

## 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 \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Is an Attorney Involved Regarding this Accident? \_\_\_\_\_ If so, Name of Attorney \_\_\_\_\_

Ethnicity: Hispanic or Latino / Non-Hispanic or Non-Latino Preferred Language: English / Spanish \_\_\_\_\_  
Race: White / Black or African American / Asian / Native American or Other Pacific Islander / American Indian or Alaskan

### 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.

Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### 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, physical therapy, 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.

\_\_\_\_\_ Our physicians are also proud to partner with Local Ambulatory Surgery Centers including Blue Springs Surgery Center, and Lake Mary Surgery Center. As part of this partnership, some of our Physicians may have ownership interest in these centers. We are also proud to have our own Physical Therapy in our DeLand office. By initialing and signing below, I acknowledge I have been informed of this ownership.

**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 Signature \_\_\_\_\_

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: \_\_\_\_\_



## NEW PATIENT PAPERWORK

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Patient Preferred Pharmacy: \_\_\_\_\_ Address/Intersection: \_\_\_\_\_

Height: \_\_\_\_ ft. \_\_\_\_ in.

Weight: \_\_\_\_\_ lbs.

### CHIEF COMPLAINT

Body Part \_\_\_\_\_

Is your problem the result of an injury or accident? Yes  No  If yes, what is the date of injury/accident? \_\_\_\_\_

Have you been seen in the ER for this problem? Yes  No  How long have your symptoms been present? \_\_\_\_\_

Pain Level Today (Circle):      0          1          2          3          4          5          6          7          8          9          10

Is the problem ... getting better  worsening  or remains unchanged  ?

Have you had any prior treatment? Yes  No  If yes, when and where? \_\_\_\_\_

Have you had any prior imaging? Yes  No  If yes, when and where? \_\_\_\_\_

### SOCIAL HISTORY

Do you smoke tobacco? Yes  No  Former  If yes, do you smoke daily  or occasionally  ?

Do you drink alcohol? Yes  No  If yes, do you drink daily , 2-3 times a week , or socially  ?

Are you currently working? Yes  No  If yes, list any restrictions \_\_\_\_\_

If no, are you retired , disabled , or student  ?

### MEDICAL HISTORY

Do you have a personal history of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anesthesia reaction      | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> MRSA                    |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Drug Addiction/Alcohol Abuse | <input type="checkbox"/> Pulmonary Embolism      |
| <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Bone/Joint Infections    | <input type="checkbox"/> Heart Attack                 | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Hepatitis Type: _____        | <input type="checkbox"/> Stomach Ulcers          |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> Other Conditions: _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Blood Pressure          | _____  |
| <input type="checkbox"/> Claustrophobia           | <input type="checkbox"/> High Cholesterol             | _____  |

Have any direct relatives suffered from the below conditions? Please check appropriate box.

Condition	Father	Mother	Sibling
None			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			

**PREVIOUS ORTHOPAEDIC SURGERIES**

Surgery	Right	Left
Arthroscopy: Knee		
Arthroscopy: Shoulder		
Carpal Tunnel		
Total Shoulder		
Total Hip		
Total Knee		
Spinal Surgery Neck (Indicate Levels)		
Spinal Surgery Back (Indicate Levels)		

Please list any other orthopedic (bone, muscle, joint) surgeries you have undergone: \_\_\_\_\_

Please list any other surgeries you have undergone: \_\_\_\_\_

**Review of systems over the last 6 months. Please check below.**

<b>GENERAL</b>	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weakness	<input type="checkbox"/> None
<b>EYE</b>	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss		<input type="checkbox"/> None
<b>ENT</b>	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Ear Pain/Ringing	<input type="checkbox"/> None
	<input type="checkbox"/> Tooth/Gum Issues	<input type="checkbox"/> Nose Bleeds			<input type="checkbox"/> None
<b>CARDIOVASCULAR</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> None
<b>RESPIRATORY</b>	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> None
<b>GI</b>	<input type="checkbox"/> Heartburn/Ulcers	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> None
<b>GENITOURINARY</b>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> None
<b>SKIN</b>	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> None
<b>NEUROLOGICAL</b>	<input type="checkbox"/> Frequent Falls	<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Numbness	<input type="checkbox"/> Change in Bowel	<input type="checkbox"/> None
	<input type="checkbox"/> Change in Bladder	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> None
<b>PSYCHOLOGICAL</b>	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> None
<b>ENDOCRINOLOGY</b>	<input type="checkbox"/> Fever	<input type="checkbox"/> Heat/Cold Intolerance	<input type="checkbox"/> Night Sweats		<input type="checkbox"/> None
<b>HEMATOLOGY</b>	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/> DVT	<input type="checkbox"/> None
<b>MUSCULAR</b>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Muscular Weakness	<input type="checkbox"/> Muscle Pain		<input type="checkbox"/> None
<b>MISC.</b>	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint/Limb Swelling	<input type="checkbox"/> Stiffness		<input type="checkbox"/> None

Please list or provide a list of all allergies to medication, food and environmental factors: \_\_\_\_\_

Please list or provide a list of all current medications: \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_

# SPINE CENTER PAPERWORK

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

## CHIEF COMPLAINT

How long have you had pain? \_\_\_\_\_ Pain at night? Yes  No

How did it begin? \_\_\_\_\_

Pain Level Today (Circle):      0          1          2          3          4          5          6          7          8          9          10

Does the pain extend into any of the following areas? Buttock  Thigh  Calf  Foot  Shoulder  Arm  Hand

Which activity or position worsens the pain?      Standing  Sitting  Bending  Lifting  Reaching

Lying on Back  Coughing or Sneezing  Weather

What have you found makes it more comfortable? Rest  Activity  Medications  Position  Corset

Have you had any numbness?      Yes  No  If so, where? \_\_\_\_\_

## MEDICAL HISTORY

Have you had a similar problem in the last year?      Yes  No

If yes, what was the diagnosis: \_\_\_\_\_

How was it treated? \_\_\_\_\_

Any recent weight changes?      Yes  No       Any difficulty with control of urine or stool?      Yes  No

I have had the following tests:      Regular X-Ray  CT Scan  MRI  Myelogram  Discogram

EMG  Nerve Conduction Study

Please mark and list any provider(s) who have treated you for this condition:

Other Orthopaedic <input type="checkbox"/>	Spine Doctor <input type="checkbox"/>	Neurologist <input type="checkbox"/>
Rheumatologist <input type="checkbox"/>	Pain Management <input type="checkbox"/>	Physical Medicine <input type="checkbox"/>
Physical Therapist <input type="checkbox"/>	Chiropractor <input type="checkbox"/>	Oncologist <input type="checkbox"/>
Primary Care <input type="checkbox"/>	Emergency Room <input type="checkbox"/>	Other <input type="checkbox"/>

## OCCUPATIONAL HISTORY

Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

My job requirements are:

- Heavy lifting over 60 pounds/frequent bending and stooping
- Medium lifting 30-50 pounds
- Lifting 10-20 pounds
- My job is highly stressful, it makes me tense

**On the human form, draw the location and type of pain you are experiencing using the symbols below.**

Numbness    ++++                      Pins and Needles    0 0 0 0  
 Burning    xxx x                      Stabbing    ////  
 Aching    ----

