DAVID H. GILBERT, MD

Board Certified – Fellowship Trained – American Board of Orthopaedic Surgery
Certificate of Added Qualifications (CAQ) in Surgery of the Hand

5301 N. Dixie Highway, Suite 203
Oakland Park, FL 33334
Telephone: (954) 771-3334 FAX: (954) 771-1069



- Photo ID
- Ins Card

REMEMBER to bring:
A list of any allergies you have and all of the medications you are currently taking

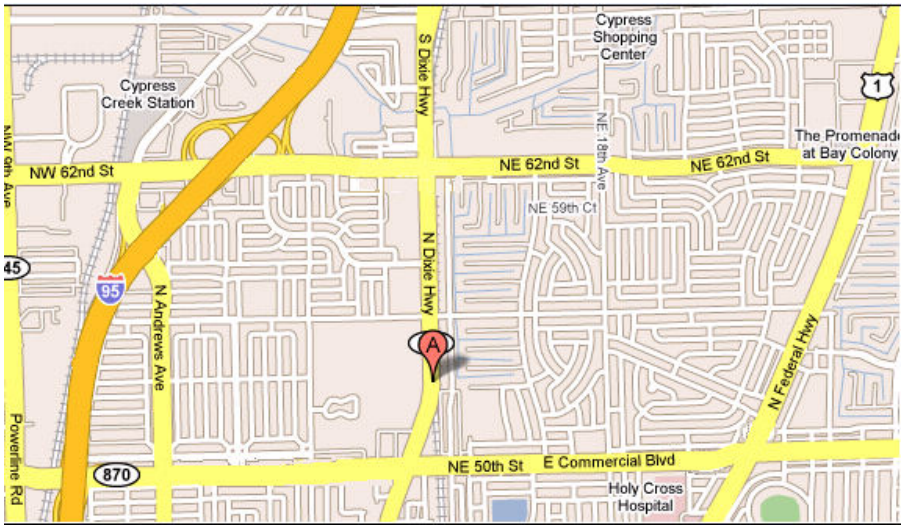
HMO Patients:

Please be sure to bring your Referral from your Primary Care Physician

Please bring completed paperwork with you to your appointment

Directions to David H. Gilbert, MD
5301 N. Dixie Hwy, Suite 203. Oakland Park, FL 33334

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



- We are the green two-story building at
  5301 North Dixie Highway, Suite 203
  Oakland Park, FL 33334



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WELCOME!

The staff at David Gilbert's office 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 physician 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
- Any studies/tests (ie. **MRI, CT Scan**) with the official report and images (CD or films) 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 in conforming to government requirements.**

Remember these important things:

- On **EACH** visit keep us updated on studies/tests/surgeries you have had since we last saw you and (especially if you travel north) try to bring copies of your studies/tests 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.

David H. Gilbert, MD, and Staff

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PATIENT INFORMATION

PLEASE PRINT

Appt Date:_____

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

Mailing Address _____City_____ State____ Zip_____

Sex: ☐ M ☐ F

Social Security # _____ - _____ - _____

Date of Birth _____ Age _____

Referring Physician: _____ City: _____Phone #_____

Marital Status: ☐ S ☐ M ☐ W ☐ D

Cell # ( ) _____ Home # ( ) _____

CONTACT METHOD: ☐ Cell ☐ Home

Email (print clearly): _____

Employer: _____ Work # _____

Employer's Address: _____

If Student: ☐ Full ☐ Part Time School Name: _____

Emergency Contact: _____Phone# _____Relationship:_____

RESPONSIBLE PARTY (i.e: Caregiver, Legal Guardian, Parent)

Name: _____ Relationship to Patient: _____

Email _____ Phone # _____

INSURANCE INFORMATION

**** Workers' comp patients DO NOT fill out below ****

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

Insured's Date of Birth: _____ Sex: ☐ M ☐ F

It is our office policy to collect co-pays, co-insurance and deductibles at time of service and prior to any surgical procedures

DATE: _____ ***ANSWER ALL QUESTIONS TO AVOID DELAYS***

PATIENT HEALTH INFORMATION

PLEASE PRINT

HEIGHT: _____ WEIGHT:_____ ☐ RIGHT ☐ LEFT (HAND DOMINANT)

NAME _____AGE: _____

REASON FOR VISIT / BODY PART? _____

WHAT IS YOUR PRIMARY SYMPTOM? ☐ PAIN ☐ WEAKNESS ☐ STIFFNESS ☐ INSTABILITY

HOW DID YOUR INJURY OCCUR? _____

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

HAS BODY PART HAD PREVIOUS INJURY? ☐ Yes ☐ No

IF SYMPTOMS INCLUDE PAIN WHAT IS SEVERITY OF PAIN? Circle rating of 1-10 for severity of symptoms 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

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 ☐ Heat ☐ Therapy ☐ Injections (How many?) _____ ☐ Rest (Specify amount of time) _____

RELATED PAST SURGERIES? (Specify with dates) _____

NAME OF PERSON WHO RECOMMENDED or REFERRED YOU TO THIS OFFICE?

☐ DOCTOR _____ ☐ FAMILY /FRIEND _____ ☐ OTHER_____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Allergies: (List all medications you are allergic to)	What reaction did you have?

PATIENT NAME: _____ **DATE:** _____

REVIEW OF SYSTEMS:

Please indicate below your history of or current problems with an **"X" by YES**. If you have never encountered a problem with any of the problems below, indicate with an **"X" by NO**.

General

☐ Yes ☐ No Weight Loss
☐ Yes ☐ No Weight Gain
■ Yes ☐ No Fever / Chills
☐ Yes ☐ No Difficulty Sleeping

Head, Eyes, Ears, Nose & Throat

☐ Yes ☐ No Change in vision
☐ Yes ☐ No Ear infections or drainage
☐ Yes ☐ No Sinus infections
☐ Yes ☐ No Problems swallowing
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Cataracts
☐ Yes ☐ No Impaired hearing

Cardiovascular

☐ Yes ☐ No Chest pain (angina)
☐ Yes ☐ No Shortness of breath (with walking or laying down)
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Difficulty walking 2 blocks
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Swelling of the feet
☐ Yes ☐ No Blood clots

Pulmonary

☐ Yes ☐ No Cough
☐ Yes ☐ No Snoring
☐ Yes ☐ No Sputum production
☐ Yes ☐ No Emphysema/COPD
☐ Yes ☐ No Asthma
☐ Yes ☐ No Sleepiness during the day

Gastrointestinal

☐ Yes ☐ No Heartburn
☐ Yes ☐ No Change of appetite
☐ Yes ☐ No Frequent vomiting
☐ Yes ☐ No Change in bowel habits
☐ Yes ☐ No Black, tarry stools
☐ Yes ☐ No Rectal bleeding

Genitourinary

☐ Yes ☐ No Pain while urinating
☐ Yes ☐ No Burning while urinating
☐ Yes ☐ No Blood in urine
☐ Yes ☐ No Hesitancy in urinating
☐ Yes ☐ No Incontinence
☐ Yes ☐ No Night time urinating (# of times per night ___)

Musculoskeletal

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Muscle weakness
☐ Yes ☐ No Frequent fractures
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Joint stiffness

Neurological

☐ Yes ☐ No Mini strokes
☐ Yes ☐ No Strokes
☐ Yes ☐ No Seizures
☐ Yes ☐ No Fainting spells

Psychiatric

☐ Yes ☐ No Anxiety
☐ Yes ☐ No Depression
☐ Yes ☐ No Other psychiatric diagnoses

Endocrine

☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Diabetes (Insulin dependent)
☐ Yes ☐ No Diabetes (Oral Medications)

Skin

☐ Yes ☐ No Rashes
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Skin cancer (Type)_____

Other:

_____

_____

PATIENT NAME: _____ **DATE:** _____

MEDICAL HISTORY

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

☐ Yes ☐ No ADHESIVE ALLERGY
☐ Yes ☐ No ALCOHOLISM
☐ Yes ☐ No ALZHEIMER'S / DEMENTIA
☐ Yes ☐ No ARTHRITIS (Location) _____
☐ Yes ☐ No BLOOD TRANSFUSION (When) _____
☐ Yes ☐ No BRONCHITIS
☐ Yes ☐ No CANCER (Type) _____
☐ Yes ☐ No DIVERTICULITIS
☐ Yes ☐ No DRUG ADDICTION
☐ Yes ☐ No EPILEPSY
☐ Yes ☐ No FRACTURES_____
☐ Yes ☐ No GOUT
☐ Yes ☐ No HEART DISEASE
☐ Yes ☐ No HEPATITIS ---------If Yes: ☐ A ☐ B ☐ C
☐ Yes ☐ No HIGH BLOOD PRESSURE
☐ Yes ☐ No HIGH CHOLESTEROL
☐ Yes ☐ No HIV POSITIVE
☐ Yes ☐ No KIDNEY STONES
☐ Yes ☐ No LATEX ALLERGY
☐ Yes ☐ No LIVER DISEASE
☐ Yes ☐ No PARKINSONISM
☐ Yes ☐ No PEPTIC ULCERS
☐ Yes ☐ No PNEUMONIA
OTHER _____

PAST SURGERY PLEASE LIST ALL OF THE OPERATIONS YOU HAVE HAD IN YOUR LIFETIME

Year	Type of Operation

SOCIAL HISTORY

Name of spouse or partner: _____

PREFERRED LANGUAGE: ☐ **English** ☐ **Spanish** ☐ **French** ☐ **Other** _____

ETHNICITY: ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino**

RACE: ☐ **White** ☐ **Black/African American** ☐ **Asian** ☐ **Am Indian/Alaskan Native** ☐ **Native Hawaiian/ other Pacific Islander**

SMOKING HISTORY: ☐ **Never** ☐ **Former Smoker /Quit Date** _____ ☐ **Current Every Day** ☐ **Current Occasionally**

Do you use Alcohol? ☐ **Yes** ☐ **No** **If yes, # of drinks** _____ **daily** _____ **weekly** _____ **monthly**

Do you have an advanced directive: (e.g. , Living Will) ☐ **Yes** ☐ **No**

OCCUPATION _____ ☐ Active ☐ Retired

HOBBIES/ACTIVITIES _____

Who is your primary care physician (PCP)? _____ _____

Address: _____ Phone: _____

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Authorization to Discuss Protected Health Information (HIPAA)

I _____authorize the office of:
(patient name)

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): **(example: spouse, mother, father, friend, assistant, secretary, school coach, etc.)**

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)**

Our office will remind you of your appointment via text message and/or phone call.

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 #: _____

_____ _____
Patient or Guardian Signature Date

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www.browardorthopedic.com

REVISED HIPAA PRIVACY POLICY

David H. Gilbert, M.D. Privacy Notice - Effective September, 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should have any questions regarding these policies please do not hesitate to speak to our office manager at (954) 771-3334.

INFORMATION WE COLLECT ON YOU

We collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian. David H. Gilbert MD does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. David H. Gilbert MD, maintain physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with David H. Gilbert MD.

CHANGES TO OUR PRIVACY POLICY

All new patients will receive a copy of our privacy policy. David H. Gilbert MD occasionally reviews the privacy policy and reserves the right to amend it. Notification of changes will be posted on our website and copies available at the front desk prior to the effective date of any changes.

YOUR RIGHT TO RESTRICT USE OF INFORMATION

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

If you would like a more detailed explanation of our policy please ask our receptionist or review this policy posted in our waiting room.

_____

Print Name

_____ _____

Signature **Date**

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Dear Patient:

We ask that you read and sign below 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. (This does not apply to workers' compensation patients injured on the job with a compensable work-related injury)

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 are for our surgical fees only! You are 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.

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 rescheduling your appointment. Some insurance companies state that you cannot go out of network. It is impossible to keep up with the changes, and often we are not aware of them until it is too late.

I hereby assign, transfer, and set over to David Gilbert, MD & Associates, and all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize the release of any medical information needed to determine these benefits. This is a lifetime authorization with David Gilbert, MD & Associates. In the event of any litigation arising from the care of David Gilbert and/or staff, including but not limited to allegations of medical malpractice or unpaid bills/claims, David Gilbert, MD & Associates shall be entitled to recover all reasonable costs incurred, from the non-prevailing entity/party, if David Gilbert, MD is the prevailing entity/party (of the litigation). These costs include staff time, court costs, attorney fees, expert fees, and all other related expenses incurred in such litigation. In the event of a non-adjudicative settlement of litigation between the parties or a resolution of a dispute by arbitration, the term "prevailing entity/party" shall be determined by that process. 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 $35 fee assessed for checks returned by the bank for any reason. I authorize David Gilbert, MD & Associates, 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 David Gilbert, MD & Associates, 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. I give consent to David Gilbert, MD & Associates, to view my medication history.

Name: _____
(Please Print)

Patient's Signature _____ Date _____
(If minor, parent to sign)

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David H. Gilbert, M.D.
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Microvascular Reconstruction

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Medication History Consent Form

By signing this consent form you are agreeing that David H. Gilbert, MD and Associates can access my pharmacy benefits data electronically through ePrescribe. This consent enables David H. Gilbert, MD and Associates to:

- Send my prescription electronically
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, ePrescribe to these pharmacies
- Download a historic list of all medications prescribed for a patient by any other provider.

Understanding all of the above, I hereby provide informed consent to David H. Gilbert, MD and Associates to obtain formulary information, and information about other prescriptions prescribed by other providers.

_____	_____	_____
Print Patient Name	Date of birth	Date

_____
Patient/Parent Signature

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NOTICE OF VIDEO SURVEILLANCE

Dear Patients and Visitors,

To help ensure the safety, security, and well-being of our patients, visitors, staff, and property, this office is equipped with video surveillance cameras, including examination rooms where you will NOT be disrobing.

The surveillance system is in operation throughout designated areas of the facility and will record video only (no audio) activity for security, safety, and operational purposes. Recordings are maintained in accordance with applicable laws and office policies.

By entering these premises, you acknowledge that you will be recorded by our surveillance system.

Thank you for your cooperation and understanding.

Name: _____
(Please Print)

Patient's Signature _____ Date _____
(If minor, parent to sign)