FLORIDA ORTHOPAEDIC ASSOCIATES
PATIENT REGISTRATION

Date_____

Patient Name_____ SSN _____

Mailing Address_____ City, St., Zip_____

Date of Birth_____ Age_____ Male/Female Married/Single/Widowed/_____

Phone #1 _____ Home/Work/Cell Phone #2_____ Home/Work/Cell

E-Mail Address_____

Employer_____ Occupation _____

Primary Care Physician_____ PCP Phone #_____

Referring Physician_____ Ref Phone #_____

PLEASE CIRCLE – Preferred Language: English / Spanish / _____
Race: White / Black or African American / Asian / Native Hawaiian or Other Pacific Islander / American Indian or Alaskan
Ethnicity: Hispanic or Latino / Non-Hispanic or Non-Latino / Unspecified

INJURY INFORMATION

Reason for today's visit _____ Date of Injury/Accident _____

How did the Injury occur _____

If seen in the ER: Date _____ Hospital_____

GUARANTOR INFORMATION (Please 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 _____ Date of Birth _____

Policy Number _____ Group Number _____

Secondary Health Insurance

Insurance Co. Name _____ Phone _____

Policy Holder's Name _____ Date of Birth _____

Policy Number _____ Group Number _____

ACCIDENT INSURANCE

Is an attorney involved regarding this accident? ☐ Yes ☐ No Name of Attorney _____

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 Florida Orthopaedic Associates, PA, 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.

_____ I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above-named practice's Notice of Privacy Practices.

Date _____

_____ _____

Print Patient's Name Patient or Patient's Representative Signature

_____ _____

If Signed by Representative, State Name of Representative Relationship to Patient

FLORIDA ORTHOPAEDIC ASSOCIATES

DR. WALDBAUM - FOLLOW-UP PAPERWORK

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

Pharmacy: _____ 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: _____

FLORIDA ORTHOPAEDIC ASSOCIATES

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.

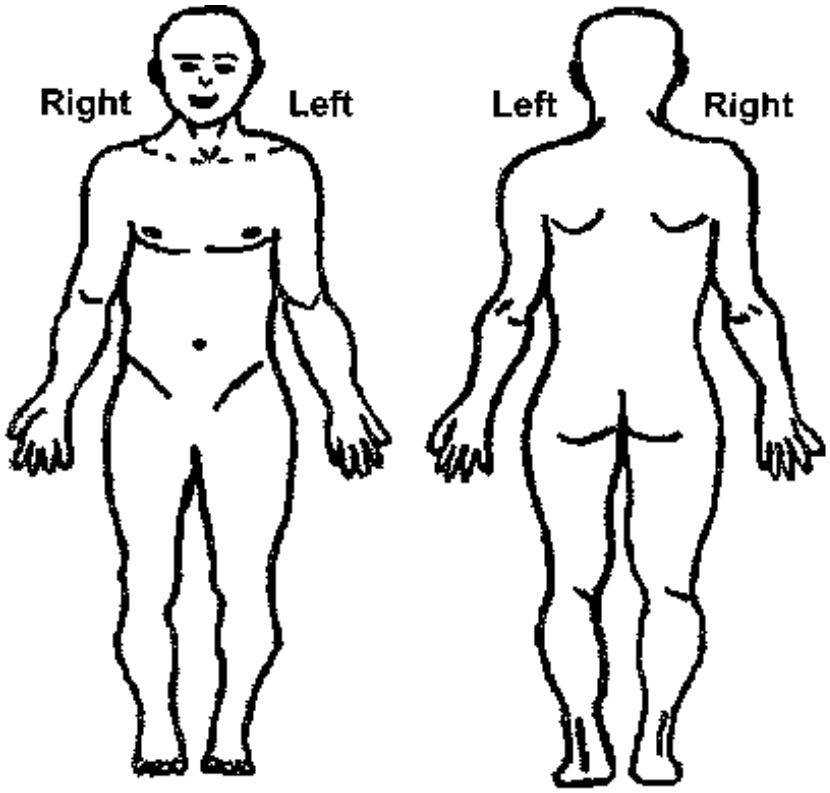
Numbness
= = = =

Pins and Needles
0 0 0 0

Burning
x x x x

Stabbing
/ / / /

Aching
- - - -



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?	☐ stable	☐ improving	☐ worsening
Any new associated symptoms?	☐ numbness	☐ weakness	☐ other _____
Found medications helpful?	☐ no	☐ yes	☐ N/A (not taking meds for pain)
Found therapy helpful?	☐ no	☐ yes	☐ N/A (not taking therapy