

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: _____



DR. WALDBAUM - FOLLOW-UP PAPERWORK

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

Patient Preferred Pharmacy: _____ Address/Intersection: _____

Height: ____ ft. ____ in.

Weight: _____ lbs.

MEDICAL HISTORY

Are there any changes in your medical condition since your last visit to our office? (I.e. high blood pressure) Yes No

If yes, please describe: _____

Has there been any change to your surgical history since your last visit to our office? Yes No

If yes, please list: _____

Have there been any changes in allergies since your last visit to our office? Yes No

If yes, please list: _____

Are there any new medications or changes in medication doses since your last visit to our office? Yes No

(If you are unsure what was previously reported, please ask the receptionist for a list.)

If yes, please indicate changes here: _____

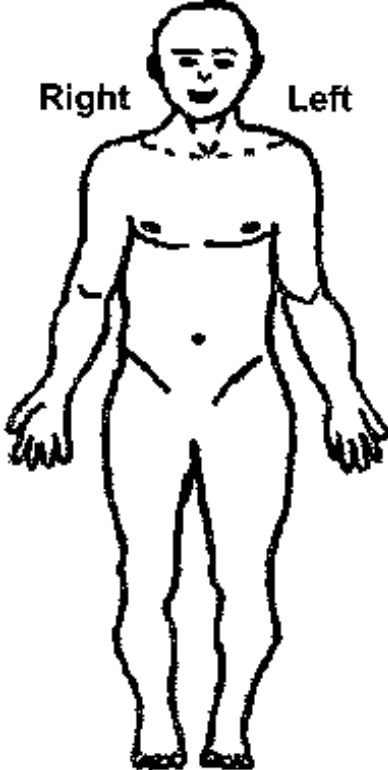
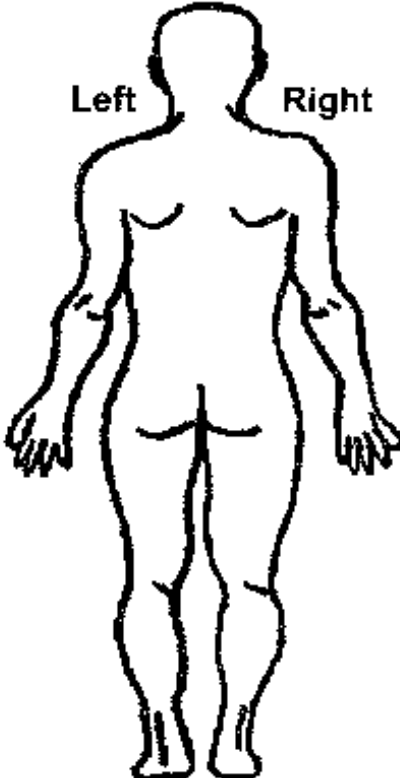
PATIENT SIGNATURE:

DR. WALDBAUM - FOLLOW-UP INFORMATION SHEET

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

PAIN DIAGRAM

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

<p>Numbness ====</p> <p>Pins and Needles 0000</p> <p>Burning xxxx</p> <p>Stabbing ////</p> <p>Aching ----</p>	<p>Right Left</p> 	<p>Left Right</p> 
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PAIN SCORE

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
Best Day Over the Last Week	0	1	2	3	4	5	6	7	8	9	10
Worst Day Over the Last Week	0	1	2	3	4	5	6	7	8	9	10

Since your last visit ...

Has the pain been?	<input type="checkbox"/> stable	<input type="checkbox"/> improving	<input type="checkbox"/> worsening
Any new associated symptoms?	<input type="checkbox"/> numbness	<input type="checkbox"/> weakness	<input type="checkbox"/> other _____
Found medications helpful?	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> N/A (not taking meds for pain)
Found therapy helpful?	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> N/A (not taking therapy)