ADVANCED ORTHOPEDIC SURGERY

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PATIENT INFORMATION:

Date: ______________

Patient Name: ________________________ Social Security No.: ______________
Last First Middle

Address: ____
Street City State Zip

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Age:________ Sex: ☐ Female ☐ Male Date of Birth: ______________ Height: __________ Weight: __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email: ______________

Race: White / African American / Asian / American Indian *Ethnicity:* Hispanic / Non-Hispanic Primary Language Spoken:__________

Name & SS# of person responsible for Account: ______________

Patient Employer Name & Phone #: ______________ Family Doctor: ______________

Occupation: ______________

Emergency Contact Name & Phone #: ______________ Relationship: ______________

How did you hear about our Practice? ☐ Physician Referral ☐ Friend/Family Member ☐ Yellow Pages ☐ Other: ______________

Name of referring physician: ______________

REASON FOR VISIT: *Which part of the body are we seeing you for today?*

____

Is this problem due to: ☐ Sports Injury ☐ Auto Accident ☐ Work Related ☐ Other: ______________

Date of Injury: ____________ Describe Injury/Accident/Onset: ______________

MEDICAL HISTORY: *Do you or have you ever had any of the following? (check all that apply)* ☐ I have no medical problems

☐ Stroke	☐ Hepatitis	☐ Urinary Tract Infections	☐ Polio	☐ Bleeding Disorders
☐ Hypertension	☐ Cancer - What Kind?	☐ Mental Illness	☐ HIV or Aids	☐ Blood Clots
☐ Heart Attack	______________	☐ Alcoholism	☐ Diabetes	☐ Bronchitis
☐ Heart Valve Disease	☐ Tuberculosis	☐ Depression	☐ Hypothyroidism	☐ Anxiety
☐ Heart Rhythm Problems	☐ Inflammatory Bowel Disease	☐ I am currently pregnant	☐ Low Back Pain	☐ Gout
☐ Stomach Ulcers	☐ Seizures	☐ Rheumatoid Arthritis	☐ Blood Transfusions	☐ Neuropathy
☐ Kidney Disease	☐ Asthma	☐ Osteoarthritis	☐ Lung Disease	☐ COPD

FAMILY HISTORY: *Has anyone in your family had any of the following? (check all that apply)* ☐ I have no medical problems in my family

☐ Stroke	☐ Anemia	☐ Urinary Tract Infections	☐ Polio	☐ Neuropathy
☐ Hypertension	☐ Cancer - What kind?	☐ Mental Illness	☐ HIV or Aids	☐ COPD
☐ Heart Attack	______________	☐ Alcoholism	☐ Diabetes	☐ Lung Disease
☐ Heart Valve Disease	☐ Tuberculosis	☐ Depression	☐ Hypothyroidism	☐ Blood Transfusions
☐ Heart Rhythm Problems	☐ Inflammatory Bowel Disease	☐ Gout	☐ Low Back Pain	☐ Bleeding Disorders
☐ Stomach Ulcers	☐ Seizures	☐ Rheumatoid Arthritis	☐ Anxiety	☐ Blood Clots
☐ Kidney Disease	☐ Asthma	☐ Osteoarthritis	☐ Hepatitis	☐ Bronchitis

SOCIAL HISTORY:

Alcohol Consumption: ☐ Yes ☐ No ☐ Previous User ***If Yes, list type & frequency of use*** ______________

Tobacco Consumption: ☐ Yes ☐ No ☐ Previous User ***If Yes, list type & frequency of use*** ______________

Recreational Drugs: ☐ Yes ☐ No ☐ Previous User ***If Yes, list type & frequency of use*** ______________

PAST SURGICAL HISTORY: *If you have undergone surgery, please give details below* ☐ I have never undergone surgery

1. ______________ Date: ________ 4. ______________ Date: ________
2. ______________ Date: ________ 5. ______________ Date: ________
3. ______________ Date: ________ 6. ______________ Date: ________

ALLERGIES:

Are you allergic to any drugs or medications ☐ Yes ☐ No ***If Yes, which ones?*** ______________

What type of allergic reactions do you have? ☐ Hives ☐ Nausea ☐ Throat Swelling ☐ Rash ☐ Other ______________

MEDICATIONS: *List any drugs, medications or herbals you are presently taking, including strength and how often it is taken.*

Do you use Aspirin or Blood Thinner? ☐ Yes ☐ No

ALL MEDICATIONS MUST BE LISTED...THIS INFORMATION CAN BE CRITICAL TO YOUR HEALTH CARE!

1. ______________ 5. ______________
2. ______________ 6. ______________
3. ______________ 7. ______________
4. ______________ 8. ______________

(OVER)

INSURANCE INFORMATION

Primary Health Insurance Co.: ______________________ Secondary Health Insurance Co.: ______________________

Group/I.D. # ______________________ Group/I.D. # ______________________

Policy Holder's Name: ______________________ Policy Holder's Name: ______________________

Social Security No. ______________________ Social Security No. ______________________

Policy Holder's DOB: __________ Phone: __________ Policy Holder's DOB: __________ Phone: __________

Address/City/ST/Zip ______________________ Address/City/ST/Zip ______________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Other __________ Relationship to Patient: ☐ Self ☐ Parent ☐ Other __________

If applicable, please comlete the following:

Auto/Workers' Comp Insurance Co. ______________________ Address/City/State ______________________

Claim # __________ Group ID# __________ Policy Holder: __________ Phone: __________

Is there an attorney involved? ☐ Yes ☐ No Name of attorney ______________________

INSURANCE ASSIGNMENT

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. However, if your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

I hereby authorize my insurance benefits to be paid directly to Advanced Orthopedic Surgery. I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional service rendered.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______________________ DATE __________

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

PATIENT SIGNATURE ______________________ PATIENT SIGNATURE ______________________

MEDICARE B # ______________________ DATE ______________________

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of medical, psychiatric, alcohol, HIV testing and/or drug abuse information for insurance for insurance carriers or for continuing patient care.

Any of the classifications above may be crossed off if that information is not to be released.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______________________ DATE __________

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient name above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE ______________________ DATE __________

CERTIFICATION OF AUTHENTICITY

I certify that the information provided on this form is complete and correct.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______________________ DATE __________

SUBSEQUENT VISIT — CHANGES TO PERSONAL INFORMATION

DATE OF VISIT	NECESSARY CHANGES	PATIENT OR RESPONSIBLE PARTY SIGNATURE
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Advanced Orthopedic Surgery
250 3rd Street N.W.
Winter Haven, FL 33881
863-318-9696

Consent to release of Information

New regulations which govern the amount of information which may be relayed within our medical office environment and outside medical practices, have been enacted recently by our government, and is known as HIPPA. Please be aware, no release of confidential information will be released to third parties without prior authorization from you, the patient. We do, however, request your level of information release. **Please mark the following to indicate the level of information release:**

_____Approved to submit confidential information to parties related to my medical care and to family members.

_____You may release information to parties related to my medical care,but limit release to family, or other third parties. **(Please list below names or appropriate parties for release of medical information).**

__________________________ Relationship: ____________________

__________________________ Relationship: ____________________

__________________________ Relationship: ____________________

_____ DO NOT release any information regarding my medical care, unless cleared by me personally.

Patient Signature: ___________________________________

Date: _______________

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ACKNOWLEDGEMENT FORM

Our Notice Of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used and released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name: ____

Signature:____

Date: ____

Witness: ____