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?

☐ None	☐ COPD	☐ Heart Attack	☐ Pulmonary Embolism
☐ Anesthesia reaction	☐ Congestive Heart Failure	☐ Hepatitis Type: _____	☐ Seizures
☐ Arthritis	☐ Claustrophobia	☐ HIV/AIDS	☐ Stroke
☐ Blood Clots	☐ Diabetes	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Bone/Joint Infections	☐ Drug Addiction/Alcohol Abuse	☐ High Cholesterol	☐ Other: _____
☐ Cancer	☐ Emphysema	☐ MRSA	☐ 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:

SPINE CENTER PAPERWORK

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

CHIEF COMPLAINT

How long have you had pain? _____ Pain at night? Yes ☐ No ☐

How did it begin? _____

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

Does the pain extend into any of the following areas? Buttock ☐ Thigh ☐ Calf ☐ Foot ☐ Shoulder ☐ Arm ☐ Hand ☐

Which activity or position worsens the pain? Standing ☐ Sitting ☐ Bending ☐ Lifting ☐ Reaching ☐

Lying on Back ☐ Coughing or Sneezing ☐ Weather ☐

What have you found makes it more comfortable? Rest ☐ Activity ☐ Medications ☐ Position ☐ Corset ☐

Have you had any numbness? Yes ☐ No ☐ If so, where? _____

MEDICAL HISTORY

Have you had a similar problem in the last year? Yes ☐ No ☐

If yes, what was the diagnosis: _____

How was it treated? _____

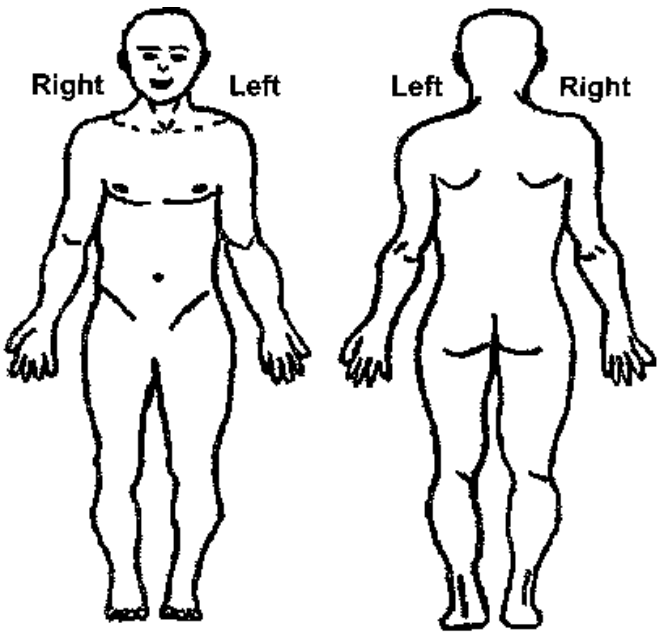
Any recent weight changes? Yes ☐ No ☐ Any difficulty with control of urine or stool? Yes ☐ No ☐

I have had the following tests: Regular X-Ray ☐ CT Scan ☐ MRI ☐ Myelogram ☐ Discogram ☐

EMG ☐ Nerve Conduction Study ☐

Please mark and list any provider(s) who have treated you for this condition:

Other Orthopaedic ☐	Spine Doctor ☐	Neurologist ☐
Rheumatologist ☐	Pain Management ☐	Physical Medicine ☐
Physical Therapist ☐	Chiropractor ☐	Oncologist ☐
Primary Care ☐	Emergency Room ☐	Other ☐



OCCUPATIONAL HISTORY

Occupation: _____ How long? _____

My job requirements are:

☐ Heavy lifting over 60 pounds/frequent bending and stooping

☐ Medium lifting 30-50 pounds

☐ Lifting 10-20 pounds

☐ My job is highly stressful, it makes me tense

On the human form, draw the location and type of pain you are experiencing using the symbols below.

Numbness + + + +
Burning x x x x
Aching - - - -
Pins and Needles 0 0 0 0
Stabbing / / / /