PATIENT INFORMATION

FULL NAME _____ DATE _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL ADDRESS _____

MARITAL STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ SPOUSE NAME _____

SECOND ADDRESS _____

PHYSICIAN _____ PHONE _____

PATIENT REFERRED BY _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP TO PATIENT _____

IS THIS VISIT DUE TO AN ACCIDENT? _____ TYPE _____

INSURANCE INFORMATION

POLICYHOLDER _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____ INSURANCE CO. _____

MEMBERSHIP ID _____ GROUP # _____

PATIENT HISTORY

Name _____ Date _____

Date your problem started _____ Did pain begin ☐ gradually or ☐ sudden onset?

Describe what happened _____

_____

Check each of the following that applies:

- ☐ My back sometimes gets stuck when I bend forward.
- ☐ After walking, bending forward relieves my pain.
- ☐ My back sometimes feels like it is giving way when I bend forward.
- ☐ My pain stops me when I walk a certain distance.
- ☐ I have trouble with urine or bowel control.
- ☐ The pain is worse after exercise or exertion.
- ☐ Walking and moving around is more comfortable then either sitting or standing.
- ☐ Sitting is more comfortable than standing.
- ☐ Standing is more comfortable than sitting.
- ☐ My leg often hurts or tingles when I stand up after sitting.
- ☐ My leg often hurts or tingles when I bend forward.
- ☐ The pain is worse when I wake up in the morning.
- ☐ The pain is worse when I go to bed at night.
- ☐ I am not able to do housework without pain.
- ☐ I am not able to work at my job without pain.

Do you have problems sleeping? _____ Why? _____

List family members (e.g., mother, sister) with a history of arthritis or back problems.

_____

List all medications (*prescribed, over-the-counter or herbal*) you are taking now: _____

_____

_____

What is your present state of health? (List your health problems/diagnoses below.)

_____

_____

If you have a specific question, please write it here. _____

_____

LIST ALL DRUG ALLERGIES _____
(IF "NONE", PLEASE INDICATE "NONE")

_____

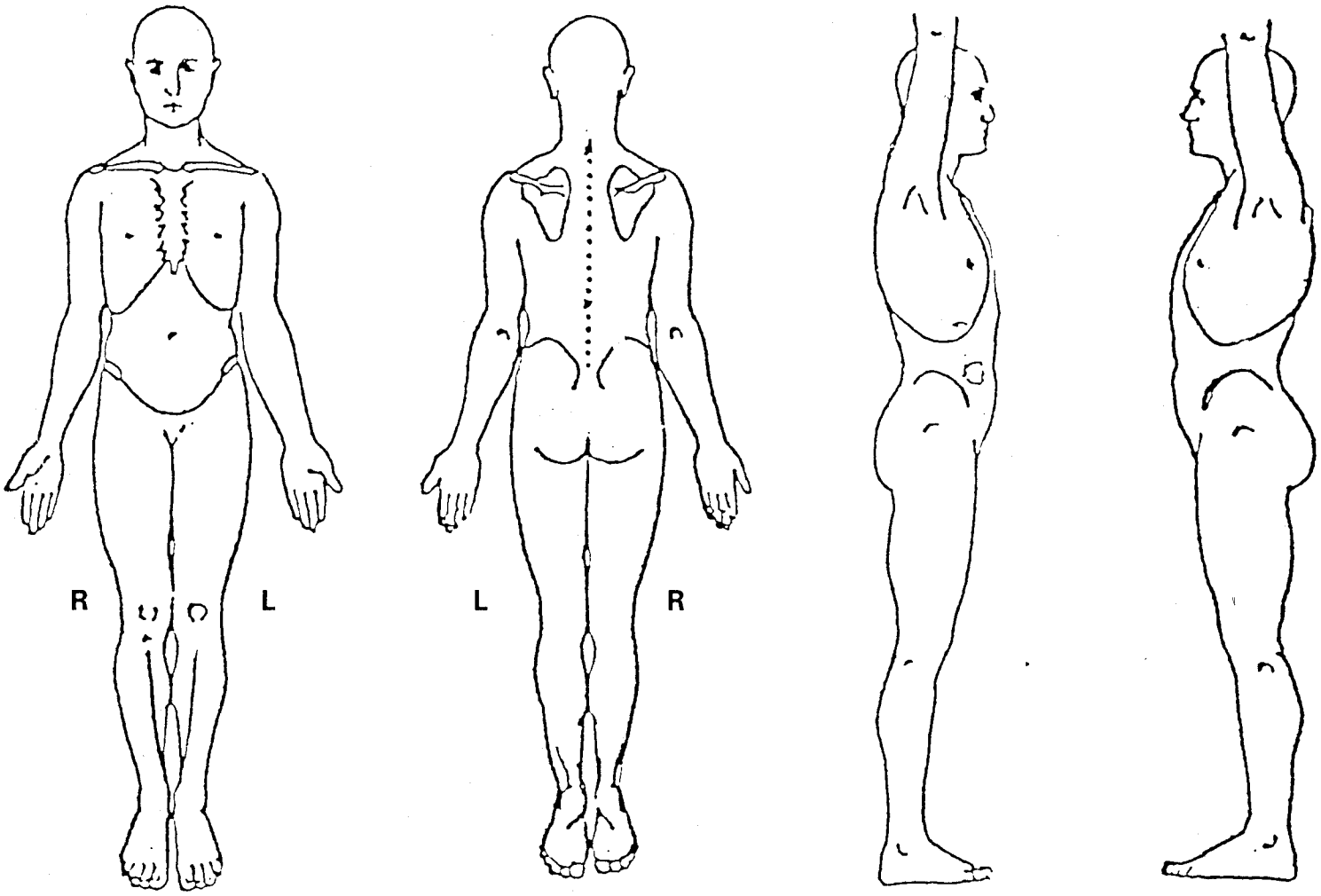
Name _____ **Date** _____

Please mark the diagrams below to indicate where on your body you feel sensations using the following symbols:

Pain xxx	**Burning** = = =	**Numbness** ooo
Stabbing /////	**Ache** ^ ^ ^	**Numb-like feeling** zzz

.....

FRONT **BACK** **Right Side** **Left Side**



Please rate your overall pain: least  worst

MOTOR VEHICLE ACCIDENT HISTORY

Patient _____ Date _____

Date of the accident _____ Time of the accident_____

The accident occurred in ☐ Florida ☐ (Specify state) _____

Were you the driver or the passenger? ☐ Driver ☐ Passenger

If a passenger, where were you sitting: ☐ Front/passenger ☐ Front/middle ☐ Rear/driver side

☐ Rear/passenger ☐ Rear/middle ☐ Pickup Bed Other _____

Were you wearing a seatbelt? ☐ Yes ☐ No

What make and model of vehicle were you in? _____

What was the make and model of the other vehicle? _____

What damage was done to your vehicle? _____

_____

At what speed were you traveling? _____ Other vehicle's speed?_____

Were you at a stop sign or a traffic signal? ☐ No ☐ Yes ☐ Stop sign ☐ Traffic Signal

Please give a brief description of the accident including location and direction of travel.

_____

_____

AUTO INSURANCE INFORMATION

Company_____ Adjuster's Name_____

Policyholder's Name _____Phone _____

Policy #_____ Claim #_____

Claims Address_____

Phone(s) _____ Fax _____

ATTORNEY INFORMATION

Attorney's Name/Firm _____

Address _____

City, State, Zip _____

Attorney's Assistant _____ Title _____

Phone(s) _____ Fax _____

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Clearwater FL 33756
727-787-5555
www.ProlotherapyFlorida.com

LETTER OF PROTECTION

To Whom It May Concern:

I do hereby authorize Felix S. Linetsky MD to furnish you, my attorney, with a full report of his examination, diagnosis, etc. in regard to the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to Felix S. Linetsky such sums as may be due and owing for medical services rendered me both by reason of the incident and by reason of any other bills due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. Linetsky. I hereby further give a lien on my case to Dr. Linetsky against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Dr. Linetsky for all medical bills submitted by his office for services rendered and that this agreement is made solely for Dr. Linetsky's additional protection and in consideration of his waiting for payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I have been advised that if my attorney does not wish to cooperate in protecting Dr. Linetsky's interest, Dr. Linetsky will not await payment and may declare the entire balance due and payable.

_____	_____
PATIENT'S SIGNATURE	PATIENT'S PRINTED NAME
_____	_____
WITNESS	DATE
_____	_____
ATTORNEY'S SIGNATURE	DATE

33110

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

NOTE TO PATIENT: There are risks involved in any procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment.

I authorize Felix S. Linetsky MD and such physicians, associates, assistants and other personnel or the hospital or medical facility chosen by him or her to perform the following (IN MEDICAL TERMS KNOWN AS):

REGENERATIVE INJECTION THERAPY ALSO KNOWN AS

PROLOTHERAPY, SCLEROTHERAPY OR RECONSTRUCTIVE THERAPY

(IN COMMON TERMS KNOWN AS):

INJECTION OF AN IRRITATING SOLUTION INTO THE LIGAMENTS ABOUT A JOINT

and/or to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above procedure.

- **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications of the treatment or procedure which are described generally on the back of this consent form. These risks include the risk of bleeding, infection, pain, anesthesia risks and death.

- **SPECIFIC RISKS AND COMPLICATIONS.** I am satisfied with my understanding of specific risks of this procedure or treatment including (Doctor to describe specific risks where applicable):

ALLERGY OR ADVERSE REACTION TO ANY COMPONENT OF THE INJECTION; IRRITATION OF SURROUNDING STRUCTURES (INCLUDING POSSIBLE NEURALGIA); ECCEYMOSIS (BRUISING); SWELLING; DIZZINESS; HYPERTENSION; EPIDURAL INFILTRATION; PAIN ABOUT THE INJECTION AREA AND JOINT; HEADACHE; NAUSEA; PNEUMOTHORAX

- **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including (Doctor to describe specific alternative procedures and complications where applicable):

OPEN SURGICAL REPAIR OF LIGAMENTS; CHRONIC MEDICATION FOR THE RELIEF OF PAIN; EXTERNAL AND INTERNAL SUPPORTS (FUSION) OF THE AFFECTED JOINT;

DO NOTHING

- **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

- **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

- **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

- **OTHER SERVICES.** I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

- **PHOTOGRAPHY.** I consent to the photographing, filming or videotaping of the treatment or procedure for educational or diagnostic use.

- **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

- **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.

I have read and been given a copy of this form.

DATE: _____ TIME _____ AM/PM

SIGNATURE: _____
(PATIENT, PARENT OR LEGAL GUARDIAN)

TRANSLATED BY (IF APPLICABLE): _____

PHYSICIAN: _____

WITNESS: _____

PLEASE READ THE GENERAL INFORMATION ON BACK.

WHITE-Office Copy CANARY-Patient Copy

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. **YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This notice is provided pursuant to Florida law.

Wording pursuant to 2001 Florida Statutes, Title XXXII, Chapter 458, Section 458.320(5)(f)

I have read the paragraph above and I acknowledge that Dr. Linetsky is not carrying medical malpractice insurance at this time.

I have read and signed the Consent Form, and I understand all the risks involved with the treatment that Dr. Linetsky provides.

I hereby release Dr. Felix Linetsky from all liability that may arise from the treatment provided.

_____

Patient Signature

_____ _____

Printed Name Date

_____ _____

Witness Date

Ver 53003