMERGENCY CONTACT: _____ PHONE#: (____) _____

HOW ARE YOU RELATED TO THIS PERSON? _____

FAMILY PHYSICIAN: _____ PHONE#: (____) _____

Insurance Information:

HEALTH INSURANCE COMPANY: _____

Subscriber #: _____ Group # _____

SECONDARY INSURANCE: _____

Subscriber #: _____ Name of the insured: _____

Policy #: _____ Group #: _____

ARE YOU BEING REPRESENTED BY AN ATTORNEY? YES / NO

Name of Attorney _____ Phone #: _____

Attorney's Address: _____

SIGNATURE: _____ **DATE:** _____

OVIEDO

40 Alexandria Blvd; Suite 1030 Oviedo FL 32765
Phone: 321.765.4373 Fax: 407.542.0666

KISSIMMEE

206 w. Oak St. Ste. B, Kissimmee, FL 34741
Phone: 407-930-0838 Fax: 407-930-0841

Integrity Medical Group, LLC

HEALTH INFORMATION

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?
(IN ORDER OF IMPORTANCE WITH 1 BEING MOST IMPORTANT)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

How long have you had this condition (s)? _____ Have you had this condition in the past? Y / N

Is this condition getting progressively worse? YES [] NO [] CONSTANT [] COMES AND GOES []

Is this condition interfering with your: WORK [] SLEEP [] DAILY ROUTINE [] OTHER: _____

Date of last physical examination _____

Height: _____ Weight: _____ Marital Status: _____ Children: _____

Occupation: _____

Have you had any surgical operations in the past? Y / N EXPLAIN _____

Are you allergic to any medications? Y / N List if any: _____

List any medication currently being taken:

Have you been in an auto accident before? YES / NO WHEN? _____

DESCRIBE: _____

Have you had any other personal injury or accident? YES / NO WHEN? _____

DESCRIBE: _____

Are you pregnant? YES / NO / POSSIBLY TOBACCO: YES / NO ALCOHOL: YES / NO

***PLEASE INDICATE WHICH OF THE FOLLOWING CONDITIONS APPLY TO YOU OR YOUR FAMILY MEDICAL HISTORY**

YOU	FAMILY	CONDITION	YOU	FAMILY	CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Implants
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Circulatory Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders	<input type="checkbox"/>	<input type="checkbox"/>	HIV Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Urinary Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Lung/Respiratory Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Nerve Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disorders

SIGNATURE: _____ DATE: _____

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Current Condition:

List treatments you have had for this problem and all health professionals that you are currently seeing:

<u>PHYSICIANS</u>	<u>SPECIALTY</u>	<u>TREATMENT & DURATION</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

BRIEFLY DESCRIBE THE INCIDENT:

Destination after the accident/ injury:

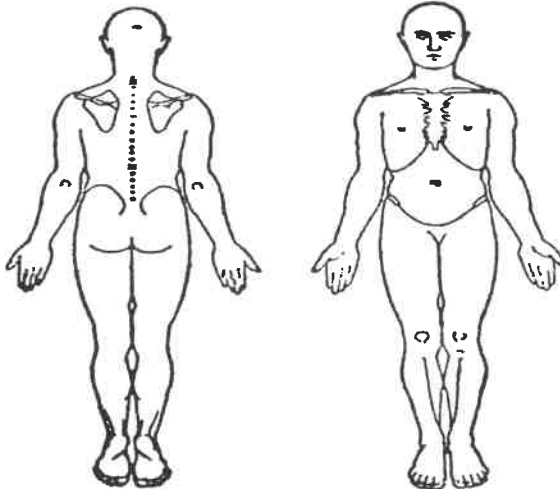
When did you go to the hospital? _____ Hospital name: _____

Who drove you to the hospital? _____ Were you admitted? _____

Date discharged: _____ Were X-rays taken? _____

Has a doctor or dentist ever diagnosed a TMJ disorder prior to the accident? _____

Please mark your areas of pain on the figures below:



Signature: _____ Date: _____

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_____ I authorize the release of a full report of examination findings, diagnosis, treatment program, etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for the treatment rendered to me regardless of insurance coverage.

_____ I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that **Integrity Medical Group, LLC** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Integrity Medical Group, LLC** will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize _____ **Integrity Medical Group, LLC** to release a copy of my patient records or x-rays containing protected health information to **my insurance company and/or attorney representing me in this case**. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057 (12) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient's or Patient's Legal Representative's Signature

Patient's Date of Birth

Date Signed

Specific description of information to be disclosed:

Signature: _____

Date: _____

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Attorney: _____

Name: _____
DOB: _____
SS#: _____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or result of the injuries for which I have been treated for injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that which I may eventually recover said fee.

Patient Signature: _____ **Date:** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately to protect the said doctor named above.

Attorney Signature: _____ **Date:** _____

**Attorney: Please date, sign and return one copy to doctor's office at once.
Keep one copy for record.**

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POWER OF ATTORNEY TO ENDORSE CHECKS

KNOW ALL MEN BY THESE PRESENT: That the undersigned has made constituted and appointed, and by these presents does hereby make, constitute and appoint the ***Integrity Medical Group, LLC*** any and all of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or is the undersigned and the said ***Integrity Medical Group, LLC*** which checks, drafts, or money orders are to pay for the services of the like which have been made by _____ (Ins. Co.) at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does give and grant unto the said ***Integrity Medical Group, LLC*** as attorney the full power and authority to do and perform all and every act and thing what so ever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present in so far as the endorsing and cashing of said checks are concerned.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which they said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, thus

_____ Day of _____, _____
(Day) (Month) (Year)

PATIENT/PARENT GUARDIAN SIGNATURE: _____

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Don Behrmann, M.D., PhD
Paul Shuler, M.D.
Thomas Cooper, M.D.
Tom Koehne, P.A.
Jacob Phillips, P.A.
Rafael Romero, P.A.

INITIATION OF TREATMENT

To Whom It May Concern:

This is to inform you that I was injured ___/___/___ Slip & Fall or Personal Injury incident. I intend to initiate treatment as outlined by the doctors at *Integrity Medical Group, LLC*

CONSENT FOR TREATMENT

I hereby authorize *Integrity Medical Group, LLC* and whomever the doctor may designate as his assistant to perform examination, physiotherapy, physical therapy and perform non-invasive diagnostic tests and, if any unforeseen condition arises in the course of the procedures calling for judgment, procedures in addition to or different from those non complicated. I further request and authorize this office to perform whatever my treating doctor deems advisable. The nature and purpose of these procedures have risks involved and the possibility of complications has been fully explained to me. I acknowledge that no guarantee has been made to me as the result that may be obtained.

SIGNATURE: _____ **Date:** _____

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