Dr. James Leiber, Dr. Ron Torrance, Dr. Ignatios Papas & Dr. Lisa Valastro
5630 Marquesas Circle Sarasota, FL 34233 Phone: 941-357-1773
8600 Hidden River Parkway Suite 700 Tampa, FL 33637 Phone: 813-544-3123
100 2nd Avenue South Suite 904S St. Petersburg, FL 33701 Phone: 941-357-1773
1412 Trovillion Avenue, Winter Park, FL 32789 Phone: 407-856-3695
Fax (all locations): 941-256-7452

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME(FIRST– LAST– MIDDLE INITIAL)			**HOME PHONE**	**CELL PHONE**
ADDRESS			**CITY, STATE**	**ZIP**
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: ❑ **SELF** ❑ **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 ADDRESS, 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**
ID NUMBER, GROUP NUMBER	**EMPLOYER**	**EMPLOYER PHONE**
PRIMARY DOCTOR/ FAMILY DOCTOR	**REFERRING DOCTOR**	
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**
PREFERRED PHARMACY	**PHARMACY LOCATION**	**PHARMACY PHONE**

Regenexx™
At New Regeneration Orthopedics

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 SEND TO A COLLECTIONS 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 RECORDS DEPARTMENT.

SIGNATURE OF PATIENT, 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**
PRINTED NAME	
THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE YEAR, OR I WILL PROVIDE WRITTEN NOTICE OF REVOCATION TO THE MEDICAL RECORD DEPARTMENT.	
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 federal health privacy law, as described below.

I, _____, authorize Regenexx Tampa Bay to release and obtain my private health information to/from (check all that applies):

❑ My Spouse/Partner:_____

❑ My Primary Care Physician/ Staff:_____

❑ My Pharmacy: _____

❑ My Parent/ Child(ren): _____

❑ My Personal Representative: _____

❑ Other Names: _____

❑ None of the Above

May our office leave a message on your voicemail? ❑ 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. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the attention of the *Privacy Officer at 2401 University Parkway, Suite 104, Sarasota 34243.* I understand that my revocation will not affect any action taken, 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 Medications
- 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 specified 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** 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.**

I acknowledge that I have been notified of Regenexx Tampa Bay Privacy Practices and understand that if I have a question or complaint, that I should contact the Privacy Office. (**Patient Initials**_____)

I, the undersigned, authorized Regenexx Tampa Bay 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 consents.

_____ _____

Patient Signature Date

_____ _____

Patient or Responsible Party Date

REQUEST FOR RELEASE OF MEDICAL RECORDS

_____ _____/____/_____ _____-____-_____

Patient Name Date of Birth SSN

To (Provide Facility/ Location):_____

Fax number:_____ Phone Number: _____

I REQUEST THAT RECORDS BE RELEASED THAT PERTAIN TO THE FOLLOWING BODY REGION(S):

_____

SPECIFICALLY, I REQUEST FOR THE FOLLOWING TO BE SENT:

❑ X-Ray (Radiology Report & Imaging Disk) ❑ MRI's (Radiology Report & Imaging Disk)

❑ Consult Reports ❑Operative Reports ❑ Complete Records ❑Other:_____

PLEASE RELEASE TO:

❑ 5630 Marquesas Circle, 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

❑ 100 2nd Avenue South, Suite 904S, St. Pete, FL 33701 Phone: (727)284-5250 Fax: (941)256-7452

❑ 1412 Trovillion Avenue, Winter Park, FL 32789 Phone: (941)357-1773 Fax: (941)256-7452

REQUESTING PROVIDER:

❑ James Leiber, D.O. ❑ Ignatios Papas, D.O. ❑ Ronald Torrance, D.O. ❑ Lisa Valastro, D.O.

I authorize your facility to release the medical records requested by Regenexx Tampa Bay.

_____ _____

Patient Signature Date

I UNDERSTAND THAT THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, ACQUIRED IMMUNODEFICINCY 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

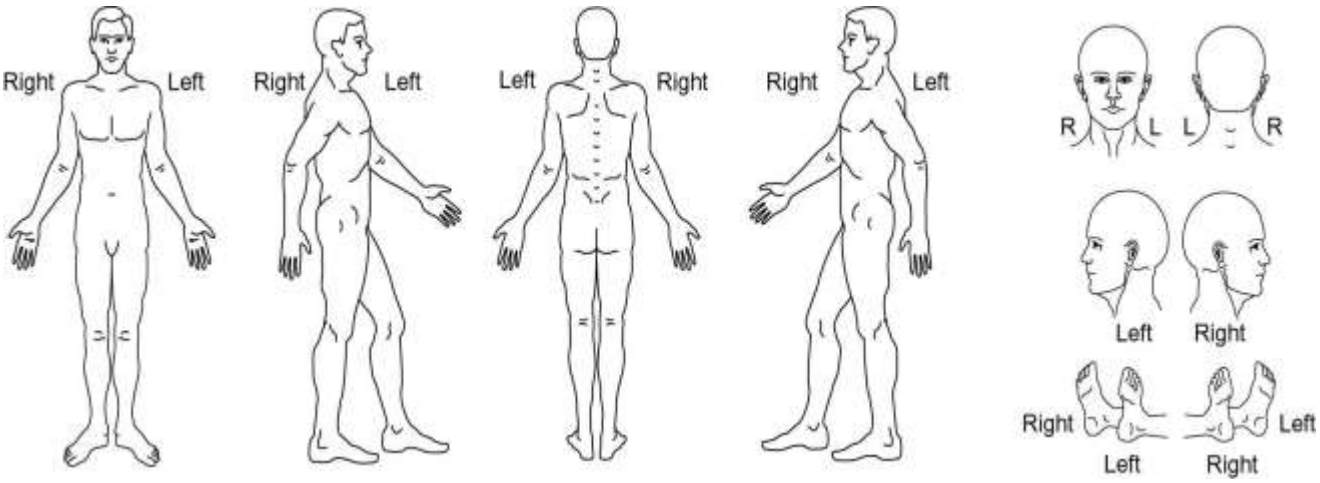
PATIENT NAME _____ AGE _____ DOB_____

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>**? _____

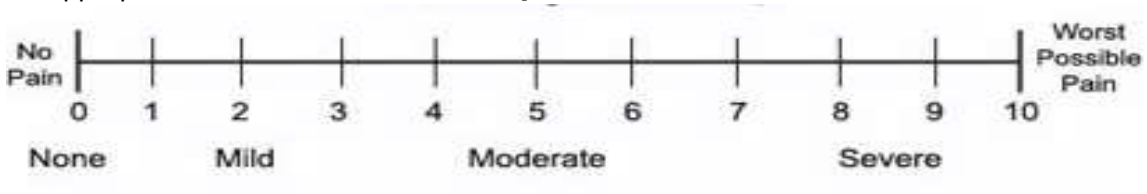
   _____

   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 **radiate** 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. _____