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, Lake Mary Surgery Center and Rinehart Road 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 _____

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 USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		Phone	
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name				Phone		
Address				Fax		
City/State Zip	City		State		Zip	

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address				Fax		
City/State Zip	City		State		Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

You must check "yes" or "no" if you authorize the release of Sensitive Protected Health Information, test results, records or communications specific to:

	Yes	No
HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases	☐	☐
Mental Health Information and/or Records	☐	☐
Domestic Violence	☐	☐
Genetic Testing Information and/or records	☐	☐
Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind information is to be disclosed.) Describe:	☐	☐
Other:		

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Personal Representative: _____

Print Name of Personal Representative (if applicable): _____

Relationship to patient: _____

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 _____