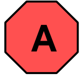
MICHAEL T. REILLY, M.D. F.A.A.O.S.
DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
SPORTS MEDICINE & RECONSTRUCTIVE SURGERY
UPPER & LOWER EXTREMITIES

DAVID H. GILBERT, M.D.
DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY
HAND, WRIST, & UPPER EXTREMITY
MICROVASCULAR RECONSTRUCTION

**Office: (954) 771-3334 Fax: (954) 771-1069**
**www.BrowardOrthopedic.com**

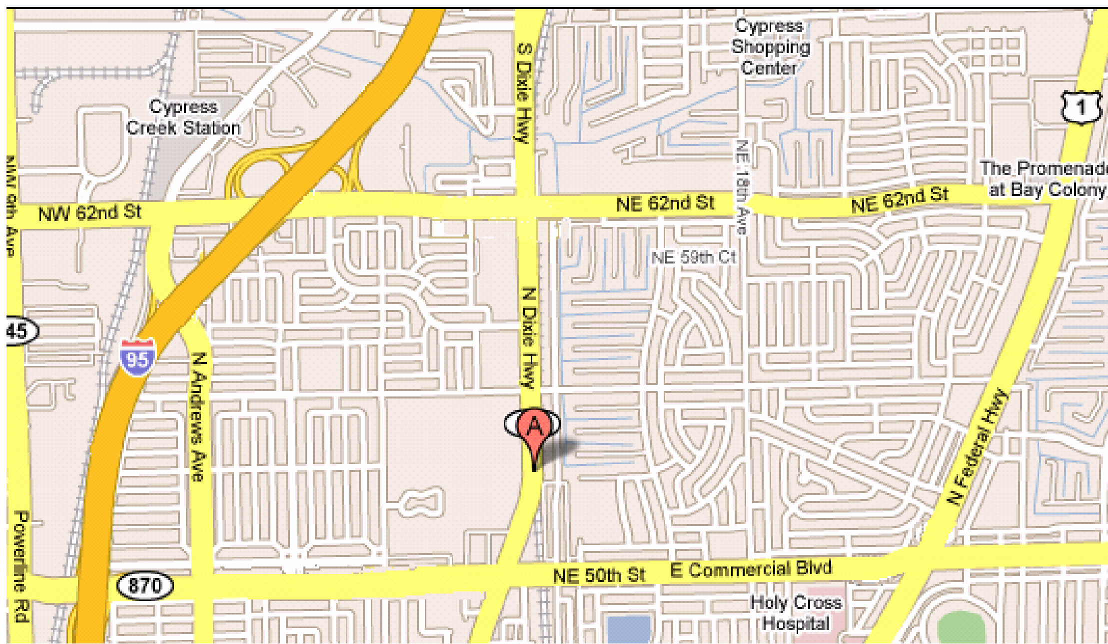
- **Photo ID**
- **Ins Card**
- **Pharmacy, phone #, and address**

**Please bring completed paperwork with you to your appointment**




## Directions to Broward Orthopedic Specialists
### 5301 N. Dixie Hwy, Suite 203. Ft Lauderdale, FL 33334

- From the Florida Turnpike or I-95,
- Take the exit for Commercial Boulevard **East** to Dixie Hwy.
- Turn left onto Dixie Highway, going north.
- You will see a Publix Plaza on your left-hand side, then the Green Tree Apartments.
- Make a left at the next entrance after the Green Tree Apartments.




- We are the green two-story building at
  **5301 North Dixie Highway, Suite 203**

**BROWARD ORTHOPEDIC**
**SPECIALISTS**

MICHAEL T. REILLY, M.D. F.A.A.O.S.
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## WELCOME!

All the staff at Broward Orthopedic Specialists would like to take this time to extend a heartfelt welcome to you as a new patient to our practice. Seeing a doctor is not something that most people look forward to; however, we want you to know that you are important to us. Every effort will be made to make your visits comfortable and productive. We look forward to providing you with the best trained technical staff and physicians Florida has to offer.

Patient satisfaction is the most rewarding part of providing medical care. The goal of this practice is to deliver the highest quality orthopedic care possible in a gentle and compassionate manner. Your relationship with this office begins when you schedule your first appointment and continues with your visit and any follow-up care that may be necessary. We value this relationship with you and will always strive to improve upon it.

Enclosed you will find many papers to fill out which will help expedite your visit with us. It will save you time and you will be able to better fill out these pages in the comfort of your home rather than waiting until the day you come to the office for your first appointment.

Remember to bring these important things on your initial visit to our office:

- Picture ID
- Your insurance cards
- **Your pharmacy name, phone #, and address**
- Any studies with the report (ie. MRI, CT Scan) pertaining to your visit
- All enclosed completed forms
- Please pay special attention when filling out your forms to the section on “Current Medications” and “Allergies”. **This must be filled out completely.**

Remember these important things:

- On **EACH** visit keep us updated on studies/surgeries you have had since we last saw you and (especially if you travel north) try to bring copies of your studies with the report back with you or have them mailed to us.
- Feel free to call with any questions you may have. We will always do our best to get you the information you need.
- Visit our website ***www.BrowardOrthopedic.com*** for more information.

Once again, **WELCOME** to our office. We truly hope that you will feel comfortable here and will be pleased with our services. We look forward to your visit with us.

Michael T. Reilly, MD, David H. Gilbert, MD, and Staff

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Dear Patient:

We ask that you read and sign the following page because it concerns all of us. Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company regarding your coverage. **It is your responsibility to know your individual coverage.** Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

It is our office policy to collect co-pays, co-insurance and deductibles at time of service and prior to any surgical procedures. **PLEASE NOTE:** Any fees paid to our practice is for our surgical fees only! You responsible for any additional facility fees, hospital fees, lab tests, anesthesiology fees, etc. We neither collect these fees nor can estimate what they will be. We are not associated with the billing departments of any hospital, outpatient center or other physician's office. If you receive a statement from them, please contact them directly in order to settle your account.

To assist you in finding out what coverage you have, feel free to ask for assistance in finding phone numbers or addresses of your insurance company. Many insurance companies today need referral forms from a primary care physician or group. If your insurance meets this requirement it will be your responsibility to furnish this referral at time of service. Failure to do so may require you to reschedule your appointment. Some insurance companies state you cannot go out of network. Many companies have instituted a mandatory second opinion program, and these are constantly changing day by day. It is impossible to keep up with the changes and often we are not aware of them until it is too late.

________________________________________

Please Sign

________________________________________

Please Print

# PLEASE PRINT

## PATIENT INFORMATION

Name: (First) ______________________________(MI) _____ (Last) ________________________________________

Date of Birth ________________________ Age ________ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Primary Mailing Address _____________________________________City________________ State_____ Zip_________

Secondary Mailing Address __________________________________City_______________ State_____ Zip_________

Home Phone # ( ) ___________________________ Cell # ( ) _________________________________

**PREFERRED PHONE # TO CONFIRM APPTS / CALL BACKS/ TEST RESULTS, etc:** # ( ) _________________________________

Social Security # _________ - ________ - _______________ Email: __________________________________________

Work # ________________________ Employer: ________________________________________________________

Employer's Address: ______________________________________________________________________________

If Student, School Name: ______________________________________________ ☐ Full ☐ Part Time

Referring Physician: __________________________ City: _____________________Phone #______________________

Friend or Relative Not Living with You: ____________________________________ Phone # ______________________

## ☐ RESPONSIBLE PARTY or ☐ EMERGENCY CONTACT INFORMATION

Name: ___________________________________________Relationship to Patient: ____________________________

Address: (Street, City, State, Zip) ________________________________________________________________________

Phone # __________________ Social Security # ____________________ Driver License # ______________________

Work # ___________________ Employer: _____________________________________________________________

## INSURANCE INFORMATION

**☐ Auto ☐ Health ☐ Other ________________ ☐ Workers' Comp** DATE OF INJURY: ______________

Insurance Co: ___________________________________________________ Phone # ___________________________

Group # _____________________ Policy or I.D. # ______________________________________________________

Insured's Name: ______________________________________ Relationship to Patient: ☐Self ☐Spouse ☐Dependent

Insured's Employer: _________________________________________ Phone # ______________________________

Insured's Social Security # _________________________ Date of Birth: ________________________ Sex: ☐ M ☐ F

***If the patient it covered by a second insurance policy, please complete the following information below for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!***

## SECONDARY INSURANCE INFORMATION

Insurance Co: ___________________________________________________ Phone # ___________________________

Group # _____________________ Policy or I.D. # ______________________________________________________

Insured's Name: ______________________________________ Relationship to Patient: ☐Self ☐Spouse ☐Dependent

Insured's Employer: _________________________________________ Phone # ______________________________

Insured's Social Security # _________________________ Date of Birth: ________________________ Sex: ☐M ☐F

I hereby assign, transfer, and set over to MICHAEL T. REILLY, M.D. & DAVID H. GILBERT, M.D., PA, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This is a lifetime authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees. There will be a $25 fee assessed for checks returned by the bank for any reason.

I authorize MICHAEL T. REILLY MD & DAVID H. GILBERT MD to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100 percent of my benefits, within ninety (90) days of any and all appeals or request for information. I also agree that any fines levied against my insurance company will be paid to MICHAEL T. REILLY MD & DAVID H. GILBERT MD, for acting as my personal representative.

I authorize release of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests.

Patient's Signature ________________________________________________ Date ________________________
(IF MINOR, PARENT SIGNATURE)

DATE: ____/____/____ HEIGHT: __________

**PLEASE PRINT** **PATIENT HEALTH INFORMATION** WEIGHT: __________

***ANSWER ALL QUESTIONS TO AVOID DELAYS***

☐ RIGHT HAND DOMINANT

☐ LEFT HAND DOMINANT

PATIENT NAME ______________________________AGE: __________

REASON(S) VISIT______________________________

LIST CONTRIBUTING EVENTS OR KNOWN CAUSES FOR SYMPTOMS: ______________________________

HOW LONG HAS SYMPTOMS BEEN PRESENT (Or date of injury?) ______________________________

DO SYMPTOMS INCLUDE PAIN?: Yes ☐ No ☐ (If yes, check all that apply with severity of pain)

SEVERITY OF PAIN: Circle rating of 1-10 for severity of symptoms with 10 being the worst

☐ Sharp 1 2 3 4 5 6 7 8 9 10 ☐ Dull 1 2 3 4 5 6 7 8 9 10

☐ Burning 1 2 3 4 5 6 7 8 9 10 ☐ Stabbing 1 2 3 4 5 6 7 8 9 10

FREQUENCY OF PAIN: ☐ CONSTANT ☐ INTERMITTENT ☐ PROGRESSIVE ☐ NOT PROGRESSIVE

DO SYMPTOMS INCLUDE? ☐ SWELLING ☐ WEAKNESS ☐ NUMBNESS

☐ DECREASED RANGE OF MOTION ☐ PINS/NEEDLES SENSATION

IF APPLICABLE, IS THE JOINT? ☐ POPPING ☐ LOCKING ☐ CLICKING ☐ INSTABILITY/GIVING WAY

WHAT ACTIVITIES WORSEN YOUR CONDITION? ______________________________

**PAST TREATMENT OF YOUR CURRENT PROBLEM?** (Check all that apply)

☐ ICE TREATMENT ☐ PHYSICAL THERAPY ☐ INJECTIONS (How many?) __________

☐ HEAT TREATMENT ☐ REST (Specify amount of time) __________

RELATED PAST SURGERIES? (Specify with dates) ______________________________

MEDICATIONS (For current problem) ______________________________

**OTHER MEDICATIONS YOU ARE CURRENTLY TAKING** (List) ______________________________

______________________________

**Do you have drug allergies?** ☐ **No** ☐ **Yes (List)**______________________________

## MEDICAL HISTORY

**HAVE YOU BEEN DIAGNOSED TO HAVE ANY OF THE FOLLOWING?** (You **MUST** answer **Yes or No** to all questions)

Yes☐ No☐ ALCOHOLISM
Yes☐ No☐ ARTHRITIS (Location) __________
Yes☐ No☐ ASTHMA
Yes☐ No☐ BLOOD CLOTS
Yes☐ No☐ BLOOD DISEASES---- ☐ Anemia ☐ Leukemia
Yes☐ No☐ BLOOD TRANSFUSION (When) __________
Yes☐ No☐ BRONCHITIS
Yes☐ No☐ CANCER (Type) __________
Yes☐ No☐ CATARACTS
Yes☐ No☐ COLITIS
Yes☐ No☐ DIABETES
Yes☐ No☐ DIVERTICULITIS
Yes☐ No☐ DRUG ADDICTION
Yes☐ No☐ EMPHYSEMA
Yes☐ No☐ EPILEPSY
Yes☐ No☐ FRACTURES/BROKEN BONES (Where?)__________
Yes☐ No☐ GASTRIC REFLUX
Yes☐ No☐ GOUT
Yes☐ No☐ GLAUCOMA

Yes☐ No☐ HEART DISEASE---☐ Mitral Valve Prolapse ☐ Murmurs ☐ Abnormal Rhythm ☐ Congestive Heart Failure ☐ Heart Attack (MI) How many? ______
Yes☐ No☐ HEPATITIS ---------If Yes: ☐ A ☐ B ☐ C
Yes☐ No☐ HERNIA ------------ ☐ Inguinal ☐ Hiatal
Yes☐ No☐ HIGH BLOOD PRESSURE
Yes☐ No☐ HIGH CHOLESTEROL
Yes☐ No☐ HIV POSITIVE
Yes☐ No☐ KIDNEY DISEASE----☐ Kidney Stones ☐ Kidney Cysts
Yes☐ No☐ LATEX ALLERGY
Yes☐ No☐ LIVER CIRRHOSIS
Yes☐ No☐ OSTEOPOROSIS
Yes☐ No☐ PARKINSONISM
Yes☐ No☐ PEPTIC ULCERS
Yes☐ No☐ PROSTATE---☐ Enlarged ☐ Inflammation ☐ Cancer
Yes☐ No☐ PSORIASIS
Yes☐ No☐ STROKE
Yes☐ No☐ THYROID DISEASE
OTHER ______________________________

**PATIENT NAME:** ________________________________________________

**PAST SURGERY** **(ONLY Check Those That Apply)**

- ☐ APPENDECTOMY
- ☐ ARTHROSCOPY
- ☐ BACK SURGERY
- ☐ NECK SURGERY
- ☐ BREAST SURGERY
- ☐ CATARACT SURGERY
- ☐ CARPAL TUNNEL
- ☐ CESAREAN SECTION
- ☐ D & C
- ☐ GALLBLADDER SURGERY
- ☐ HEART BYPASS
- ☐ HEART VALVE REPLACEMENT
- ☐ HERNIA REPAIR
- ☐ HYSTERECTOMY ☐ TUBAL LIGATION
- ☐ JOINT REPLACEMENT (Location ________________________________________
- ☐ KIDNEY SURGERY
- ☐ PACEMAKER
- ☐ PROSTATE SURGERY
- ☐ SKIN CANCER
- ☐ TONSILLECTOMY
- ☐ OTHER SURGERY ____________________________________________________________

**DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?** (You **MUST** answer **Yes or No** to all questions)

- ☐ Yes ☐ No FEVER
- ☐ Yes ☐ No FATIGUE
- ☐ Yes ☐ No DOUBLE VISION
- ☐ Yes ☐ No LOSS OF HEARING
- ☐ Yes ☐ No RINGING IN THE EARS
- ☐ Yes ☐ No SHORTNESS OF BREATH
- ☐ Yes ☐ No VERTIGO / IMBALANCE
- ☐ Yes ☐ No VARICOSE VEINS
- ☐ Yes ☐ No NIGHT LEG CRAMPS
- ☐ Yes ☐ No ARTHRITIS
- ☐ Yes ☐ No ANKLE SWELLING
- ☐ Yes ☐ No ABDOMINAL PAIN
- ☐ Yes ☐ No CHEST PAIN
- ☐ Yes ☐ No SWOLLEN GLANDS
- ☐ Yes ☐ No SKIN CHANGES / RASHES
- ☐ Yes ☐ No CHANGE IN BOWEL OR BLADDER HABITS
- ☐ Yes ☐ No FREQUENT BLADDER INFECTIONS
- ☐ Yes ☐ No ANXIETY REQUIRING MEDICATION
- ☐ Yes ☐ No MIGRAINES
- ☐ Yes ☐ No INSOMNIA
- ☐ Yes ☐ No SINUSITIS
- ☐ Yes ☐ No WEIGHT LOSS

**FAMILY HISTORY** (Check if applies)

☐ FATHER'S HEALTH ☐ GOOD ☐ FAIR ☐ POOR ☐ DECEASED (cause) ______________________

☐ MOTHER'S HEALTH ☐ GOOD ☐ FAIR ☐ POOR ☐ DECEASED (cause) ______________________

☐ ANY FAMILY MEMBER WITH CURRENT RELATED ORTHOPAEDIC PROBLEM (Relationship to patient) ____________________

**SOCIAL HISTORY**

LANGUAGES SPOKEN: ☐ ENGLISH ☐ SPANISH ☐ FRENCH ☐ OTHER ____________________________

OCCUPATION ____________________________________________________________ ☐ ACTIVE ☐ RETIRED

IF STUDENT (SCHOOL YOU ATTEND)________________________________________________________________

HOBBIES/ACTIVITIES ______________________________________________________________________

ALCOHOL USE? ☐ NONE ☐ RARE ☐ OCCASIONAL ☐ SOCIAL ☐ FREQUENT

SMOKING HISTORY: ☐ NON-SMOKER ☐ PREVIOUS SMOKER (How long ago did you quit?) ____________________

☐ CURRENT SMOKER AMOUNT? ☐ 1/4 PACK/DAY ☐ 1/2 PACK/DAY ☐ ______ PACKS/DAY

WHO IS YOUR LOCAL MEDICAL DOCTOR? ____________________________________________________________

**WHO RECOMMENDED YOU TO THIS OFFICE?** (Please give name of person who referred you to this office)

☐ DOCTOR ______________________________ ☐ FAMILY ________________________________

☐ FRIEND ______________________________ ☐ OTHER ________________________________

**DO NOT FILL IN BELOW THIS LINE - FOR PHYSICIAN USE ONLY**

____________________________ _____/_____/ ____ ____________________________ _____/_____/ ____

____________________________ _____/_____/ ____ ____________________________ _____/_____/ ____

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**CONSENT & ACKNOWLEDGMENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

---

By signing below, you consent to the use and disclosure of your protected health information (see definition below) by *Michael T. Reilly, M.D. & David H. Gilbert, M.D.,* our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Privacy Practices ("Notice"). You have he right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting *Michael T. Reilly, M.D. & David H. Gilbert, M.D.* at (954) 771-3334 and requesting a revised Notice. We will also post any revised notice at the office of *Michael T. Reilly, M.D. & David H. Gilbert, M.D.* and our website (BrowardOrthopedic.com). You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

*My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

This information will not be sold to outside entities for marketing purposes.

____________________________________
Signature / Acknowledgment

____________________________________
Name of Patient or Guardian (PLEASE PRINT)

__________________________
Date

MICHAEL T. REILLY, M.D. F.A.A.O.S.
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# Pharmacy Information

Please print all information clearly

Date: ____________________

Patient Name: ________________________________________

Pharmacy Name: ________________________________________________________

Pharmacy Address: ________________________________________________________

Pharmacy City ______________________________ Zip ____________________

Pharmacy Phone #: ________________________

## Known Drug Allergies:

| Drug Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

MICHAEL T. REILLY, M.D. DAVID H. GILBERT, M.D.

5301 N. DIXIE HWY, SUITE 203
FT. LAUDERDALE, FL 33334
PHONE: (954) 771-3334 * FAX: (954) 771-1069

## Authorization to Discuss Protected Health Information

I ________________________________________, authorize the office of Michael T Reilly, MD & David H. Gilbert MD to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information to the following named person(s): **DO NOT list physicians**, they are already included under HIPAA law

1. _______________________________________(relationship) _______________________
2. _______________________________________(relationship) _______________________
3. _______________________________________(relationship) _______________________
4. _______________________________________(relationship) _______________________

- **BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.**

- **YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE (In this case write “none” on line 1)**

**Please list phone numbers where we are allowed to contact you for:**

- Lab results, MRI’s, ultrasounds, scans, any changes of scheduled appointments, etc.

Cell #: __________________________________

Home #: __________________________________

Work #: __________________________________

**PLEASE NOTE: Our office will remind you of your appointment via text message and phone call.**

*****************************************************************************************************

Patient Name: ______________________________________________

Date of Birth: ________/_________/_________

______________________________________ ________/________/________

Patient or Guardian Signature Date

# MICHAEL T. REILLY, MD

NAME: ______________________________________________________

DATE: ______________________________

Mark the areas on diagram where you feel your described sensations. Mark areas of radiation. Include all affected areas. **[Use appropriate symbol below]**

| | | SYMBOL |
|---|---|---|
| NUMBNESS / PINS & NEEDLES | = | O |
| PAIN / DISCOMFORT | = | X |