Thomas M. Mixa , M.D, P.A.
PH: 727-321-9644 FAX: 727-321-8580
Email@drmixa.com

MIXA ORTHOPEDICS

1609 Pasadena Ave. S. STE 1A
South Pasadena, Fl. 33707

PATIENT REGISTRATION FORM

Patient Name _____ (First / Middle / Last) Date of Birth ____/____/____

Self

Mailing Address _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email Address _____
SSN _____
Ok to Leave Message? _____ Home _____ Cell _____ Both

Guarantor (Responsible Party)

Name _____ Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ SSN _____

Employer

Company Name _____
Phone Number _____
Ok to Leave Message? _____ Yes _____ No

Primary Insurance

Insurance Name _____
Mailing Address _____
City _____ State _____ Zip _____
Phone Number _____
Subscriber ID _____ Group ID _____
Co-Pay _____ Deductible _____
Subscriber Name _____
Date of Birth _____ SSN _____
Relation to Patient _____

Secondary Insurance

Insurance Name _____
Mailing Address _____
City _____ State _____ Zip _____
Phone Number _____
Subscriber ID _____ Group ID _____
Co-Pay _____ Deductible _____
Subscriber Name _____
Date of Birth _____ SSN _____
Relation to Patient _____

Primary Care Physician

Name _____
Office Phone _____ Fax _____

Referring Physician

Name _____
Office Phone _____ Fax _____

Emergency Contact

Name _____ Relation _____
Home Phone _____ Cell Phone _____

Pharmacy

Pharmacy Name _____
Phone Number _____

1609 PASADENA AVE. S.
SUITE 1 A
SOUTH PASADENA, FL. 33707
PH: 727-321-9644
FAX: 727-321-8580

MIXA ORTHOPEDICS
MEDICAL HISTORY

Date:

PLEASE PRINT ALL INFORMATION					
NAME:			**DOB:**		
What is your approximate weight?	Lbs.	Height?	ft	in	
Referred here by: (circle one)	self	family	friend	doctor	attorney other
Name of Person / Physician making referral:					
List Current Treating Physicians including PCP:					
Describe the reason for your visit:					
Body Part to be examined:			Right	Left	Both
How did your symptoms/injury begin? (describe in detail)					
Approximate date symptoms began or date of injury:			New or Old injury (circle one)		
On a scale of 1-10 (10 being most severe) circle the # that best describes your pain:	1 2 3 4 5 6 7 8 9 10				
Resulting from: (circle which applies)	Sports	Accident	Work Related	Involving Litigation	
Are Symptoms:	constant	intermittent	worsening	improving	unchanged
Circle all that apply:	pain	stiffness	swelling	instability	weakness numbness/tingling
What makes symptoms worse?					
What makes symptoms better?					
What previous formal treatment have you had for this problem? (Medications, therapy, surgery, injections)					

PAST SURGICAL HISTORY

Previous Type of Operation	**Year**
1.	
2.	
3.	
4.	
5.	

Any previous fractures? YES ☐ NO ☐ WHERE?

****DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO**

If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, etc)

CURRENT MEDS: (List any medications you are taking at this time. Include items such as aspirin, vitamins, etc.

NAME OF DRUG	REASON FOR USE	DOSING INSTRUCTIONS (strength & frequency)	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

MEDICAL HISTORY/ REVIEW OF SYSTEMS

Please check if you have a history of any of the following	YES	NO
GENERAL		
Are you currently pregnant?		
Diabetes – type I ☐ type II ☐		
Stroke		
Kidney Disease		
Ulcers		
Asthma or Lung Disease		
Cancer: Type?		
Fatigue		
Weakness		
Fevers		
Skin problems/disorders: Type?		
Rheumatic Fever		
Tuberculosis		
Recent weight gain/loss: (circle one) How much?		
BLOODBORNE PATHOGENS		
HIV / AIDS		
Hepatitis		
Other		
SITES OF INFECTION		
Urinary		
Dental		
Other		
NEUROLOGICAL		
Headaches		
Dizziness		
Fainting		
Memory Loss		
Loss of Consciousness		
Muscle Spasms		
Numbness or Tingling of Hands/Feet		
Blindness or Trouble Seeing		
Deafness or Trouble Hearing		
Seizures		

	YES	NO
CARDIOVASCULAR		
Chest Pain/Angina		
Heart Attack/Myocardial Infarction		
Palpitations		
High Blood Pressure / Hypertension		
Shortness of Breath		
Swelling of Lower Extremities		
HEMATOLOGIC		
Anemia		
Blood Clots		
Bleeding Tendency		
Easily Bruised		
Circulatory Problems		
Currently on Blood Thinners		
--if yes, what type?		
Phlebitis		
MUSCULOSKELETAL		
Joint Pain		
Joint Swelling		
Muscle Weakness		
Muscle Tenderness		
Morning Stiffness		
Arthritis / Osteoarthritis		
Rheumatoid Arthritis		
Osteoporosis		
Bone / Joint Infections		
Gout		
PSYCHOLOGICAL		
Depression		
Anxiety Disorder		
Other illnesses or diseases which are not listed?		

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO
Diabetes (sugar)		
Heart Disease		
Anesthetic Complications		
Cancer: Type?		

	YES	NO
Abnormal Bleeding Tendencies		
Rheumatoid Arthritis		
Osteoarthritis		
Gout		

SOCIAL HISTORY

Occupation: Job Duties:

Marital Status: # of Children ____

Do you smoke? YES ☐ If Yes: How many packs per day? ___ Year Started ____ Have you been counseled to quit or cut down? YES ☐ NO ☐
NO ☐ If No: Former Smoker? YES ☐ Year Started ____ Year Quit ____

Do you consume alcohol? YES ☐ NO ☐ If so, how many drinks per week? ____ Is there a history of abuse? YES ☐ NO ☐

Have you ever had a problem with drugs? YES ☐ NO ☐

Do you participate in recreational drug use? YES ☐ NO ☐ If yes, or in past, list type and amount:

Please list all sports and hobbies you are involved in:

Patient Signature: I, as the patient, state the information is correct and accurate to the best of my knowledge.	**DATE:**

Thomas M. Mixa , M.D, P.A.
PH: 727-321-9644 FAX: 727-321-8580
Email@drmixa.com

1609 Pasadena Ave. S. STE 1A
South Pasadena, Fl. 33707

FINANCIAL CONSENT

Patient Name:_____ **DOB:**_____ **Date:** _____

I hereby authorize said assignee to release all information necessary to secure payment. I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me.

I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductible and co-pays, and that payments are due at the time services are rendered.

I understand and agree that in the event that I fail to make payments for services rendered to me, my name and account may be turned over to an attorney or a collection agency, and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney's fees that may be incurred in the collection of any outstanding balance. I authorize the physician to release any information necessary to allow payment of any claim or any information acquired in the course of my examination or treatment to my referring physician. I understand and agree if I do not keep my appointment or fail to give a 48-hour notice of appointment change I will be charged a
$25 charge. This charge is not covered by insurance.

Patient Signature:_____ **Date:** _____

PRIVACY CONSENT

I have been provided with a copy of the practice's Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

CONSENT FOR TREATMENT

I hereby voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures I understand that I am under the care of supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of the physician(s).

Patient Signature:_____ **Date:** _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I hereby voluntarily consent to the rendering of care, to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Patient Signature:_____ **Date:** _____

MIXA ORTHOPEDICS

Thomas M. Mixa , M.D, P.A.
PH: 727-321-9644 FAX: 727-321-8580
Email@drmixa.com

1609 Pasadena Ave. S. STE 1A
South Pasadena, Fl. 33707

PRESCRIPTION DRUG POLICY

Patient Name:_____ **DOB:**_____ **Date:** _____

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from Dr. Mixa, you are also accepting the responsibly to use the drug for yourself and only in the prescribed manner. Our responsibility is to prescribe medications in an appropriate dosage and amounts, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects. We will answer any questions you may have about the prescription drug you are being given.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We accept NO excuse for their loss or theft and will not order replacements. We will not prescribe them if you are using them other than exactly as prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first store may be canceled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescription. When your medications are getting low and you feel you need a refill, please call our office with the name of your pharmacy and the pharmacy phone number 24-48 hours prior so that we will have sufficient time to confirm your medication and then to call your prescription into your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR) or call the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

I agree to the following guidelines:

1) I will take any medications only as prescribed and I will not change the amount or the frequency without authorization from my physician.

2) I understand that due to the high potential for abuse and these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will be provided during regular office hours.

3) According to State laws, you MAY NOT HAVE MORE THAN ONE PHYSICIAN PRESCRIBING NARCOTICS. It is mandatory that we EFORCE, before prescribing narcotics.

4) I will submit to random urine or blood tests if requested by my physician to assess my compliance.

5) If I do not follow these guidelines, I understand that my treatment may be terminated.

Patient Signature:_____ **Date:** _____

Thomas M. Mixa , M.D, P.A.
PH: 727-321-9644 FAX: 727-321-8580
Email@drmixa.com

MIXA ORTHOPEDICS

1609 Pasadena Ave. S. STE 1A
South Pasadena, Fl. 33707

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ **DOB:**_____ **Date:** _____

I hereby authorize _____ , Medical Records Department, to release my medical records to:

Thomas Mixa M.D., P.A.
1609 Pasadena Ave S. Suite 1 A
South Pasadena, Fl. 33707

This request and authorization applies to:

- ❑ Healthcare information relating to the following treatment, condition, or dates: _____
- ❑ All Healthcare Information
- ❑ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, nonspecific urethritis, syphilis VDRL, Chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

❑ Yes ❑ No I authorize the release of STD results, HIV/AIDS, testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

❑ Yes ❑ No I authorize the release of any records regarding drug alcohol, or mental health treatment to the person(s) listed above.

Patient Signature:_____ **Date:** _____