

**TOTAL ORTHOPAEDIC CARE MEDICAL INFO SHEET**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

JOB DESCRIPTION \_\_\_\_\_ Name and Phone Number of Pharmacy: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ RIGHT-HANDED \_\_\_\_\_ LEFT-HANDED \_\_\_\_\_

WHO IS YOUR MEDICAL DOCTOR? \_\_\_\_\_

WHY ARE YOU SEEING THE DOCTOR TODAY? \_\_\_\_\_

WAS THIS CAUSED BY AN INJURY? Y N IF YES, DATE OF INJURY? \_\_\_\_\_

HOW DID THE INJURY OCCUR? \_\_\_\_\_

IS YOUR INJURY WORK RELATED? Y N Intake Coordinator Initials: \_\_\_\_\_

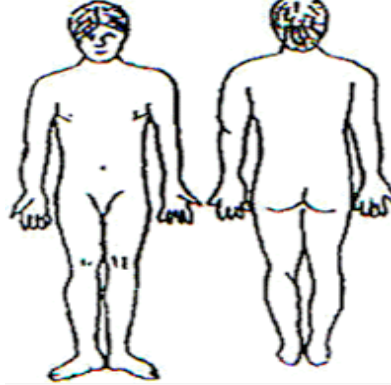
HAVE YOU EVER HAD PAIN/DISCOMFORT/OR SIMILAR SYMPTON IN THIS AREA PRIOR TO THIS VISIT? Y N

EXPLAIN: \_\_\_\_\_

WHAT MEDICATIONS DO YOU TAKE DAILY?	
Name of Medication	Reason for Medication

Do you Coumadin/ Plavix / Lovenox or other blood thinners? Y N Y N

**MARK PROBLEM AREAS**  
RIGHT LEFT LEFT RIGHT



ARE YOU ALLERGIC TO ANY OF THESE? (circle all that apply)

ANTI-INFLAMMATORY      ASPIRIN      PENICILLIN  
 DYES      LATEX  
 OTHER \_\_\_\_\_

DO YOU NOW, OR HAVE YOU HAD IN THE PAST ANY OF THE FOLLOWING: (circle all that apply)

ARTHRITIS	HEART DISEASE	INFLAM BOWEL DISEASE	STROKE
BLEEDING DISORDER	HEPATITIS	LUNG DISEASE	THYROID DISEASE
BLOOD CLOTS	HIV	NEUROLOGICAL DISORDER	URINARY DISEASE
CANCER	HIATAL HERNIA	OSTEOPOROSIS	TB
CHOLESTEROL	HIGH BLOOD PRESSURE	REFLUX DISEASE	
DIABETES		STOMACH/INTESTINAL ULCERS	
EPILEPSY	NONE OF THE ABOVE	OTHER _____	

PAST SURGICAL HISTORY (please circle all that apply)

CANCER	HAND	PACEMAKER
CATARACTS	HEART	TUBES (EARS)
GALLBLADDER	JOINT REPLACEMENT	OTHER _____
GYNECOLOGICAL	NECK/SPINE	NONE OF THE ABOVE

ANY ANESTHESIA PROBLEMS? (please explain) \_\_\_\_\_

WERE YOU EVER HOSPITALIZED FOR A PROBLEM OTHER THAN LISTED ABOVE? Y N

IF YES, PLEASE EXPLAIN: \_\_\_\_\_

MEMBER	FAMILY		HISTORY	
	ALIVE	DECEASED	AGE	IF DECEASED, CAUSE OF DEATH
FATHER	A	D		
MOTHER	A	D		
SIBLING(S)	A	D		

PLEASE CONTINUE TO PAGE 2

PATIENT: \_\_\_\_\_

DATE: \_\_\_\_\_

**COULD YOU POSSIBLY BE PREGNANT? Y N**

DATE OF LAST MENSTRUAL PERIOD \_\_\_\_\_

DO YOU SMOKE CIGARETTES? Y N IF YES, HOW MANY PACKS/DAY \_\_\_\_\_

DO YOU DRINK ALCOHOL? Y N HOW MANY DRINKS DAY? \_\_\_\_\_

ANY HISTORY OF DRUG ABUSE? Y N

IF YOUR INJURY OCCURRED IN A MOTOR VEHICLE ACCIDENT, WERE YOU THE (please circle)

DRIVER? PASSENGER FRONT SEAT? PASSENGER BACK SEAT? PEDESTRIAN?

IMPACT DIRECTION? FRONT END REAR END PASSENGER SIDE DRIVER SIDE

WERE YOU WEARING A SEAT BELT? Y N

DID YOU HIT YOUR HEAD ON THE: DASHBOARD? WINDSHIELD?

DID YOU HIT THE STEERING WHEEL? Y N

DID YOU LOSE CONSCIOUSNESS? Y N

DID THE AIRBAG DEPLOY? Y N

PLEASE LIST ANY OTHER AREAS OF IMPACT ON YOUR BODY: \_\_\_\_\_

DO YOU HAVE AN ATTORNEY AS A RESULT OF THIS INJURY? Y N

NAME OF ATTORNEY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

PHONE: \_\_\_\_\_

\_\_\_\_\_

WHAT LANGUAGES DO YOU SPEAK? \_\_\_\_\_

I HEREBY CONSENT TO AND AUTHORIZE A PHYSICIAN AND/OR ANY HEALTH CARE PROFESSIONAL AT TOTAL ORTHOPAEDIC CARE (T.O.C.) TO PERFORM A PHYSICAL EXAMINATION, DIAGNOSTIC PROCEDURE(S) AND TO PRESCRIBE A THERAPEUTIC REGIMEN. I HEREBY AUTHORIZE THE PHYSICIANS OF T.O.C. TO RELEASE/COLLECT INFORMATION INCLUDING DIAGNOSIS ACQUIRED IN THE COURSE OF MY EXAM TO/FROM ANY HEALTH CARE FACILITIES, PHYSICIANS, OR INSURANCE CARRIERS.

THE STAFF AT T.O.C. IS AUTHORIZED TO CALL ME AT ( ) \_\_\_\_\_ SHOULD THEY NEED TO CONTACT ME. IF YOU ARE NOT AVAILABLE WHEN WE CALL, MAY WE LEAVE A MESSAGE WITH WHOMEVER ANSWERS OR ON YOUR ANSWERING MACHINE? Y N

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

**Total Orthopaedic Care, P.A.**

Patient Last Name: \_\_\_\_\_ First: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Lang: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Martial Status: \_\_\_\_\_

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

Employment Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Preferred Dr: \_\_\_\_\_

Referred By: \_\_\_\_\_ Date First Seen: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Primary Insurance Holder: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Additional Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

**Consent for Treatment / Assignment of Benefits**

I hereby consent to and authorize a physician and/or any health care professional of T.O.C. to perform a physical examination, diagnostic procedure, and to prescribe a therapeutic regime. I hereby authorize the physicians of T.O.C. to release any information including diagnosis acquired in the course of my exam to any health care facilities, physicians, insurance carriers, or collection agencies.

By listing my email address above, I consent to receiving appointment reminders, newsletters, and other T.O.C. related information which will include my name, date, time, and location of my appointment and my physician's name.

I hereby authorize my insurance carrier to pay directly to T.O.C. the medical benefits otherwise payable to me for their services, but not exceed the charges of those services. I hereby irrevocably assign to T.O.C. any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida statues for any service and/or charges provided by T.O.C.

I further understand that I am fully responsible for services provided that are not covered by my insurance.

\_\_\_\_\_  
Patient/Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

*M.A. Hajianpour M.D. F.I.C.S.  
Michael Feanny M.D. FRCS (C)  
Babak Sheikh M.D.  
Mario Berkowitz M.D.*

# TOTAL ORTHOPAEDIC CARE

*Adult and Pediatrics  
Orthopaedics & Physical Therapy*

Dear Patient;

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one (1) insurance company or health care provider. Please sign this form, complete section one and fill in section two if applicable

In order to expedite your claim(s) processing, please complete the following information:

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
Insurance Company \_\_\_\_\_ ID Number \_\_\_\_\_  
Provider's Name \_\_\_\_\_ Date of Service \_\_\_\_\_

### Section One

Is the reason for the visit to your doctor due to either A or B?

- A) Medical Related Illness Yes \_\_\_\_\_ No \_\_\_\_\_  
B) Accident Related Injury Yes \_\_\_\_\_ No \_\_\_\_\_

If yes to B, please check one of these categories #1 and complete items 2 and 3

- 1) Auto \_\_\_\_\_ Home \_\_\_\_\_ School \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_  
(Specify Where) \_\_\_\_\_  
2) Date of Accident \_\_\_\_\_  
3) How did the accident happen ? \_\_\_\_\_

Was a third party responsible for you injury? \_\_\_\_\_ If so, provide the following:  
Name of individual or company : \_\_\_\_\_

Are you covered by any other insurance due to spouse, work, or alternative coverage?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide the following:

- 1) Name of insurance \_\_\_\_\_  
2) How are you covered? (aka: spouse) \_\_\_\_\_

Section Two (Information to be filled out only if auto Accident or related injury)

- 1) Were you in your own vehicle or someone else's \_\_\_\_\_  
2) Name of insurance company and telephone number \_\_\_\_\_  
3) Policy number \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Lauderdale Lakes**  
4850 W Oakland Park Blvd Suite 201  
Lauderdale Lakes FL 33313  
Main Office/Correspondence

**Pembroke Pines**  
10794 Pines Blvd. Suite 104  
Pembroke Pines FL 33026

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1951 S.W. 172 Ave Suite 115  
Miramar FL 3302



**Phone: 954-735-3535 Fax: 954-484-7000 Website: www.toc.md**

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Mario Berkowitz M.D.*

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*Adult and Pediatrics  
Orthopaedics & Physical Therapy*

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You must bring the following items to your scheduled appointment:

1. Your insurance card
2. Photo identification
3. Referral or authorization
4. Your copay will be collected prior to seeing the doctor
5. If you had any testing such as X-RAYS, MRI, Bone Scan, or CAT Scans, you must bring films/CD and reports.
6. Your pharmacy phone number
7. A list of your current medications
8. Patient Packet - You must print the 5 pages, fill them out, and bring them to your appointment
9. If you have any questions, call our office at 954-735-3535.

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