David G. Berry, MD, FACS
Robert S. Davidson, MD, FACS
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Surgical Associates of West Florida

Rick J. Schmidt, MD, FACS
Theodore R. Small, MD, FACS
Mark Zuzga, DO, FACOS, RVT

PATIENT CLINICAL UPDATE

** All information is kept confidential. Please answer honestly to assure the best possible treatment for you. Please complete all pages. **

(Please Print) Today's Date: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____

Social Security Number: _____ Sex: ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer: _____ Occupation: _____

PRIMARY AND REFERRING PHYSICIAN INFORMATION:

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

REASON FOR YOUR VISIT

What is the reason for this visit? _____

_____

How long have you had the problem? _____

_____

Visit Our Web Site at **www.WestFloridaSurgery.com**

Countryside Location
1840 Mease Drive, Ste 301
Safety Harbor, Florida 34695
(727) 712-3233, Phone
(727) 712-1853, Fax

Dunedin Location
646 Virginia Street, Suite 201
Dunedin, Florida 34698
(727) 712-3233, Phone
(727) 712-1853, Fax

Trinity Location
2102 Trinity Oaks Blvd, Suite 204
New Port Richey, Florida 34655
(727) 712-3233, Phone
(727) 712-1853, Fax

Clearwater Location
430 Morton Plant St, Suite 301
Clearwater, Florida 33756
(727)712-3233, Phone
(727)712-1853, Fax

Physician's Initials _____

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CLINICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE** _____

CURRENT MEDICATIONS *(List all medications / herbal / dietary supplements / alternative medications and treatments you are currently taking)* PHARMACY PHONE NUMBER #_____

Medication	*Dosage*	*# Per Day / Frequency*	*Reason for Taking*

****** *Please list any other current medications on the other side of this sheet or attach a list.* *******

MEDICATION ALLERGIES *(Are you allergic to any medications?)*

Medication	*Reaction*

Do you have any problems with anesthesia? ☐ Yes ☐ No

Have you had an allergic reaction to tape? ☐ Yes ☐ No

Do you have an allergy to any latex products? ☐ Yes ☐ No

PAST MEDICAL HISTORY (Please list all major medical problems)

☐ Stroke
☐ Seizures
☐ Glaucoma
☐ Emphysema
☐ Asthma
☐ Heart Attack / Disease
☐ Gallstones
☐ Vein Trouble
☐ High Blood Pressure
☐ Diabetes
☐ Juvenile Onset Diabetes
☐ Thyroid
☐ Hepatitis
☐ Elevated Cholesterol/Triglycerides
☐ Arthritis
☐ Sleep Apena
☐ Kidney Stones / Disease
☐ Anemia
☐ Cancer
☐ Bleeding Disorder
☐ Diverticulosis
☐ Angina
☐ Lung Disorders
☐ Other _____

PAST SURGICAL HISTORY

Check all that apply	*Year*		*Year*		*Year*
☐ Appendectomy	_____	☐ Hernia, Inguinal	_____	☐ Colonoscopy	_____
☐ Breast Biopsy	_____	☐ Hernia, Ventral	_____	☐ Endocosopy	_____
☐ Chest Surgery	_____	☐ Mastectomy	_____	☐ Other _____	_____
☐ Coronary Artery Bypass	_____	☐ Prostate	_____	☐ Other _____	_____
☐ Gall Bladder	_____	☐ Tonsillectomy	_____	☐ Other _____	_____
☐ Hysterectomy, Abdominal	_____	☐ Vascular Surgery	_____	☐ Other _____	_____
☐ Hysterectomy, Vaginal	_____	☐ Tubal Ligation	_____	☐ Other _____	_____

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CLINICAL HISTORY FORM (Continued)

PATIENT NAME: _____ **TODAY'S DATE** _____

FAMILY HISTORY

Family Member	*Alive/Deceased*	*Age*	*Health Problems (i.e. cancer, heart disease, etc)*
Father	_____	_____	_____
Mother	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Brother / Sister	_____	_____	_____
Children	_____	_____	_____

SOCIAL HISTORY

Tobacco ☐ None ☐ Currently smoke ___ packs/day and have done so for _____ years
☐ Previously smoked _____ packs/day for _____ years. Stopped in _____
☐ Smokeless Tobacco / Chewing Tobacco

Alcohol ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously Heavy

Caffeine ☐ None ☐ 1-3 Servings Daily ☐ 3-4 Servings Daily ☐ More than 6 servings Daily

Drug Use ☐ _____ ☐ _____

PERSONAL HISTORY OF CANCER

Type of cancer ☐ _____ ☐ Not applicable

When was your cancer treated? _____

What type of cancer treatment did you receive? ☐ Chemo Therapy ☐ Radiation Therapy ☐ Surgery

PATIENT'S SIGNATURE

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: _____

Today's Date: _____

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Surgical Associates of West Florida

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

Please read carefully.

This agreement is made between Surgical Associates of West Florida - SAWF and their physicians extenders, agents, employees, or any of the foregoing referred to hereinafter as "doctors" and_____ hereinafter referred to as "patient".

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians**, or any other legal claimant.**

Disputes and Consideration: In the unfortunate event of any claim for medical malpractice or otherwise, and in consideration for this agreement, the parties would like to (a) keep things as simple as possible; (b) enhance early resolution of their differences;(c) avoid lengthy drawn out litigation through the courts; (d) avoid the stress associated with traditional litigation and jury trials; and (e) minimize all costs, expenses and attorney's fees. Therefore, the parties voluntarily agree to the following pursuant to their constitutional right to contract:

It is understood by the patient that he or she has voluntarily selected and he or she is neither required to use SAWF, nor any of the doctors involved in their treatment and that there are other competent physicians in Florida who may act as the patient's treating physician.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever related to personal injury, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statues.

I understand that by signing this agreement I am waving my right to a jury trial, and instead, have agreed to participate in arbitration.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Each party shall choose one arbitrator and these two individual selected arbitrators shall choose a third arbitrator. Each party shall be entitled to the discovery provided for under the Florida Rules of Civil Procedure and agree to be governed by the Florida Evidence Code and Chapters, 766 &768, Florida Statutes, in any matter subject to this arbitration agreement. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and may be enforced by a court of competent jurisdiction.

Prior to commencing any action under this Doctor-Patient Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes.

Limitation of Damages: Patient agrees that in the event of any dispute with the Doctor, for any reason whatsoever, including any negligence claim relating to the diagnosis, treatment, or care of the Patient or any other personal injury claim, Patient's non-economic damages (including, but not limited to, damages for pain and suffering) shall be limited to a maximum of $250,000 per incident and shall be calculated on a percentage basis with respect to capacity to enjoy life, pursuant to the formula contained in Florida Statutes, Section 766.207. For example, if the Patient's injuries resulted in a 50% reduction in his or her capacity to enjoy life, this would warrant an award of not more than $125, 000 in non-economic damages. This limit applies regardless of the number of claimants or defendants in the arbitration proceeding. This limitation of damages provision does not limit or restrict in any way the Patient's right to seek all economic damages actually incurred by the Patient, including any medical expenses and lost wages.

ARBITRATION AGREEMENT BETWEEN DOCTOR AND PATIENT

Please read carefully.

Duty to Defend and Indemnify: For each individual or entity with a claim that is not bound by this agreement ("non-party"), it is the parties' intent that they shall adopt and comply with this agreement 100% so that the parties can avoid piecemeal litigation and ensure consistency, closure, and finality in one forum. For each non-party claim against the patient's physician brought outside this agreement, you shall (a) defend and (b) indemnify the patient's physician against said claim(s) up to the amount the chief arbitrator deems reasonable under the circumstances.

Severability Clause: If any provision of this Agreement shall be held invalid under any applicable laws, such invalidity shall not affect any other provision of this Agreement that can be given effect without the invalid provision. Further, all terms and conditions of this agreement shall be deemed enforceable to the fullest extent permissible under applicable law, and, when necessary, the court is requested to reform any and all terms or conditions to give them such effect.

By signing below, the patient confirms that:

- The Patient has had an opportunity to read this Doctor-Patient Agreement, or to have it read to him or her if necessary.
- The Patient indicates that they understand English or has had the Doctor-Patient Agreement translated for him or her by _____.
- The Patient has had an opportunity to ask questions about this Doctor-Patient Agreement.
- The Patient understands this Doctor-Patient Agreement and has no unanswered questions.
- The Patient has not been coerced or compelled to sign this Doctor-Patient Agreement, and does so if his or her own free will.
- The Patient is also aware that they may consult with an attorney before signing this Doctor-Patient Agreement.

This agreement shall remain in effect for all treatment and surgery provided to the patient, presently and at any future date.

BY SIGNING THIS DOCTOR-PATIENT AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature:_____ Date:_____

Parent, Guardian or Legal Representative Signature:_____