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:**