# Worker's Compensation Forms

Patient Name: _____ DOB: _____

Employer Name: _____

Address: _____

Claim Number: _____ Date of Injury/DOI: _____

Description of Accident: _____

## Adjuster's Information

Adjuster's Name: _____

Adjuster's Phone Number: _____ Fax Number: _____

## Workers' Compensation Insurance Carrier Information

Company Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

**Have you completed a Notice of Injury Form for your employer?** ☐ **Yes** ☐ **NO**

**Any person who knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of felony of the third degree. In the event the illness or condition is not a result of Workers Compensation, I hereby agree to pay the fees for services rendered.**

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# Worker's Compensation Forms

## GENERAL PATIENT INFORMATION

Patient (FULL, LEGAL) Name: _____

Date of Birth: _____ Social Security Number (required): _____

Patient Gender: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: _____ Have you ever been a patient in this practice before? ☐ Yes ☐ No

Ethnicity (select one): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ Black/African American ☐ American Indian ☐ Asian ☐ White ☐ Hawaiian/Pacific Island

☐ Other_____

Home Address: _____

Alternate Address (If applicable): _____

E-Mail:_____ Home: _____ Cell: _____

Emergency Contact: _____ Phone#: _____

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# Worker's Compensation Forms

****Please provide a brief explanation for today's visit:** _____

**Smoking Status:** ☐ Former ☐ Never a smoker ☐ Current smoker, Packs per day_____

**Have you had: Pneumonia Vaccine?** ☐ No ☐ Yes, when? _____ **Flu Vaccine?** ☐ No ☐ Yes, when? _____

**Review of Systems:** Do you have any of problems related to the following systems? Check the appropriate box.

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Fatigue** | ☐ | ☐ | **Abdominal Pain** | ☐ | ☐ |
| **Fever** | ☐ | ☐ | **Black or tarry stool** | ☐ | ☐ |
| **Chills** | ☐ | ☐ | **Bloody stool** | ☐ | ☐ |
| **Eyes watering or discharge** | ☐ | ☐ | **Urinary frequency** | ☐ | ☐ |
| **Loss of hearing** | ☐ | ☐ | **Urinary incontinence** | ☐ | ☐ |
| **Nasal passage blockage** | ☐ | ☐ | **Muscle weakness** | ☐ | ☐ |
| **Sore throat** | ☐ | ☐ | **Easy bruising** | ☐ | ☐ |
| **Chest pain or discomfort** | ☐ | ☐ | **Joint Pain, where_____** | ☐ | ☐ |
| **Palpitations** | ☐ | ☐ | **Dizziness** | ☐ | ☐ |
| **Feeling of the feet being cold** | ☐ | ☐ | **Fainting** | ☐ | ☐ |
| **Shortness of breath** | ☐ | ☐ | **Depression** | ☐ | ☐ |
| **Cough** | ☐ | ☐ | **Skin Lesion** | ☐ | ☐ |
| **Coughing up blood** | ☐ | ☐ | **Numbness or tingling in legs/feet** | ☐ | ☐ |
| **Nausea** | ☐ | ☐ | **Swelling in legs/feet** | ☐ | ☐ |
| **Vomiting** | ☐ | ☐ | **Other:** | ☐ | ☐ |

**Family History:** (please select all that apply)

| | Father | Mother | Brother | Sister |
|---|---|---|---|---|
| **Breast Cancer** | | | | |
| **Ovarian Cancer** | | | | |
| **Other Cancer** | | | | |
| **Heart Disease** | | | | |
| **Stroke** | | | | |
| **Hypertension** | | | | |
| **Diabetes** | | | | |
| **Atherosclerotic Vascular Disease** | | | | |
| **Aneurysm** | | | | |
| **Other (please specify)** | | | | |

*For nurse, only*: BP_____ HR _____ Temp _____ RR _____ Sat _____ Ht _____ Wt _____

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

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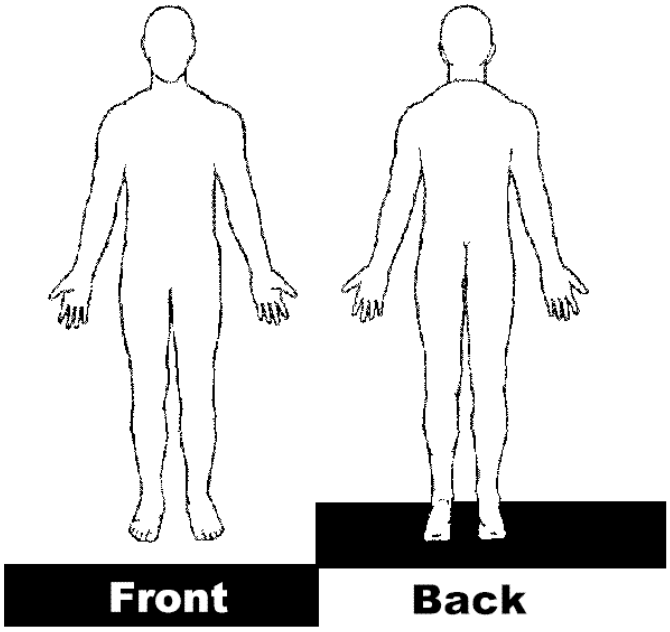
**Have you had any x-rays or tests to evaluate current problem?** ☐ No ☐ Yes, please explain_____

**Have you had a similar problem before?** ☐ Yes ☐ No If Yes, how long ago? _____

**Do you have pain related to your current problem**? ☐ Yes ☐ No

If **YES**, pleas CONTINUE with questionnaire. If **NO**, please STOP and CONTINUE ON THE OTHER SIDE

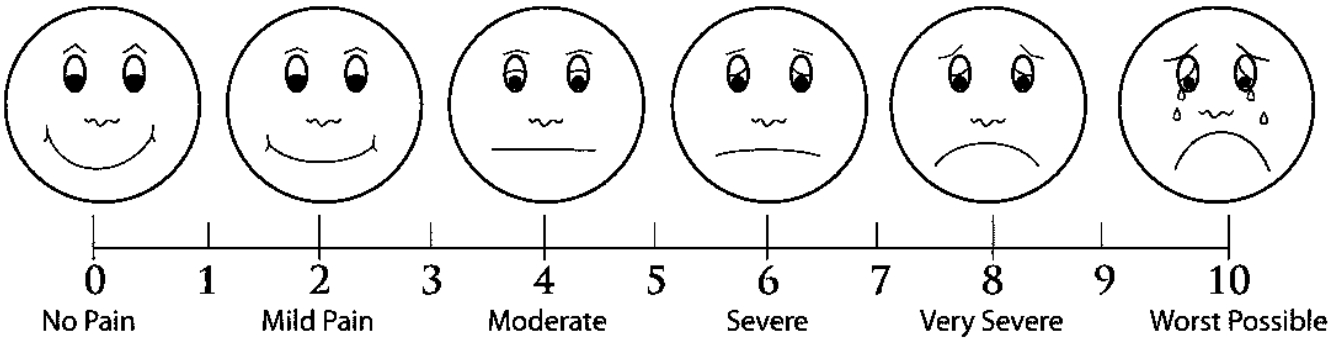
**Where is the pain?** (mark an "X" on the diagram)




**Describe your pain/symptoms:** (check if applicable)

- ☐ Stays all the time
- ☐ Comes and goes
- ☐ Pressure
- ☐ Throbbing
- ☐ Numbness
- ☐ Aching
- ☐ Dull
- ☐ Sharp
- ☐ Heavy
- ☐ Burning
- ☐ Tingling
- ☐ Gnawing
- ☐ Shooting
- ☐ Pricking

**Please, rate your pain/comfort level using the scale below:**




What is your goal for pain relief using above scale? _____

What activities/positions increase your pain? _____

What activities/positions decrease your pain? _____

What activities does pain interfere with or prevent you from doing? _____

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# Worker's Compensation Forms

**Allergies:** ☐ None **Latex Allergy:** ☐ Yes ☐ No

Medication Allergies Reaction

_____

_____

_____

_____

Food Allergies: ☐ No ☐ Yes _____

Dye/Tape Allergies: ☐ No ☐ Yes _____

Shellfish/Iodine Allergies: ☐ No ☐ Yes _____

**Current Medications:** ☐ Check here if attaching a home medication list

**Preferred Pharmacy:** Name_____ Phone Number: _____

Is this a mail-in pharmacy? ☐ Yes ☐ No

| Medication | Dosage | Times per day | Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Patient Signature:** _____ **Date:** _____

SURGICAL SPECIALISTS OF SOUTHWEST FLORIDA, P.A. & SWFL VASCULAR CENTER

# Worker's Compensation Forms

**Social History:** Advanced Directives (Living will): ☐ Yes ☐ No

Occupation: _____ | ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol: ☐ No ☐ Yes Drinks per day/week: _____

Drug Use or Addiction: ☐ No ☐ Yes Drug(s): _____ Caffeine use: ☐ No ☐ Yes How often? _____

**Past Medical History:** ☐ No Medical History | Check all that apply

- ☐ Aortic Aneurysm
- ☐ Carotid Artery Stenosis
- ☐ Stroke
- ☐ Peripheral Arterial Disease
- ☐ Varicose Veins
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Intermittent Claudication
- ☐ Irregular heart beat
- ☐ Murmur
- ☐ Heart Attack (MI)
- ☐ Venous insufficiency
- ☐ Colitis
- ☐ Constipation
- ☐ Diverticulosis/Diverticulitis
- ☐ Gallbladder disease
- ☐ Esophageal reflux
- ☐ Gastrointestinal Bleeding
- ☐ Hernia: _____
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Intestinal obstruction
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Kidney Disease
- ☐ Colon polyps
- ☐ Hematuria
- ☐ Kidney stones
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Diabetes Mellitus
- ☐ Neuropathy
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ HIV
- ☐ Tuberculosis
- ☐ Alzheimer's Disease
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Anemia
- ☐ Coagulation Defects
- ☐ Sickle Cell Disease
- ☐ DVT: _____
- ☐ Pulmonary Embolism
- ☐ Cancer: _____
- ☐ Other: _____

**Past Surgical History:** ☐ No Surgical History | Please list surgeries and approximate date

- ☐ Aneurysm Repair
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ AV Graft/Fistula
- ☐ Brain Surgery
- ☐ Breast Biopsy
- ☐ Cataract Removal
- ☐ Cardiac Bypass
- ☐ Gallbladder Removal
- ☐ Heart Catherization
- ☐ Heart valve replacement
- ☐ Hemorrhoidectomy
- ☐ Hernia: _____
- ☐ Hysterectomy
- ☐ Kidney Removal
- ☐ Mastectomy [ ] L [ ] R
- ☐ Pacemaker
- ☐ Implanted Defibrillator
- ☐ Prostate Surgery
- ☐ Spine (back/neck)
- ☐ Splenectomy
- ☐ Thyroid Surgery
- ☐ Tonsils/Adenoids
- ☐ Total Hip [ ] L [ ] R
- ☐ Total Knee [ ] L [ ] R
- ☐ Tubal Ligation

Other: _____
Other: _____
Other: _____

**Patient Signature:** _____ **Date:** _____

## CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name: _____ SSN#: _____

☐ I give my permission to **Surgical Specialists of Southwest Florida, P.A.**, to disclose my protected health information to the following family or friends:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**OR**

☐ I request that all my protected health information be disclosed only to "Me" and no one else other than my other healthcare providers.

**May we leave a message on your answering machine/voice message about your medical care? ☐ Yes ☐ No**

By signing this form, you are granting consent to Surgical Specialists of Southwest Florida to use and disclose your protected health information for purposes of treatment payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I understand that I am financially responsible for all charges of services to me, including the balance remaining after payment of possible insurance benefits. I assign the benefits payable for physicians' services to the physician furnishing the services.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 936-8555. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

***We utilize an automated system to remind you of your next appointment. By signing this you also give us permission to include you in this automated calling system. If you do not wish to be reminded of future appointments, please let the receptionist know this.***

**Patient Signature: _____ Date: _____**

# CONSENT FORM FOR ePRESCRIBE PROGRAM

## ePrescribe Program

ePrescribing is way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

## Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Surgical Specialists of Southwest Florida, PA to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature Patient Date

_____

Relationship to Patient