

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: _____



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? _____

Pain Level Today (Circle): 0 1 2 3 4 5 6 7 8 9 10

Is the problem ... getting better worsening or remains unchanged ?

Have you had any prior treatment? Yes No If yes, when and where? _____

Have you had any prior 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?

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

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