# 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: _____

FLORIDA ORTHOPAEDIC ASSOCIATES

# 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? _____

Is the problem … getting better ☐ worsening ☐ or remains unchanged ☐ ?

Have you had any prior treatment or 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?

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

_____

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.

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

# NECK AND BACK PAIN INFORMATION SHEET

Name: _____ Age: _____ Date: _____

How long have you had pain? _____ Do you have pain at night? Yes_____ No_____

How did it begin? _____

Any warning signs? _____

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 _____ Lying on back _____

Coughing or Sneezing _____ Lifting _____ Bending _____ Reaching _____ Weather _____

Housework _____ Activities of daily living _____

What have you found makes it more comfortable? (mark all that apply)

Rest _____ Activity _____ Medications _____ Position _____ Corset _____

Have you had any numbness? _____ If so, where? _____

Have you had a similar problem in the past year? _____

- If so, what was the diagnosis? _____
- How was it treated? _____

Any recent weight changes? _____ Any difficulty with control of urine or stool? _____

I have had the following tests: Regular X-Ray _____, CT Scan _____, MRI _____

Myelogram _____, Discogram _____, EMG _____, Nerve Conduction Study _____

List any other doctors and their specialty who have treated you for this condition:

_____

_____

Employed? Yes / No Occupation : _____ For how long? _____

My job requirements are:

_____ Heavy Lifting over 60 pounds/frequent bending and stooping

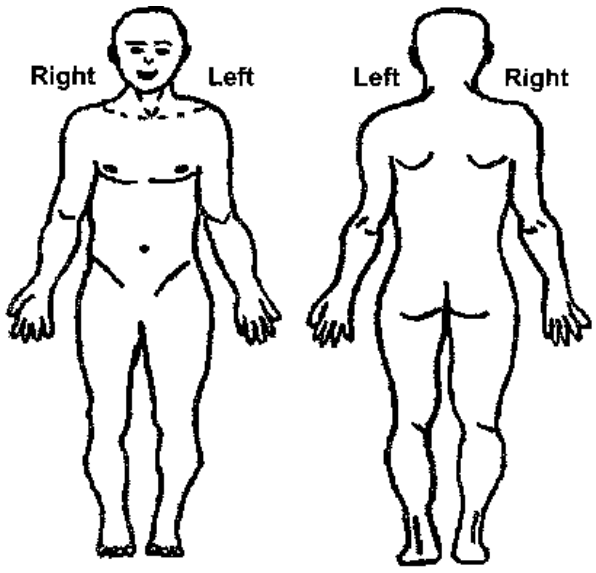
_____ Medium lifting 30-50 pounds

_____ Light lifiting 10-20 pounds

_____ My job is highly stressful - it makes me tense

Pain Level on scale

1 - 10. Ten is worst _____




On the human form mark where and type of pain you are experiencing.

Numbness = = = =
Pins & Needles 0 0 0 0
Burning x x x x
Stabbing / / / /
Aching - - - -