

Ocala Orthopaedic Group

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Ocala, FL 34471-5570
(352) 351-3422 FAX (352) 351-8260
www.ocala-orthopaedic.com

PATIENT INFORMATION SHEET (ORTHO)

TODAYS DATE: _____

PLEASE PRINT CLEARLY

DATE OF ACCIDENT: _____
(Work Comp or Automobile Only)

TYPE OF CASE: HMO MCARE AUTO ACC. WORKER'S COM. OTHER _____

REFERRING PHYSICIAN: _____

PATIENT NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ AGE: _____ SEX: _____ EMAIL: _____

SOCIAL SEC. #: _____ DRIVER'S LIC. #: _____

PERM. ADDRESS _____
CITY STATE ZIP

MAILING ADDRESS _____
CITY STATE ZIP

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ X _____

MARITAL MARRIED SINGLE WIDOW DIVORCED

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

PARENT/
GUARDIAN NAME: _____ DOB: _____ S.S.#: _____

EMERGENCY CONTACT: _____ PHONE: (_____) _____

EMPLOYER'S NAME: _____

ADDRESS: _____

CONTACT PERSON: _____

PRIMARY INSURANCE NAME: _____

DEDUCTIBLE AMOUNT: _____ CO-PAY: _____

IF DIFF. FROM PATIENT:

SUBSCRIBER'S NAME: _____ DOB: _____ S.S.#: _____

ADDRESS IF DIFF. FROM ABOVE: _____

CITY STATE ZIP

SECONDARY INSURANCE NAME: _____

DEDUCTIBLE AMOUNT: _____ CO-PAY: _____

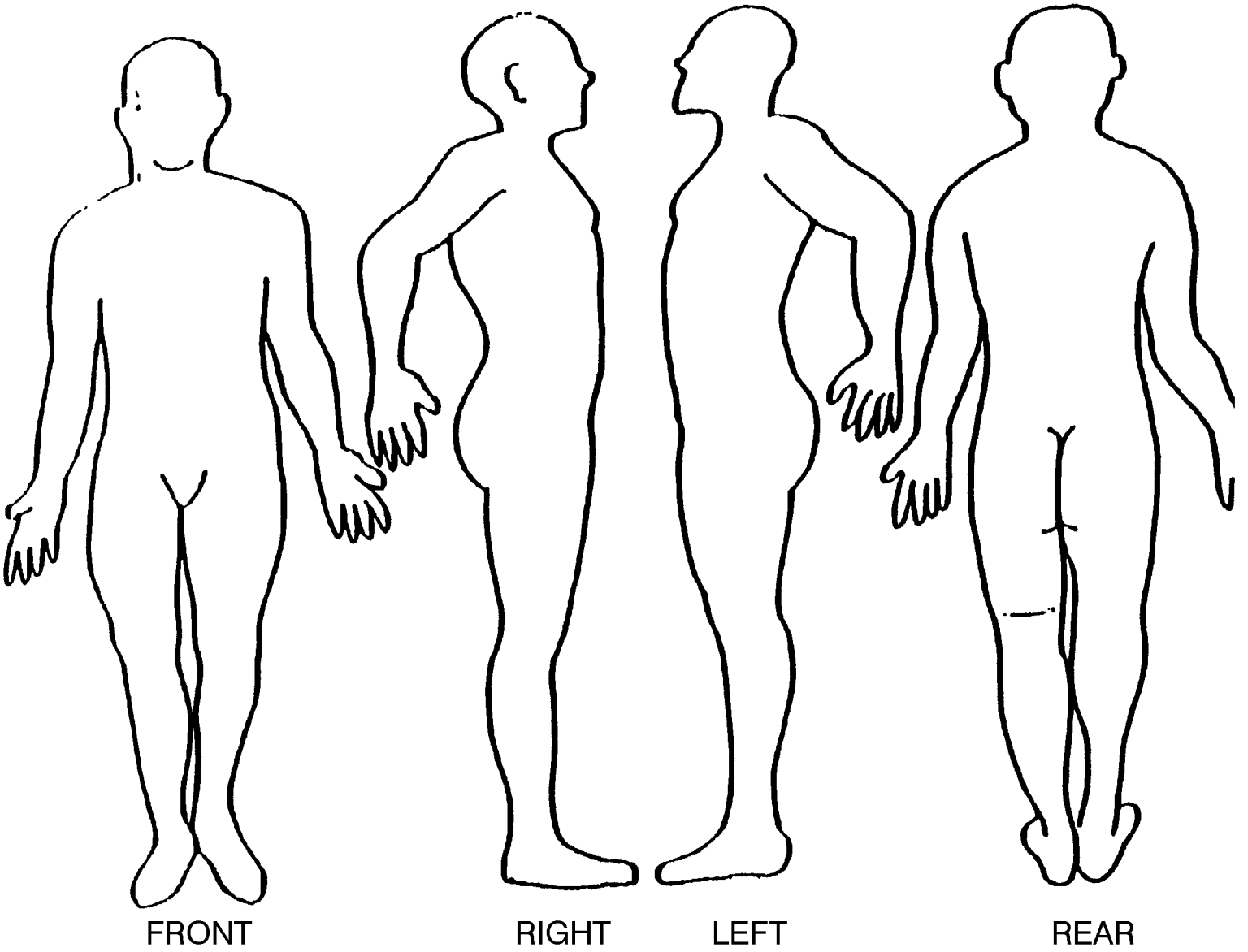
IF DIFF. FROM PATIENT:

SUBSCRIBER'S NAME: _____ S.S.#: _____

ADDRESS IF DIFF. FROM ABOVE: _____

CITY STATE ZIP

PLEASE MARK AREA OF PAIN



PATIENT INFORMATION SHEETS

FAMILY PHYSICIAN: _____ PHONE # _____

BRIEFLY DESCRIBE WHY YOU ARE HERE:

FOR ATHLETES

PLEASE LIST THE SPORTS IN WHICH YOU PARTICIPATE _____

IS THIS VISIT DUE TO A SPORTS INJURY? YES NO

DATE OF INJURY: _____

SITE OF INJURY: NECK SHOULDER ARM WRIST HAND ELBOW
 HIPS BACK LEG THIGH KNEE ANKLE
 FOOT

SIDE AFFECTED: RIGHT LEFT BOTH

ARE YOU RIGHT HANDED? LEFT HANDED?

HAVE YOU HAD XRAYS TAKEN RELATED TO THIS PROBLEM? YES NO

IF "YES" - WHERE TAKEN? _____

HAVE YOU HAD PREVIOUS SURGERY RELATED TO THIS PROBLEM? YES NO

CHECK YOUR PAST OR ONGOING ILLNESSES:

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> ULCERS | <input type="checkbox"/> BLOOD CLOTS |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> HIGH TRIGLYCERIDES | <input type="checkbox"/> STROKE | <input type="checkbox"/> LIVER PROBLEM | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> HEART FAILURE | <input type="checkbox"/> TUBERCULOSIS (TB) | <input type="checkbox"/> MINI-STROKE | <input type="checkbox"/> CIRRHOSIS | <input type="checkbox"/> BLEEDING PROBS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BREATHING PROBS | <input type="checkbox"/> CIRCULATION PROBS | <input type="checkbox"/> YELLOW JAUNDICE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> LEG PAIN/WALKING | <input type="checkbox"/> HIATAL HERNIA | <input type="checkbox"/> BOWEL DISORDER | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> SICKLE CELL DISEASE | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> VERTIGO | <input type="checkbox"/> EYE DISORDER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> POLIO | <input type="checkbox"/> GOUT | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ANXIETY |
| <input type="checkbox"/> CLAUSTROPHOBIA | <input type="checkbox"/> BROKEN BONES | <input type="checkbox"/> TRAUMA/ACCIDENTS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> MIGRAINES |
| <input type="checkbox"/> HERPES | <input type="checkbox"/> SHINGLES | <input type="checkbox"/> VALVE PROLAPSE | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> LEUKEMIA |
| <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> LUPUS | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ARRHYTHMIA | <input type="checkbox"/> VERBAL/PHYSICAL ABUSE | | <input type="checkbox"/> WORK RELATED INJURIES | <input type="checkbox"/> OTHER NOT LISTED |

LIST ALL PREVIOUS SURGERIES: NONE

HOSPITALIZATIONS FOR THINGS OTHER THAN SURGERY: NONE

MEDICINES TO WHICH YOU ARE ALLERGIC: _____ TAPE ALLERGY YES NO
_____ LATEX ALLERGY YES NO

HAVE YOU EVER HAD PROBLEMS WITH EITHER LOCAL OR GENERAL ANESTHESIA? YES NO

PLEASE LIST **ANY AND ALL MEDICINES** WHICH YOU TAKE. THIS SHOULD INCLUDE THE STRENGTH/DOSAGE AS WELL AS HOW OFTEN YOU TAKE IT. LIST EVEN THE THINGS THAT YOU TAKE ONLY OCCASIONALLY. **PLEASE INCLUDE** THINGS LIKE ASPIRIN, TYLENOL, VITAMINS, ALLERGY MEDS, EYE DROPS, HERBAL SUPPLEMENTS (THINGS YOU CAN BUY FOR YOURSELF WITHOUT A PRESCRIPTION.) NONE

ARE YOU PARTICIPATING IN ANY MEDICAL STUDY/PROGRAM/PROTOCOL? YES NO

PLEASE CHECK ILLNESSES WHICH HAVE OCCURRED IN YOUR **BLOOD RELATIVES**:

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> STROKES | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> LUPUS | <input type="checkbox"/> CANCER |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> BLEEDING TENDENCIES |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> LEUKEMIA | <input type="checkbox"/> CIRCULATION PROBLEMS |
| | <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> ABUSE | <input type="checkbox"/> TRAUMATIC DEATH |

OTHER _____

SOCIAL HISTORY: (PLEASE CHECK) MARRIED WIDOWED SINGLE DIVORCED SEPARATED

NUMBER OF CHILDREN LIVING AT HOME _____ LIVING AWAY FROM HOME _____

SMOKE CIGARETTES: YES NO USED TO

ALCOHOL/BEER: YES NO OCCASIONAL RARE USED TO

RECREATIONAL/STREET DRUGS: YES NO USED TO

OCCUPATION: _____ RETIRED (DATE) _____

RELIGIOUS PREFERENCE: _____

HOBBIES/ACTIVITIES: _____

PLEASE CHECK THE THINGS WHICH YOU HAVE EXPERIENCED **RECENTLY** (THE PAST 7-10 DAYS):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> FLU SYMPTOMS | <input type="checkbox"/> FEVER | <input type="checkbox"/> CHILLS | <input type="checkbox"/> COUGH |
| <input type="checkbox"/> SORE THROAT | <input type="checkbox"/> CHEST PAIN/PRESSURE | <input type="checkbox"/> NECK/ARM PAIN | <input type="checkbox"/> WEIGHT/HUNGER LOSS |
| <input type="checkbox"/> RACING HEART | <input type="checkbox"/> SKIPPED HEART BEATS | <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> COLD SYMPTOMS | <input type="checkbox"/> INCREASED GAS | <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> URINARY CHANGES | <input type="checkbox"/> DARK/TARRY STOOLS | <input type="checkbox"/> BLOOD IN STOOLS | <input type="checkbox"/> MUSCLE WEAKNESS |
| <input type="checkbox"/> URINARY PAIN | <input type="checkbox"/> URINARY FREQUENCY | <input type="checkbox"/> UNUSUAL THIRST | <input type="checkbox"/> UNUSUAL HUNGER |
| <input type="checkbox"/> BRUISE/BLEED EASILY | <input type="checkbox"/> EAR ACHE | <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> BOWEL CHANGES |

FOR WOMEN: NAME OF GYNECOLOGIST: _____

FIRST PERIOD: (DATE/AGE) _____ DATE OF LAST NORMAL PERIOD: _____ MENOPAUSE _____

DATE OF LAST MAMMOGRAM: _____ DATE OF LAST PAP/PELVIC: _____

NUMBER OF PREGNANCIES: _____ # LIVE BIRTHS: _____ MISCARRIAGES: _____ ABORTIONS: _____

DID YOU BREAST FEED? YES NO

HAVE ANY WOMEN IN YOUR FAMILY EVER HAD BREAST/UTERINE/OVARIAN CANCER? YES NO

HAVE YOU EVER TAKEN HORMONES OR BIRTH CONTROL PILLS? YES NO

***** IF YOU PLAN SURGERY, PLEASE DISCONTINUE ASPIRIN INTAKE 10 DAYS PRIOR TO SURGERY. *****

FINANCIAL POLICY/LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENTS AND RELEASE OF INFORMATION:

AS YOUR PHYSICIANS, WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE MEDICAL CARE. IN ORDER TO ACHIEVE THIS GOAL, WE NEED YOUR ASSISTANCE, AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED

We accept cash, personal checks, Mastercard, Visa. Returned checks are subject to a \$25.00 service fee and you will lose your privilege of writing checks in our office.

Patients will be responsible for a service charge for accounts sent to the collection agency. The agency bills our office a percentage on the balance of the account.

CANCELLED APPOINTMENTS

Patients who do not cancel appointments can be charged for an office visit if they no-show their appointment.

CHILDREN OF DIVORCED PARENTS

Payment is due at the time of service no matter who is responsible by the order of the divorce decree.

WORKERS' COMPENSATION

We will obtain authorization from the work comp carrier in order for you to be seen. We will file the insurance with your company's carrier. In the event you fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not the result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

FINANCIAL AGREEMENT

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as your medical care providers, our relationship and concern is with you and your health, not your insurance company. **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.** On any balance on your account after 90 days where payment has not been made by either the insurance company or yourself as agreed, collection action may be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

RELEASE OF INFORMATION

I the below named patient, do hereby authorize any physician examining and/or treatment me to release to any third payor (such as an insurance company or government agency, example: Blue Shield of Florida or Medicare) any medical condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

PHYSICIAN INSURANCE ASSIGNMENT

I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

MEDICARE/MEDICAID

Patient's certification authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carries any information needed for this of a related Medicare claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.

MEDIGAP (SECONDARY INSURANCE)

Name of Beneficiary	Health Insurance Company	Medigap Policy #
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I, the below request that payment of authorized MEDIGAP benefits be made on my behalf to OCALA ORTHOPAEDIC GROUP for any services furnished me by (physician/supplier). I authorize any holder of medical information about me to release to OCALA ORTHOPAEDIC GROUP any information needed to determine benefits or the benefits payable for related services.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for my insurance or third payer within a reasonable period of time not to exceed 60 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collections.

CONSENT FOR TREATMENT: I agree to be treated by the staff at Ocala Orthopaedic Group. I understand that I may see a Physician Assistant under the supervision of a medical doctor. 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 examination.

Circle One: **Physician** **PA**

PATIENT'S SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____