Florida Orthopaedic Associates, P.A.

PATIENT REGISTRATION Date______________________

Patient Name____ SSN ______________________

Home Address____ City, St., Zip ___________________

Date of Birth_____________________ Age _________ Male/Female Married/Single

Phone _________________________ Home/Work/Cell Phone _______________________ Home/Work/Cell

Employer____ Occupation _____________________________________

Next of Kin __________________________________ Relationship ________________ Phone __________________

Primary Care Physician______________________________ Referring Physician _____________________________

Is an Attorney Involved Regarding this Accident? ______ If so, Name of Attorney ______________________________

Attorney Address and Phone ____

E-Mail Address____ Ethnicity __________________________

Race____ Preferred Language _________________________________

INJURY INFORMATION

Reason for today's visit ____ Date of Injury/Accident ___________

How did the Injury occur ____

If seen in the ER, Give the date seen and the hospital's name ____

GUARANTOR INFORMATION (Fill out if the patient is under 18 years of age)

Financially Responsible Party's Name ______________________________________ Phone ____________________

Date of birth _________________ SSN __________________ Relationship to patient _________________________

Home Address ____ City, St, Zip ______________________

Would you like to authorize Florida Orthopaedic Associates to release information to any other person(s) on your behalf? If yes, list name below.

Name____ Relationship__________________________________

Name____ Relationship__________________________________

Name____ Relationship__________________________________

HEALTH INSURANCE INFORMATION

Insurance Co. Name ____ Phone _________________________

Policy Holder's Name ____ D.O.B _________________________

Policy Number ____ Group Number ______________________

Secondary Health Insurance

Insurance Co. Name ____ Phone _________________________

Policy Holder's Name ____ D.O.B _________________________

Policy Number ____ Group Number ______________________

ACCIDENT INSURANCE Date of Injury ____________________

Worker's Compensation _________ Auto _________ Other ____

Employer Name __________________________ Address ____

Insurance Carrier Name ____

Billing Address ____

Claim Number ____

Authorized By ____ Case Manager/Adjuster/Other

Phone Number ___________________________________ Fax Number _______________________________________

ACKNOWLEDGEMENTS

Please **Read and initial** each item below indicating acknowledgment and acceptance.

________ I hereby authorize Dr. ___________________________, or a physician designated by him/her, or whomever he/she may designate as assistant to render medical care to me. I Consent to care and treatment that may encompass laboratory, diagnostic, or medical treatment that my physician or his/her assistant may deem necessary for my health and well being.

________ I hereby assign to Florida Orthopaedic Associates, PA (hereinafter "Assignee") any medical payment benefits available to me under the policy affording coverage to me. I authorize Assignee to release any information acquired in the course of my examination and treatment to my insurance company. If I am being treated as a result of an automobile accident, I further assign any and all rights, claims, benefits, and cause of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from the accident. In the event I do not have insurance coverage, or that my insurance coverage only covers a portion of my medical bills, I understand that I remain personally responsible for payment of any remaining balance.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated ______________________

Patient or Patient's Representative ____

Print Patient's Name ____

If Signed by Representative, State Name of Representative ____

Relationship to Patient ____

In accordance with Florida Statute 458.348(5), when scheduling the initial examination after a referral from another practitioner, the patient may decide to see the physician or any other licensed practitioner supervised by the physician. **By identifying and signing below, I am indicating my choice of practitioner for this initial examination.**

Circle one: Physician P.A.

Signed: ____ Dated: ___________________________

Authorization to Disclose Health Information

I, the undersigned, authorize

FL440: FLORIDA ORTHOPAEDIC ASSOCIATES
740 West Plymouth Avenue
Deland, FL 32720

to release my health information as noted below:

Patient Information:

Patient Full Name: ____________________________ Email Address:_______________________________________

Patient Address: ____ Date of Birth:_______________________

City: ___________________ State _______ Zip: _______________ Phone #: _______________________________

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: ____ Attention: ______________________________

Address: ____ Phone: _________________________________

City: ___________________ State _______ Zip: _______________ Fax: ________________________________

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason______________________ ☐ Other___________________________

Charges outlined below will be applied for all copies released directly to patient . The charge does not apply when the records are sent directly to a healthcare provider for ongoing treatment purposes.

Information to be Released:

Unless otherwise specified, only the following information will be released:
Abstract includes most recent, up to 2 years: Medical History, Progess Notes, Lab Reports , and Diagnostic Testing.

☐ Please provide an abstract of my records
Copy fee capped at **$15.00** for up to 2 years

☐ Other - please be specific under comments
*Over 2 yrs, will be charged per Florida Statute. See below ↘
Comments: _______________________________
____
____

PAYMENT OPTIONS:

CHECK: Please make checks available to BACTES Imaging Solutions.

CREDIT CARD: Please provide an email address (above) to have an invoice emailed. If you do not have an email address, an invoice will be sent to your mailing address .

*Florida Statute Copy Fee: $1.00 per page for the first 25 pages. $.025 for any pages over 25, plus postage.

Authorization to Release Protected:

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one — *Initial each line below*

I ☐ **DO** ☐ **DO NOT** want information about ***Mental Health** released __________
I ☐ **DO** ☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released __________
I ☐ **DO** ☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released __________
I ☐ **DO** ☐ **DO NOT** want information about ________________________ released __________
"Other sensitive information?"

Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature____**Date:**_______________

(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian ___________________________**Date:** _______________

(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Florida Orthopaedic Associates and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed.*

Rev. 9/13

PATIENT NAME ____________________________ TODAY'S DATE__________________

Primary Care Physician ___________________ Referring Physician____________________

Occupation __________________________ Name of Employer_______________________

PHARMACY & ADDRESS ____

PHARMACY PHONE # ____

CURRENT MEDICATION

MEDICATION AND DOSE DIRECTIONS DATE STARTED

____

____

____

____

____

____

____

____

____

ALLERGIES

____

____

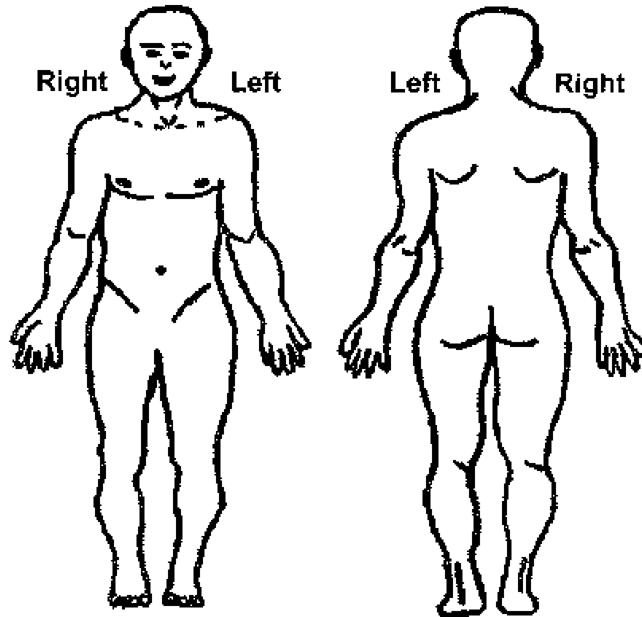
____

Height_____ft ______in Weight _________

NEW PROBLEM
INFORMATION SHEET

NAME________________________________ **DOB**__________ **DATE**____________________

Pain Diagram
Draw in the location of your symptoms in the diagram to the right using the symbols listed to indicate the type of pain you are experiencing.



Pain level
If 0 represents no pain and 10 represents the worst pain imaginable circle the number that corresponds to your pain:

Today
0 1 2 3 4 5 6 7 8 9 10

Average pain this week
0 1 2 3 4 5 6 7 8 9 10

When did the symptoms start?____

How did the pain begin?
☐ Spontaneously without a specific event causing the pain
☐ Due to trauma or other event (explain below)
____
____

Since the pain began has it been?
☐ Stable, about the same ☐ Improving ☐ Worsening

What makes the pain worse? (Check all that apply)
☐ Standing ☐ Sitting ☐ Lying on back ☐ Lifting
☐ Bending ☐ Twisting ☐ Coughing/Sneezing ☐ Reaching
☐ Walking (how far can you walk before the pain becomes intolerable? ___________________________)
☐ Other (explain) ____

What helps the symptons?
☐ Rest ☐ Therapy ☐ Medication (list__________________)
☐ Position ___________ ☐ Activity ______________________________________
☐ Other____

Have you experienced any associated?
☐ Numbness ☐ Weakness ☐ Loss of control of bladder/bowel

(OVER)

WHO ELSE HAVE YOU SEEN FOR THIS PROBLEM		
NAME	SPECIALTY	ARE YOU STILL UNDER THEIR CARE

WHAT DIAGNOSTIC TESTS HAVE YOU HAD FOR THIS CONDTITION			
TEST	DATE	WHERE WAS THE TEST DONE	RESULTS(IF KNOWN)
☐ X-RAY			
☐ MRI			
☐ CT SCAN			
☐ BONE SCAN			
☐ EMG/NCS			

WHAT TREATMENT HAVE YOU HAD FOR THIS CONDITION		
TREATMENT	DID IT HELP	COMMENTS
☐ Physical Therapy	☐ YES ☐ NO	
☐ Medication	☐ YES ☐ NO	
☐ Injections	☐ YES ☐ NO	
☐ Manipulation	☐ YES ☐ NO	
☐ Surgery	☐ YES ☐ NO	
☐	☐ YES ☐ NO	

Occupation?____

Does your work involve?

☐ Heavy lifting (>60lbs) ☐ Medium lifting (30-50 lbs)
☐ Light lifting (10-20lbs) ☐ No/minimal lifting (<10lbs)

Have you missed work or not been able to perform your regular work due to the symptoms?

☐ No ☐ Yes (explain____)

If you had any prior episodes of pain similar to this or prior injuries to this area answer below:

When did prior symptoms begin? ____

What if any diagnosis were you given in the past?

☐ Disc herniation ☐ Sprain ☐ Arthritis ☐ Spinal stenosis
☐ Other____

Treatment for prior symptoms?

☐ Surgery ☐ Physical therapy ☐ Chiropractic ☐ Injections
☐ Other____

Recovery from prior symptoms/injury? ☐ Complete ☐ Incomplete

(OVER)