

**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

NEW PATIENT PAPERWORK

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

Pharmacy: _____ Pharmacy Address/Intersection: _____

Height: ____ ft. ____ in.

Weight: _____ lbs.

CHIEF COMPLAINT

Body Part _____ Side Right Left

Is your problem the result of: No injury Auto accident Work injury Sports injury Prior surgery Other _____

If yes, what is the date of injury/accident/prior surgery? _____

Have you been seen in the ER for this problem? Yes No Which Emergency Room? _____

How long have your symptoms been present? Month _____ Year _____ (Please be as specific as possible)

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 imaging? None MRI X-ray CT DEXA scan Bone scan Nerve test (EMG)

If prior imaging, when and where? _____

Have you had any prior treatment? Ice Heat NSAID Muscle relaxers Chiropractor Physical Therapy

Home exercises Surgery Injections Bracing Tens Unit Other _____

If prior treatment, 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, student?

MEDICAL HISTORY

Do you have a personal history of the following?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Anesthesia reaction | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis Type: _____ | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Bone/Joint Infections | <input type="checkbox"/> Drug Addiction/Alcohol Abuse | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> MRSA | <input type="checkbox"/> 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
<input type="checkbox"/> Adenoidectomy
<input type="checkbox"/> Aneurysm (Brain) Surgery
<input type="checkbox"/> Aortic Bypass/Vascular Surgery
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Cataract (Eye) Surgery
<input type="checkbox"/> Cholecystectomy (Gallbladder)
<input type="checkbox"/> C-section
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Hernia Repair
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> LAP Band/Gastric Bypass Surgery
<input type="checkbox"/> Lumpectomy
<input type="checkbox"/> Mastectomy
<input type="checkbox"/> Malignancy/Cancer
<input type="checkbox"/> Stents
<input type="checkbox"/> 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	<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"/> Muscular 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: (No Known Allergies) _____

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

PATIENT SIGNATURE: