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

DR. WALDBAUM – NEW PROBLEM PAPERWORK

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

Please mark the location of your symptoms in the diagram below using the symbols listed to indicate the type of pain you are experiencing.

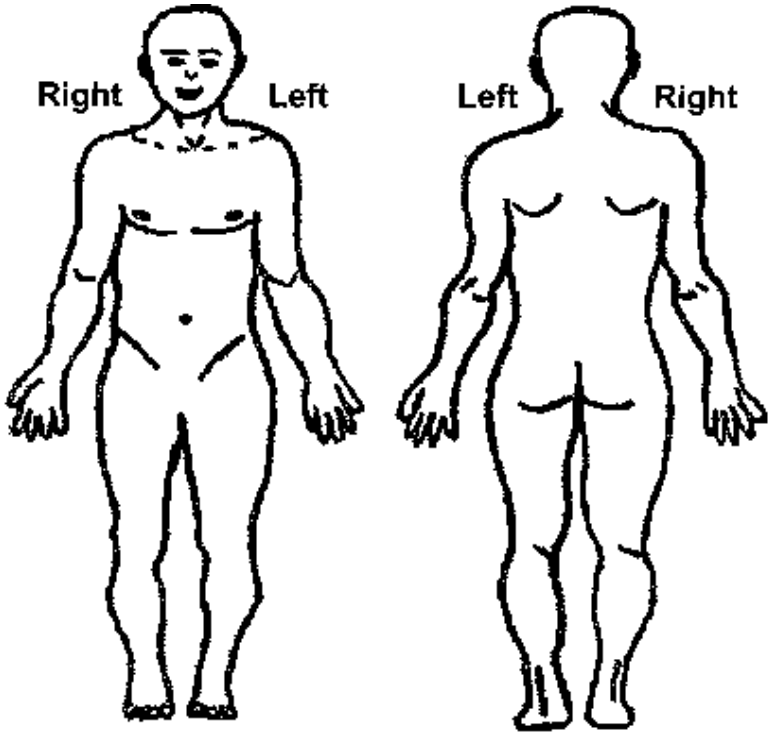
Numbness
= = = =

Pins and Needles
0 0 0 0

Burning
x x x x

Stabbing
/ / / /

Aching
- - - -



Assuming **0 represents no pain imaginable** and **10 represents the worst pain**, circle the appropriate number.

Pain Level Today	0	1	2	3	4	5	6	7	8	9	10
Average Pain This Week	0	1	2	3	4	5	6	7	8	9	10

CHIEF COMPLAINT

When did the symptoms start? _____

How did the pain begin?

- ☐ Spontaneously without a specific event causing the pain
- ☐ Due to a trauma or other event (explain) _____

Since the pain began, has it been … ☐ stable ☐ improving ☐ worsening ?

What makes the pain worse? (check all that apply)

- ☐ standing ☐ sitting ☐ lying on back ☐ lifting
- ☐ bending ☐ twisting ☐ reaching ☐ coughing/sneezing
- ☐ walking (how far can you walk before pain becomes intolerable? _____
- ☐ other (explain) _____

What helps the symptoms?

☐ rest ☐ therapy ☐ medication (list) _____
☐ position _____ ☐ activity _____

Have you experienced any associated ☐ numbness ☐ weakness ☐ loss of control of bladder/bowel

MEDICAL HISTORY

Who else have you seen for this problem?

NAME	SPECIALTY	ARE YOU STILL UNDER THEIR CARE?

What diagnostic tests have you had for this condition?

TEST	DATE	WHERE WAS THE TEST DONE	RESULTS (IF KNOWN)
☐ X-ray			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ EMG/NCS			

What treatment have you had for this condition?

TREATMENT	DID IT HELP	COMMENTS
☐ Physical Therapy	☐ Yes ☐ No	
☐ Medication	☐ Yes ☐ No	
☐ Injections	☐ Yes ☐ No	
☐ Manipulation	☐ Yes ☐ No	
☐ Surgery	☐ Yes ☐ No	

If you had any prior episodes of pain similar to this or prior injuries to this area, answer below:

When did prior symptoms begin? _____

What, if any, diagnosis were you given in the past?
☐ Disc herniation ☐ sprain ☐ arthritis ☐ spinal stenosis ☐ other _____

Treatment for prior symptoms? ☐ surgery ☐ physical therapy ☐ chiropractic ☐ injections ☐ other __

Recovery from prior symptoms/injury? ☐ complete ☐ incomplete

OCCUPATIONAL HISTORY

Occupation: _____ How long? _____

Does your work involve? ☐ Heavy lifting (>60 lbs) ☐ Medium lifting (30-50 lbs)
☐ Light lifting (10-20 lbs) ☐ No/Minimal lifting (<10 lbs)

Have you missed work or not been able to perform your regular work due to the symptoms? ☐ No ☐ Yes _____

PATIENT SIGNATURE: