JAMES VOGLINO, MD PA
6705 Red Road Suite 606
Coral Gables, Florida 33143

DR.V – SHOULDER , HIP AND KNEE

WELCOME TO OUR OFFICE!

Name: _____ Today's Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Cell: ( ) _____

Birthdate: _____ Email Address: _____

Occupation: _____ SS#: _____

Employer: _____ Work Phone#: ( ) _____

Employment Status: ___ Employed ___ Unemployed ___ Retired

Ethnicity: _____ Race: _____ Primary Language: _____

Sex: ____Male ____Female **Marital Status:** __Single __Married __Divorced __Widowed

Number of Children: ____

Primary Care Doctor: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

Insurance_____ **Policy #:** _____ **Group#:**_____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone : ( ) _____ Cell phone : ( ) _____

Birthdate: _____ Email Address: _____

Insurance: _____ Policy #:_____ Group #:_____

In case of emergency , contact: _____ **Relationship:** _____

Home Phone #: ( )_____ **Cell Phone: ( )** _____

How did you learn about our practice? _____

I hereby consent to any medical care which is deemed advisable or necessary by my physician and grant authority to James Voglino,MD, to administer and perform all examinations, treatments and diagnostic procedures needed now or in the future. I guarantee payment for all services rendered. All medical benefits including major medical benefits, private insurance and any other health plan, are assigned to James Voglino, MD, PA. The signature below confirms all of the information provided herein is true and accurate. Photocopy of this consent is to be considered as valid as original.

Signature: _____ Date: _____

James Voglino, M.D.

Orthopaedic Surgery and Sports Medicine

Please Print
Today's Date: _____

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Reason for visit: _____

Medical information – Please List
Have you had any previous surgeries? Yes_____ No_____ If yes, Please list surgeries and dates of surgery below:
Surgery_____ Date: _____
Surgery_____ Date: _____
Surgery_____ Date: _____
Surgery_____ Date: _____

Do you have any allergies? Yes_____ No_____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Are you currently taking any medication? Yes_____ No_____
If yes, please list all medications: _____
_____
_____

Medical History – Please List
Do you have a **history** of any of the following? Please mark yes or no

Asthma Yes_____ No_____
Anxiety Yes _____ No _____
Ulcers Yes_____ No_____
Cardiac Yes_____ No_____
Hepatitis Yes____ No_____
Liver Disease Yes__ No___
Tuberculosis Yes__ No__
Gastrointestinal Conditions Yes__ No___
Rheumatoid Arthritis Yes__ No___

Hepatitis Yes_____ No_____
Arrythmia Yes _____ No ___
Alzhimer Yes_____ No_____
Cancer Yes_____ No___
Kidney Disease Yes__ No_____
Parkinson Yes__ No__
Hypertension Yes__ No___

Diabetes Yes_____ No ___
COPD Yes _____ No ___
Lupus Yes_____ No ___
Gout Yes_____ No ___
Lung Disease Yes___ No___
Pancreatitis Yes___No___
Myocardial Infarction Yes___No_____
Renal Condition Yes_No___

Other:_____

Do you **drink alcoholic beverages**? Yes_____ No_____ 1-2 a day_____ More_____ Socially_____

Caffeine use? Yes __ No __ **Exercise**? Yes __No __ **Substance Abuse**? Yes __ No __

Smoking History? No history __ Currently smokes __ Used to smoke __ Quit Smoking ___ Second hand smoke__

Family History of Orthopaedic Injuries/Diseases? Yes_____ No_____

If yes, Please list below: _____

History of Osteoarthritis? Yes_____ No_____ History of Osteoporosis? Yes_____ No_____

History of Blood Clots? Yes_____ No_____
If yes to any please list: _____
Social History – review of current and past social activities: _____
Revised 7.1.2013

James Voglino, M.D.

Orthopaedic Surgery and Sports Medicine

Please Print

Name/Nombre: _____ Date/Fecha: _____

HEIGHT/ALTURA: _____ **WEIGHT/PESO:** _____

Review of Systems	Description	Yes	No
Constitutional	Unexpected weight loss, weight gain, fever, chills, fatigue		
Eyes	Corrective lenses, blurred/double vision, eye pain, redness, watering eyes		
ENT	Headaches, difficulty swallowing, nose bleed, ears ringing, ear aches		
Cardiovascular	Chest pain, palpitations, fainting murmurs		
Respiratory	Shortness of breath, wheezing, cough, lightness, chest pain, snoring		
Gastrointestinal	Heartburn, nausea, vomiting, constipation, diarrhea, bloody/tarry stool		
Genitourinary	Frequent, urgent, difficult/painful urination, back pain, bleeding		
Skin	Skin changes, poor healing, rash, itching, redness		
Neurological	Numbness, tingling, unsteady gait, dizziness, tremors, seizures		
Psychiatric	Nervousness, anxiety, depression, hallucinations		
Hematological	Easy bleeding, bruising		
Endocrine	Excessive thirst, urination; heat/cold intolerable		
Allergic	Reaction to food or environment		

Chief Complaint / Dolencia Principal:

_____

_____

If occurred in an accident – please explain / Si ocurrio en un accidente - por favor escriba los detalles:

_____

_____

_____

Date of injury / Fecha del accidente:

_____

Do you have a regular doctor? / ¿Tiene Usted un doctor Primario? Yes _____ No _____

If yes, who? / Nombre de su Doctor Primario _____

Phone Number / Numero de telefono: _____

Name of referring doctor? / Nombre el Doctor que le refirio a nuestra oficina?

_____

Additional comment / Alguna otra informacion?_____

_____

Form filled out by / Nombre de la persona que completo esta planilla: _____

Date/ Fecha: _____

Above reviewed by Dr. Voglino with the patient : _____ _____ Dr. Voglino: _____

JAMES VOGLINO, M.D
Orthopaedic Surgery and Sports Medicine

Patient Name: _____ Date: _____

Date of Accident: _____ Chief Complain: _____

1. **Location of Pain:** Shoulder□ Hip□ Knee□
Ankle□ Back□ Joint□
Other_____

2. **Describe pain:** burning□ cramping□ electric□
griping□ locking□ numbness□ sharp□
shooting□ stabbing□ cold□ can't describe□

3. **Intensity of pain:** Mild □ Moderate□ Severe□

4. **On VSA scale, patient states pain to be :**
1/10□ 2/10□ 3/10□ 4/10□ 5/10□ 6/10□
7/10□ 8/10□ 9/10□ 10/10□

5. **Pain radiating to :**
Left □ Right □ Bilateral□ Glutes□
Lower Extremities□ Other: _____

6. **Pain is aggravated by:**
Sudden movements□ Flexion □ Extension□ Rotation□
Walking□ Sitting□ Standing□ Laying down□
Lifting□ Bending□ Activities of Daily Living□
Other: _____

7. **Pain is alleviated by:**
Applied Ice □ Applied Heat□ Physical Therapy□
Medications□ Other: _____

8. **Previous Treatment:**
a. ***Injections***: Steroid□ Cortisone□ Viscous□
Other: _____

b. ***Chiropractor Treatment***: Yes □ No□
Name of Chriroprator:_____
Dates Received treatment: _____

c. ***Physical Therapy***: Yes □ No□
Dates Received therapy? _____

Dr. V – Shoulder , Hip and Knee

James Voglino, M.D.
Orthopaedic Surgery and Sports Medicine
6705 Red Road, Suite 606
Coral Gables, Florida 33143
Phone: 305-596-3707 Fax: 305-665-2724

Financial Policy

This is an agreement between James Voglino, M.D., P.A., as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders, cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance:
Insurance is a contract between you and your insurance company. We will file insurance claims only for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front and back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for , payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection Fee: A fee totaling 32% (account less than 1 yr old) and 50% (account over one year old) of the balance due will be added to your account if we have to send your account to a collection agency. In addition, an interest at the rate of 1.5% per month (or 18% per year) on any unpaid balance. Plus any and all fees and cost Dr. Voglino incurs to collect any unpaid balance or charges, including his attorney's fees and cost. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($1.00 per page for the first 25 pages and 25 cents for every page thereafter). If you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred fro another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Patient's Signature: _____ Date: _____

Responsible party (if not the patient): _____Relationship to patient: _____

Revised 6.10.2013

MEDICAL RECORDS RELEASE FORM

Date: _____

Attention: Medical Records Department

Patient: _____

DOB: _____

I hereby authorize the release of my general Medical Records including X-Rays/ MRI Reports to:

James Voglino, MD
Orthopaedic Surgeon
Sports Medicine & Rehabilitation
6705 Red Road Suite 606
Miami, Florida 33143
305-596-3707 (305)-665-2724 Fax

_____ _____

Patient or Legal Representative's Signature Date

James Voglino, M.D.
6705 Red Road, Suite 606
Coral Gables, FL 33143
Phone: 305-596-3707 Fax: 305-665-2724

Acknowledgement of Privacy Practices

I hereby acknowledge that I have reviewed a copy of James Voglino, M.D., P.A. Notice of Privacy Practices as required by federal law.

_____ _____
Date Patient Signature

Reason Patient / Personal Representative failed to sign:

_____

_____

_____
Staff Signature

Patient Consent for use and disclosure of Protected Health Information

Patient Name: _____ Date of Consent: _____

I authorize the office of James Voglino, M.D. to disclose protected health information to the following:

Name and relationship of person(s) authorized to receive information:

_____

_____

_____

Please circle one:

I **do** **do not** authorize the office of James Voglino, MD to leave telephone messages regarding my protected health information on the voicemail or answering machine.

_____ _____
Patient Signature Date of Authorization