

Florida Orthopaedic Associates, P.A.

PATIENT REGISTRATION

Date _____

Patient Name _____ Social Security No. _____

Home Address _____ City, St., Zip _____

Phone _____ Home/Work/Cellular Phone _____ Home/Work/Cellular

Date of Birth _____ Age _____ Male / Female Married / Single

Employer _____ Occupation _____

Name/Phone Next of Kin _____ Phone _____

Name of Primary Care Physician _____

Is an Attorney Involved Regarding This Accident? _____ If So, Name of Attorney _____

Attorney Address and Phone _____

INJURY INFORMATION

Reason for Today's Visit _____ Date of Accident _____

How Injury Occurred _____

If seen in the emergency room, give date seen and hospital name _____

GUARANTOR INFORMATION (Fill out when patient is under 18 years old)

Financially Responsible Party's Name _____ Social Security No. _____

Home Address _____ City, St., Zip _____

Phone _____ Relationship to Patient _____

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: _____

HEALTH INSURANCE INFORMATION

Primary Health Insurance

Insurance Co. Name _____ Phone _____

Insurance Co. Address _____

Policy Holder's Name _____ Social Security _____ D.O.B. _____

Policy Number _____ Group Number _____

Secondary Health Insurance

Insurance Co. Name _____ Phone _____

Insurance Co. Address _____

Policy Holder's Name _____ Social Security _____ 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 _____

ACKNOWLEDGMENTS

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 causes 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: _____ Date: _____