

# BROWARD ORTHOPEDIC SPECIALISTS

DAVID H. GILBERT, MD  
Specialist in Hand, Wrist and Elbow



- 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:

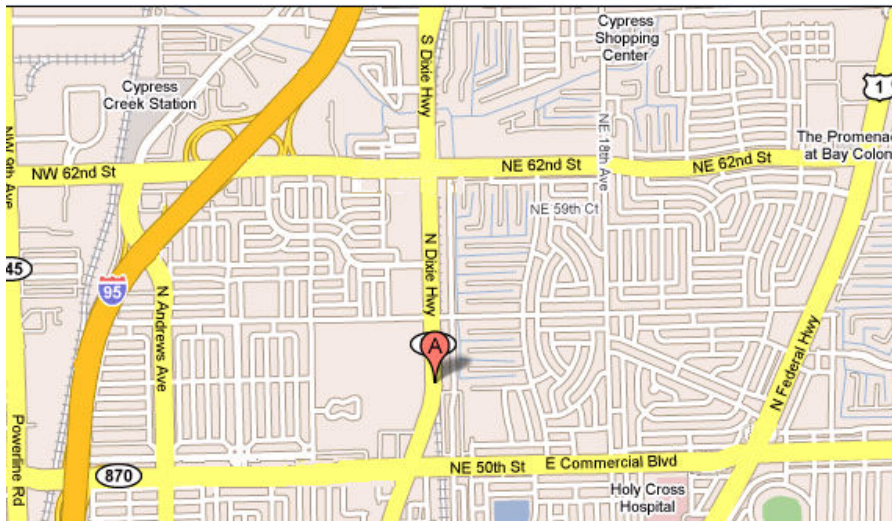
Please be sure to bring your Referral from your Primary Care Physician

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



## **Directions to 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 Fort Lauderdale, FL 33334**



# BROWARD ORTHOPEDIC

## SPECIALISTS

DAVID H. GILBERT, MD  
Specialist in Hand, Wrist and Elbow

### WELCOME!

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
- 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 with 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](http://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

# BROWARD ORTHOPEDIC

## SPECIALISTS

DAVID H. GILBERT, MD  
Specialist in Hand, Wrist and Elbow

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, 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. In the event of any litigation arising from the care of David Gilbert and/or staff ("The Practice"), including but not limited to allegations of medical malpractice or unpaid bills/claims, "The Practice" shall be entitled to recover all reasonable costs incurred, from the non-prevailing entity/party, if "The Practice" 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, 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, 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, to view my medication history.

**Name:** \_\_\_\_\_  
(Please Print)

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(If minor, parent to sign)

**PLEASE PRINT**

**PATIENT INFORMATION**

**Appt Date:** \_\_\_\_\_

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 # ( ) \_\_\_\_\_

**Email (print clearly):** \_\_\_\_\_

**CONTACT METHOD:**  Email  Cell  Home  Work phone  Written (mailed)  Patient Refused

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work # \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

If Student:  Full  Part Time School Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship: \_\_\_\_\_

---

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

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Email \_\_\_\_\_ Phone # \_\_\_\_\_

---

**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 Date of Birth: \_\_\_\_\_ Sex:  M  F

*If the patient is 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 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\***

HEIGHT: \_\_\_\_\_

**PLEASE PRINT**

**PATIENT HEALTH INFORMATION**

WEIGHT: \_\_\_\_\_

RIGHT  LEFT HAND DOMINANT

PATIENT NAME \_\_\_\_\_ AGE: \_\_\_\_\_

REASON(S) VISIT \_\_\_\_\_

WHAT IS YOUR PRIMARY SYMPTOM?  PAIN  WEAKNESS  STIFFNESS  INSTABILITY

LIST CONTRIBUTING EVENTS OR KNOWN CAUSES FOR SYMPTOMS: \_\_\_\_\_

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 Treatment  Physical Therapy

Injections (How many?) \_\_\_\_\_  Heat Treatment  Rest (Specify amount of time) \_\_\_\_\_

RELATED PAST SURGERIES? (Specify with dates) \_\_\_\_\_

WHO RECOMMENDED YOU TO THIS OFFICE? (Please give name of person who 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?

**IF WORK COMP ANSWER THE FOLLOWING FIVE (5) QUESTIONS:**

1. Was injury reported to your employer?  Yes  No If yes, what was the date reported \_\_\_\_\_
2. When was your injury first evaluated by a medical professional? Date: \_\_\_\_\_ Name: \_\_\_\_\_
3. Have you been working since your injury?  Yes  No If yes, have you been working  full duty  light duty
4. If work restrictions, please list \_\_\_\_\_
5. Name of person who defined work restrictions: \_\_\_\_\_

**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 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 HEPATITIS -----If Yes:  A  B  C
- Yes  No HEART DISEASE:
- 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
- Yes  No PROSTATE  Enlarged  Cancer

OTHER \_\_\_\_\_

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

Year	Type of Operation

**SOCIAL HISTORY**

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 Some Days

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: \_\_\_\_\_

# BROWARD ORTHOPEDIC

## SPECIALISTS

DAVID H. GILBERT, MD  
Specialist in Hand, Wrist and Elbow

### 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



# **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**