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 <u>read and initial</u> 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

DR. WALDBAUM - NEW PATIENT PAPERWORK

Patient Name: ____ Date of Birth: _______________ Date of Visit: _______________

Pharmacy: ___________________________________ Pharmacy Address/Intersection: _______________________________________

Height: ____ ft. _____in. Weight: ________ lbs.

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, ☐ student?

MEDICAL HISTORY

Do you have a personal history of the following?

- ☐ None
- ☐ 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: _________________
- ☐ Other: _________________

Have any direct relatives suffered from the below conditions? Please check appropriate box.

Condition	Father	Mother	Sibling
None (No Medical Conditions)			
Unknown			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Osteoporosis			
Rheumatoid Arthritis			
Stroke			

Patient Name ___________________________ DOB _______________

PREVIOUS HOSPITALIZATIONS / SURGERIES

☐ None

Surgery
☐ Adenoidectomy
☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass/Vascular Surgery
☐ Appendectomy
☐ Cataract (Eye) Surgery
☐ Cholecystectomy (Gallbladder)
☐ C-section
☐ Heart Surgery
☐ Hernia Repair
☐ Hysterectomy
☐ LAP Band/Gastric Bypass Surgery
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy/Cancer
☐ Stents
☐ Tonsillectomy

PREVIOUS ORTHOPAEDIC SURGERIES

☐ None

Surgery	Right	Left
Arthroscopy: Knee		
Arthroscopy: Shoulder		
Carpal Tunnel		
Total Shoulder		
Total Hip		
Total Knee		
Rotator Cuff Repair		
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 Past 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	☐ Muscular 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: (☐ No Known Allergies) ___________________

____

____

Please list or provide a list of all current medications: (☐ No Current Medications) ____

____

____

PATIENT SIGNATURE:

FLORIDA ORTHOPAEDIC
A S S O C I A T E S

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
- - - -

Right Left Left Right

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) ____

Patient Name ________________________ DOB _________

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: