Dr. James Leiber, Dr. Michael Amoroso, Dr. Ron Torrance, & Dr. Ignatios Papas
2401 University Parkway Suite 104
Sarasota, FL 34243
Phone: 941-357-1773 Fax: 941-256-7452

8600 Hidden River Parkway Suite 700
Tampa, FL 33637
Phone: 813-544-3123 Fax: 941-256-7452

Dr. Evan Musman
20754 West Dixie Highway
Miami, FL 33180
Phone: 786-855-4800 Fax: 941-256-7452

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other________________
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE
LANGUAGE	ETHNICITY		RACE
EMAIL ADDRESS			

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

- **PRIMARY INSURANCE INFORMATION** *Please provide card at the time of your appointment*

PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
ID/MEMBER NUMBER	GROUP NUMBER	EMPLOYER	EMPLOYER PHONE

- **SECONDARY INSURANCE INFORMATION** *Please provide card at the time of your appointment*

SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER
PREFERRED PHARMACY	PHARMACY LOCATION	PHARMACY PHONE

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

RELEASE OF INFORMATION: I understand that my records are protected and cannot be disclosed without written permission. I understand that this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record

Signature of Patient or, if minor Signature of parent or guardian confirming all information is truth to the best of your knowledge, received PHI and signed consent

X

		Date:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

Authorization for Use or Disclosure of Protected Health Information (PHI)

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called **PHI, Protected Health Information**, under a federal health privacy law, as described below.

I, ________________________________, authorize Regenexx Tampa Bay and/or Regenexx Gold Coast Orthopedics to release and obtain my private health information to/from (check all that applies):

□ My spouse/partner	Name of spouse/partner: ________________________
□ My primary care physician/staff	Name of physician: ______________________________
□ My pharmacy	Name of pharmacy: _____________________________
□ My parent/child(ren)	Name(s): _____________________________________
□ My personal representative	Name of representative: ___________________________
□ Other	Name: _______________________________________

□ None of the above

May our office leave a message on your machine? □ Yes □ No

Are there any restrictions on PHI to be disclosed? □ Yes □ No

If yes, please describe:

____

____

____

____

The PHI will be disclosed to confirm appointments, to render to caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Regenexx Tampa Bay or Regenexx at Gold Coast Orthopedics. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention *Privacy Officer at 2401 University Parkway, Suite 104, Sarasota 34243*. I understand that my revocation will not affect any actions taken by prior to receiving my revocation. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use of disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective for 1 year from the date signed, at which time this authorization to obtain and release this protected health information expires.

____ ________________

Patient Signature or Authorized Representative Date

____

Patient Name Printed

Patient General Consent to Treatment

I, the undersigned hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medication
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize **Regenexx Tampa Bay and/or Regenexx Gold Coast Orthopedics** to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **Regenexx Tampa Bay and/or Regenexx Gold Coast Orthopedics.**

I acknowledge that I have been notified of Regenexx Tampa Bay and Regenexx Gold Coast Orthopedics Privacy Practices and understand that if I have a question or complain that I should contact the Privacy Official. **(Patient Initials**_____________).

I, the undersigned, authorize Regenexx Tampa Bay and/or Regenexx Gold Coast Orthopedics to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ____________________
Patient Signature Date

____ ____________________
Patient or Responsible Party Date

Regenexx® Tampa Bay Regenexx® Gold Coast Orthopedics

Request Release of Medical Records

2401 University Parkway, Suite 104, Sarasota, Fl 34243 Phone: 941-357-1773 Fax: 941-256-7452
8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 Phone: 813-544-3123 Fax: 941-256-7452
20754 West Dixie Highway Miami, FL 33180 Phone: 786-855-4800 Fax: 941-256-7452

To **(Providing Facility/Location):** ____

Phone Number: _________________________________ Fax Number: ___________________________________

____ ______/_____/_______ ________-_______-__________

Patient Name **Date of Birth** **SSN**

I Request That Records Be Released That Pertain to The Following Body Region(s):

____

Specifically, I Request for The Following to Be Sent:

- ____ **X-Rays (Radiology Report and Imaging Disk)**
- ____ **Mri's (Radiology Report and Imaging Disk)**
- ____ **Consult Reports**
- ____ **Operative Reports**
- ____ **Complete Records**
- ____ **Other** ____

Please Release to:

☐ 2401 University Parkway, Suite 104, Sarasota, FL 34243 - Phone: 941-357-1773 - **Fax: 941-256-7452**
☐ 8600 Hidden River Parkway, Suite 700, Tampa, FL 33637 - Phone: 813-544-3123 - **Fax: 941-256-7452**
☐ 20754 West Dixie Highway Miami, FL 33180 Phone: 786-855-4800 - **Fax: 941-256-7452**

Requesting Provider:

☐ **James Leiber, D.O.** ☐ **Ronald Torrance, D.O.** ☐ **Evan Musman, D.O.**
☐ **Ignatios Papas, D.O.** ☐ **Michael Amoroso, M.D.**

I authorize your facility to release the medical records requested by Regenexx Tampa Bay and/or Regenexx Gold Coast.

____ ______/_____/_________

Patient Signature **Date**

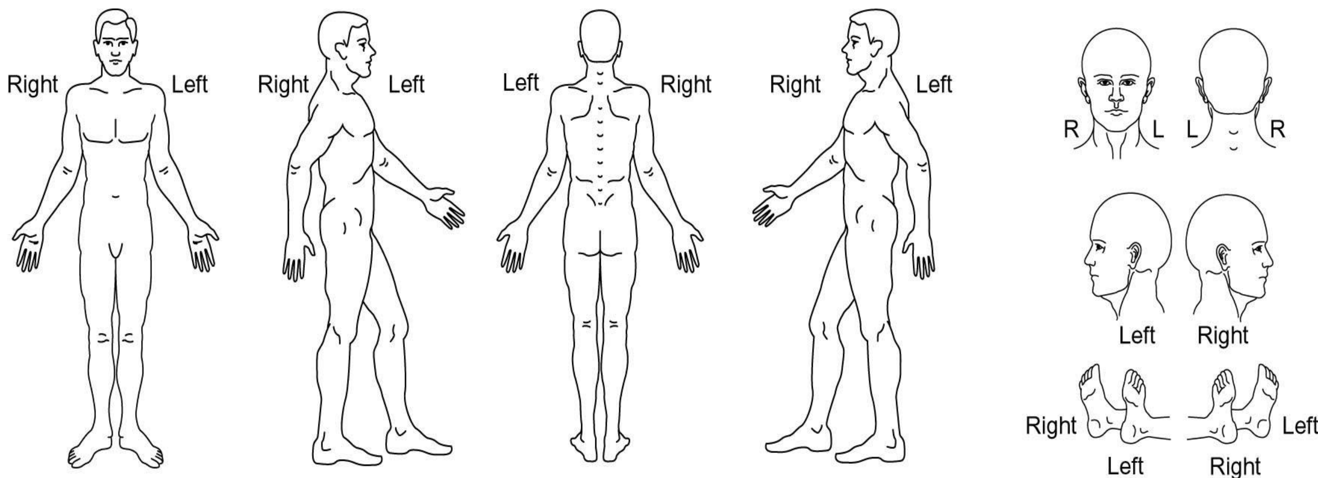
I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice. **I Understand That the Information in My Health Record May Include Information Relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (Aids), Or Human Immunodeficiency Virus (HIV). It May Also Include Information About Behavioral or Mental Health Services, And Treatment for Alcohol and Drug Abuse or Self-Paid Services. You Are Hereby Specifically Authorized to Release All Information or Medical Records Relating to Such Diagnosis, Testing, Or Treatment, Unless Specifically Excluded above. This Authorization Will Expire One Year from The Date of Signing Unless Otherwise Indicated. The Patient May Revoke This Authorization at Any time Upon Request. The Disclosed Information May No Longer Be Protected by The Privacy Practices of This Practice.**

MUSCULOSKELETAL NEW PATIENT HISTORY FORM

PATIENT NAME ____________________________________ AGE __________ DOB______________

1) **REFERRED BY:** ____
2) **PRIMARY CARE PHYSICIAN:** ______________________Last Visit: _____________________________
3) **DO YOU SEE A PAIN MANAGEMENT PHYSICIAN:** ☐ Yes ☐ No
   NAME: _________________________________ **LAST VISIT:** _______________________________
4) **REASON FOR THIS VISIT:**
   ____
   ____

PLEASE MARK THE AREAS ON THE DIAGRAM WHERE YOU ARE EXPERIENCING DIFFICULTY:



5) **IS THIS THE RESULT OF AN INJURY OR ACCIDENT? IS THIS A WORKER'S COMPENSATION OR AUTOMOBILE INSURANCE RELATED CASE? (if Yes, please provide background information)**
   ____
   ____

6) **<u>PRIMARY AREA</u> YOU WOULD LIKE TO DISCUSS TODAY: (please check one)**

☐ Neck/Upper back ☐ Mid-back /Lower Back ☐ Shoulder
☐ Elbow ☐ Wrist ☐ Hand
☐ Hip ☐ Knee ☐ Ankle ☐ Foot

Comments: ____

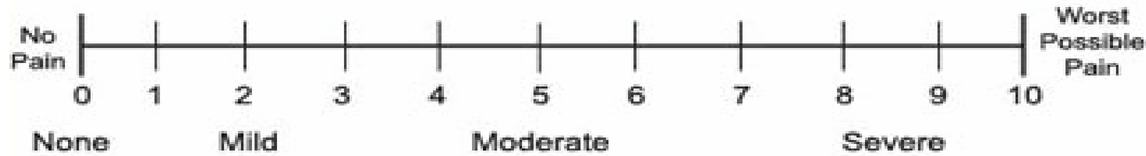
7) **THE FOLLOWING QUESTIONS PERTAIN TO THE <u>PRIMARY AREA</u> YOU'VE INDICATED IN QUESTION 4 ABOVE:**

   a) When and how did this problem **<u>start</u>**? ____
   ____

   b) How would you describe the **<u>character</u>** of your pain or complaint (check all that apply):
   ☐ Aching ☐ Tightness/Stiffness ☐ Numbness/Tingling ☐ Cramping ☐ Stabbing ☐ Sharp ☐ Shooting
   ☐ Pressure ☐ Burning ☐ Weakness
   <u>If your chief complaint today is for knee pain</u>, then please check the following (if they apply):
   ☐ Knee Popping ☐ Knee Clicking ☐ Knee Catching ☐ Knee Instability

   c) Does this pain/complaint **<u>radiate</u>** to any other locations? (if yes, describe the pattern) ________
   ____

d) How severe is the pain/complaint **currently** on a scale of 0 (no pain) to 10 (worst possible pain)? [please circle the appropriate number on the scale below]



Comments: ____

What is the pain **on average** throughout the day on a scale of 0 – 10? ________________

e) Is this pain/complaint **constant**? ☐ Yes ☐ No

i) **How much of the day** is your discomfort or pain present?

☐ Less than 1 hour ☐ 4 hours ☐ 6 hours ☐ 12 hours ☐ 18 hours ☐ 24 hours

f) How has this pain/complaint **changed over time**? ☐ getting better ☐ getting worse ☐ no change

g) What makes this pain/complaint **worse**? ____

i) Does it get worse with bending the area? (For neck or low back pain, is it worse with bending forward, backwards, or with turning?) __________________________________

ii) Does it get worse with sneezing or coughing? ☐ Yes ☐ No

h) What makes this pain/complaint **better**? ____

____

i) Is it better at certain times of day? ____

ii) Is it better with ☐ rest or ☐ motion? Are there certain positions that ease the problem?

____

8) FUNCTIONAL LIMITATIONS AND GOALS

a) What **activities** is this pain/complaint affecting?

____

b) What are your **goals** for treatment?

____

9) PRIOR TREATMENT

a) Have you taken any **Medications/Botanical Herbs/Supplements** for this problem? Please indicate below:

Name	Dose	Length of Time Taken	Helpful (Not at all/Mildly/ Moderately/Very)

b) Have you had **Physical Therapy** for this problem? ☐ Yes ☐ No When? ________________

For how long? ___________ Was this helpful? ___________________

c) Have you had **Manual Adjustments** (e.g Chiropractic or Osteopathic) for this problem?

☐ Yes ☐ No When? ___________

For how long? __________ Was this helpful? ________________

d) Have you had **Acupuncture** for this problem? ☐ Yes ☐ No When? ____________

For how long? ____________________ Was this helpful? ________________

e) Have you had **Massage** for this problem? ☐ Yes ☐ No When? _____________

For how long? ___________________ Was this helpful? ________________

PRIOR TREATMENT (CONTINUED)

f) Have you had any **Injections for** this problem? ☐ Yes ☐ No When? _______________
What kind? ____
For how long/How many times? _____________________________________
Was this helpful? __________________ If so, for how long? ______________

g) Have you had any **other treatment interventions** for this problem? ☐ Yes ☐ No
When? _____________ For how long/How many times? ___________________________
Was this helpful? __________________

What other consultations have you had regarding this problem?
____
____

10) HAVE YOU RECEIVED ANY SPECIAL TESTING OR PROCEDURES FOR THIS PROBLEM?
(PLEASE BRING COPIES OF REPORTS OR HAVE SENT TO US)

TEST	DATE	LOCATION	RESULTS (in your own words is ok)
XRAY	_______________	______________	_______________________________
CAT SCAN (CT)	_______________	______________	_______________________________
MRI	_______________	______________	_______________________________
ULTRASOUND	_______________	______________	_______________________________
EMG/NERVE CONDUCTION	_______________	_____________	______________________________
OTHER (please specify)	_______________	______________	_______________________________

11) OTHER

a. **ARE YOU CURRENTLY ON ANY BLOOD THINNERS?** ☐ Yes ☐ No

b. **ARE YOU CURRENTLY ON ANY ONGOING STEROID THERAPY?** ☐ Yes ☐ No

c. **WHAT IS YOUR CURRENT LEVEL OF STRESS?** ☐ none ☐ mild ☐ moderate ☐ severe

d. Have you ever taken **quinolone antibiotics** (Cipro, Levofloxin)? ☐ Yes ☐ No, If so, when? ________

e. Have you ever had **elevated calcium levels**? ☐ Yes ☐ No If yes, then when? ________
Do you recall the level? How can we obtain this result? ___________________________________

f. **Do you have a history of nausea/vomiting with pain medication?** ☐ Yes ☐ No ☐ Unknown

g. **Have you had any adverse reactions to local anesthetics (e.g. novicaine)?** ☐ No ☐ Yes
If yes, What was your reaction? ____

h. **Does it take longer for you to get numb at the dentist? ☐ Yes ☐ No ☐ Unsure**

i. Have you ever been in a motor vehicle accident or any other kind of accident? ☐ Yes ☐ No
If so: What injuries did you sustain? Do you feel that it is contributing to your current problem for which you are being evaluated today? ____

For FEMALES ONLY:		
When was your last **menstrual period**? ____________________________	Yes	No
Have you had laboratory tests to check your **hormone levels** (estrogen, progesterone, testosterone, DHEA)?		
Have you had laboratory tests to check your **thyroid levels**?		
Are you on any **hormone replacement therapy** (estrogen, progesterone, testosterone, DHEA, thyroid)? ________________________________		
Have you had laboratory tests to check your **Vitamin D levels**?		

For MALES ONLY:
• Do you have any of the following: ☐ low sex drive ☐ erectile dysfunction/difficulties ☐ mood problems ☐ fatigue or low energy ☐ sleep disturbances/difficulties
Have you had your **Testosterone blood levels** checked? ☐ Yes ☐ No
Have you had laboratory tests to check your **Vitamin D levels**? ☐ Yes ☐ No

REVIEW OF SYSTEMS/SYMPTOMS

(Check any symptoms or findings that you have experienced recently)

CONSTITUTIONAL	☐ weight change ☐ fatigue ☐ fever ☐ night sweats ☐ general weakness
EYES	☐ vision problems ☐ double vision ☐ yellowing of the eyes
ENT	☐ hearing problems ☐ dizziness ☐ sinus trouble ☐ sore throat ☐ ringing ears ☐ bleeding gums ☐ periodontal disease
CARDIOVASC	☐ shortness of breath ☐ chest pain ☐ leg swelling ☐ increased blood pressure
RESPIRATORY	☐ cough ☐ coughing up blood ☐ wheezing ☐ asthma ☐ other difficulty breathing ☐ snoring ☐ gasping for air during sleep ☐ fall asleep during the day
GASTROINTESTINAL	☐ trouble swallowing ☐ heartburn ☐ nausea ☐ vomiting ☐ diarrhea ☐ blood or black tarry stools ☐ abdominal pain ☐ gas ☐ bloating
GENITOURINARY	☐ pain with urination, blood in urine ☐ urgency ☐ incontinence ☐ increased urination ☐ impotence/erectile dysfunction (for males) ☐ prostate problems (males)
MUSCULOSKELELTAL	☐ joint pain ☐ joint stiffness ☐ muscle cramps ☐ muscle twitching ☐ muscle weakness ☐ loss of motion ☐ tendonitis ☐ swelling of finger or other joints ☐ redness of joints
SKIN/HAIR/NAILS	☐ rash ☐ lumps/masses ☐ itchy ☐ dryness ☐ hair changes ☐ nail changes ☐ yellowing of skin
NEUROLOGICAL	☐ fainting ☐ blackouts ☐ seizures ☐ paralysis ☐ weakness ☐ numbness ☐ memory loss ☐ numbness in a saddle distribution (inner legs and groin) ☐ headaches ☐ tremors
PSYCHOLOGICAL	☐ nervousness ☐ tension ☐ mood changes ☐ depression ☐ anxiety
ENDOCRINE	☐ decreased libido ☐ heat or cold intolerance ☐ excessive thirst ☐ increased hunger ☐ increased craving for sweets or carbs ☐ low blood pressure ☐ hot flashes
HEMATOLOGY/ ONCOLOGY	☐ easy bruising ☐ bleeding (difficulty clotting) ☐ venous thrombosis (clots) ☐ current or history of cancer

PAST MEDICAL HISTORY

CHECK ALL THAT APPLY:

Chronic Musculoskeletal Pain:

☐ Shoulder ☐ Neck ☐ Hip ☐ other:________
☐ Elbow ☐ Mid-back ☐ Knee
☐ Wrist/hand ☐ Low back ☐ Ankle/foot

Other Medical History:

☐ Abuse: ☐ Physical ☐ Emotional ☐ Sexual (Treatment: ______________________________)
☐ Abnormal Heart Rhythm ☐ Fibroids ☐ Lupus
☐ Anemia ☐ Fibromyalgia ☐ Lyme disease
☐ Anxiety ☐ Food allergies or intolerances ☐ Osteoarthritis
☐ Asthma ☐ Headaches/Migraines ☐ Osteoporosis
☐ Autoimmune Disease ☐ Heart Attack ☐ Parkinson's Disease
☐ Bipolar Disorder ☐ Heart Disease ☐ Premenstrual Syndrome
☐ Bowel or Bladder Incontinence ☐ High Blood Pressure ☐ Prostatitis
☐ Broken Bones ____________________ ☐ High Cholesterol ☐ Pulmonary Embolism (clot in lung)
☐ Cancer (what kind/when? _________ __________________________) ☐ Psoriasis
☐ Crohn's Disease ☐ Hepatitis ☐ Rheumatoid Arthritis
☐ Deep Vein Thrombosis (clot) ☐HIV/AIDS ☐ Seizures
☐ Dementia ☐ Impotence ☐ Sleep Apnea
☐ Depression ☐ Infertility ☐ Stomach Ulcers
☐ Diabetes ☐ Insulin resistance or Borderline Diabetes ☐ Stroke
☐ Emphysema or Chronic Bronchitis (COPD) ☐ Irritable Bowel Syndrome ☐ Thyroid Disease
☐ Endometriosis ☐ Insomnia or other Sleep disturbance ☐ Ulcerative Colitis
☐ Other ____

SURGICAL HISTORY/HOSPITALIZATIONS

_____________________________________ Date: ______________

_____________________________________ Date: ______________

_____________________________________ Date: ______________

SOCIAL HISTORY

What is your **Marital Status**?
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Gay/Lesbian ☐ Long term partnership ☐ Bisexual ☐ Transgender
What is your **Occupation** (if retired, from what occupation are you retired)?
____

Do you use **Tobacco** (smoke or chew)? ☐ Yes ☐ No If yes, then how much and for how long?
____

If no, then do you have a history of tobacco use? ☐ Yes ☐ No

If yes, then for many years did you smoke? _____________ How long ago did you quit? ____________

Do you use **Alcohol**? ☐ Yes ☐ No If yes, then how often and how much?
____

Do you use **Drugs**? ☐ Yes ☐ No If yes, then how often and how much?
____

Do you currently follow a **Specific Diet or Nutritional program**? ☐ Yes ☐ No
____

Do you **Cook**? ☐ Yes ☐ No

Do you **Grocery Shop**? ☐ Yes ☐ No

Do you **Read Food Labels**? ☐ Yes ☐ No

How many **Servings of Fruits/Vegetables** do you have per day (do not include fruit juice, potatoes, or processed foods)?
____

How many times per week do you **Eat Out** (include: breakfast, lunch, dinner, and dessert/snacks)?
____

Do you **Exercise**? ☐ Yes ☐ No What type and How often?
____

____

What are your **Hobbies/Interests**? ____

Do you currently have or have you had any **Environmental Exposures** to chemicals/toxins/radiation?
____

Are you **sensitive to any Environmental Chemicals** (e.g. perfumes/colognes, auto exhaust, MSG, etc)?

FAMILY HISTORY

Father: ☐ alive; age _____ ☐ deceased; age______ Medical problems ___________________

____

Mother: ☐ alive; age _____ ☐ deceased; age______ Medical problems ___________________

____

Brothers: Medical problems ____

Sisters: Medical problems ____

Other medical problems that run in the family? ☐ Diabetes ☐ Heart Problems ☐ Cancer ☐ Thyroid problems ☐ Osteoarthritis ☐ Autoimmune Diseases (for example: Rheumatoid Arthritis, Lupus, Crohn's Disease, etc.)

ALLERGIES (to medications)

Medication: __________________________ Type of Reaction: ______________

Medication: __________________________ Type of Reaction: ______________

Medication: __________________________ Type of Reaction: ______________

Add additional allergies on the back of this form or attach to the paperwork

MEDICATIONS/BOTANICAL HERBS/SUPPLEMENTS LIST

NAME **DOSAGE** **HOW OFTEN TAKEN**

1. ____
2. ____
3. ____
4. ____
5. ____